Tamlyn Cairns Partnership

HEALTH AND SOCIAL CARE NEEDS ASSESSMENT FOR HMYOI COOKHAM WOOD

Commissioned by Health and Justice
NHS England and NHS Improvement
South East

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Tamlyn Cairns is a trading name for a collaboration between Richard Tamlyn Ltd and Claire Cairns Associates Ltd

List of Abbreviations and Acronyms

Acronym	Definition
AA	Alcoholics Anonymous
ABI	Acquired Brain Injury
ACCT	Assessment Care in Custody and Teamwork
ACE	Adverse Childhood Experience
ADHD	Attention Deficit Hyperactivity Disorder
ADHS	Adult Dental Hygiene Survey
A&E	Accident and Emergency
ASD	Autism Spectrum Disorder
AUDIT	Alcohol Use Disorders Identification Test
BME	Black, Asian and Minority Ethnic
BBV	Blood-Borne Virus
BDA	British Dental Association
BMA	British Medical Association
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CD	Controlled Drug
CHD	Coronary Heart Disease
CJS	Criminal Justice System
CMHT	Community and Mental Health Team
CNWL	Central and North-West London NHS Trust
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CSEW	Crime Survey for England and Wales
CSIP	Challenge, Support and Intervention Plan
CUSP	Custody Plan
CYP	Children and Young People
CYPIP	Children and Young People's Indicator(s) of Performance
DART	Drug and Alcohol Recovery Team
DBST	Dry Blood Spot Test/ing
DDA	Disability Discrimination Act
DES	Diabetic Eye Screening
DH	Department of Health
DLD	Developmental Language Disorder
DNA	Did Not Attend
DSW	Designated Social Worker
EHC(P)	Education, Health and Care (plan)
EMDR	Eye Movement Desensitisation and Reprocessing
FTE	Full-Time Equivalent
GP	General Practice/Practitioner
HBV	Hepatitis B
HCV	Hepatitis C
HJIP	Health and Justice Indicators of Performance
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison & Probation Service
HMYOI	Her Majesty's Young Offenders Institution
HO	Home Office
HoH	Head of Healthcare

Acronym	Definition
HNA	Health Needs Assessment
HSCNA	Health and Social Care Needs Assessment
HPV	Human Papillomavirus Vaccine
IAPT	Improving Access to Psychological Therapy
IDD	Intellectual and Development Difficulty
IDTS	Integrated Drug Treatment System
IDU	Injecting Drug User
IEP	Incentive and Earned Privileges
IMB	Independent Monitoring Board
IP	In-Possession (medication)
IPP	Indefinite Imprisonment for Public Protection
LAC	Looked After Child/Children
LADO	Local Authority Designated Officer
L&D	Liaison and Diversion
LD	Learning Disability
LDSQ	Learning Disability Screening Questionnaire
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LTC	Long-Term Condition
MHA	Mental Health Act
MMR	Measles, Mumps and Rubella
MOJ	Ministry of Justice
MOU	Memorandum of Understanding
MPCCC	Multi Professional Complex Case Clinic
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NIS	National Immunisation Schedule
NOMS	National Offender Management Service
NPS/PS	New Psychoactive Substances
NRM	National Referral Mechanism
NRT	Nicotine Replacement Therapy
OCD	Obsessive Compulsive Disorder
OCU	Opiate and Crack Cocaine Use/r
ODD	Oppositional Defiant Disorder
OMU	Offender Management Unit
ONS	Office for National Statistics
OOH	Out of Hours
PD	Personality Disorder
PEEP	Personal Emergency Evacuation Plan
PHE	Public Health England
PIPE	Psychologically Informed Prison Environment
PPO	Prisons and Probation Ombudsman
PSI	Prison Service Instruction
PSO	Prison Service Order
PTSD	Post-Traumatic Stress Disorder
PWP	Psychological Wellbeing Practitioner
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RMN	Registered Mental Health Nurse
SALT	Speech and Language Therapy
SASH	Suicide and Self-Harm
SBAR	Situation, Background, Assessment and Recommendation

Acronym	Definition
SLCN	Speech, Language and Communication Needs
SMS	Substance Misuse Service
SPOC	Single Point of Contact
STC	Secure Training Centre
STI	Sexually Transmitted Infection
T2A	Transition to Adulthood
TB	Tuberculosis
TTO	To Take Out (medication)
WHO	World Health Organisation
YJB	Youth Justice Board
YO	Young Offender
YOI	Young Offender Institution

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PART A

Specific Information for HMYOI Cookham Wood

Chapter One – Introduction

1.1 Aims

This health and social care needs assessment (HSCNA) was commissioned to better understand the health needs of the resident population in HMYOI Cookham Wood and to assess the extent to which the current need and demand for health and social care in the establishment were being met.

The RCPCH Standards require that:

> *A health and wellbeing needs assessment for the secure setting (reviewing physical, mental, substance misuse and neurodisability health including speech, language and communication needs facing the secure settings population) is completed and reviewed every two years, using a structured assessment tool, by the service planners/providers/commissioners with the secure setting.*[1]

The structured assessment tools used for this work are the *Child and Maternal Health (CHIMAT) Youth Justice Health and Wellbeing Needs Assessment Toolkit* (CHIMAT 2012), and the PHE adult prison 'toolkit',[2] combined with relevant NICE guidance.

It should be noted that health needs may be *met* or *unmet* and that there is a difference between a *need* and a *demand* for a service. These concepts are addressed later in this report.

The introduction to our HSCNA approach in Part B contains further detail on the rationale for, and the intended purpose of, this health and social care needs assessment. This is specifically tailored for the needs of young offenders.

1.2 Scope

As is always the case, there is a fine line between undertaking a health needs assessment and a service audit/review. This report focuses on describing the likely and actual health needs of residents and the extent to which they appear to be being met, rather than assessing service efficacy, albeit there is some overlap in places.

1.3 Methodology

The full methodology, and rationale for this are included in Part B.

Appendix A contains the full list of those interviewed in HMYOI Cookham Wood.

A survey designed to gather patient views was administered to residents; a total of 68 responses were received (36% of the resident population based on the operational capacity of 188). The survey results are representative at a confidence level of 90% and confidence interval of +/-8%.

[1] RCPCH (2019) Healthcare Standards for Children and Young People in Secure Settings
[2] PHE (2014) Health Needs Assessment Toolkit for Prescribed Places of Detention (parts 1 and 2).

To supplement the survey, a focus group was held with eight young people on the Cedar Unit; three officers and one of the gym staff were also present and occasionally contributed to the discussion. This particular group was chosen as the most appropriate for a focus group in discussion with the prison and healthcare for several reasons, including:

- They had all been through other parts of the establishment, including Phoenix, the Bridge, etc and were therefore able to comment on issues relevant to those populations as well as their experience on the Cedar Unit.
- They were the only young people at that point in time able to comment on SECURE STAIRS from personal experience.
- As residents on an enhanced unit they were the most likely to participate constructively in a focus group.
- They were some of the most experienced in talking in groups, etc.

There was also a presentation of initial findings and discussion involving the main governor and the heads of primary care, mental health and substance misuse.

1.3.1 Comparative

The Ministry of Justice (MOJ) recently defined a list of 'comparator prisons' (i.e. those which are considered to be similar in size, population type, etc.). The below is a list of comparator prisons for HMYOI Cookham Wood:

Figure 1 – HMYOI Cookham Wood Comparator Prisons

Prison	HNA Available for Comparison?
HMYOI Wetherby	Yes (Offender HNA and Consultancy Projects 2019 – limited comparable data available)
HMYOI Werrington	Yes (Offender HNA and Consultancy Projects 2015 – limited comparable data available)

The MOJ selection of comparators is largely informed by size and security status. From a health perspective, security status is less relevant than turnover and demographic factors. In addition, our team has collated data from over 70 HNAs which we have delivered. We have extracted relevant data from these and include it where applicable.

Although we seek to include comparator data as a benchmark wherever possible, because there are far fewer young offender institutions (YOIs) than other prison types, it has not always been possible to include a large volume of comparative data. Data from our HSCNA for HMYOI Aylesbury (2019) is relatively recent. In terms of health condition prevalence, some data was included from less recent HNAs (namely HMYOI Werrington (2015).

Figure 2 – Age Range Served by Comparators

Establishment	Year of HNA	Age Range Accommodated
HMYOI Aylesbury	2019	18-21
HMYOI Wetherby	2019	15-18
HMYOI Werrington	2015	15-18

To provide a benchmark for change over time, we used some data from the previous HMYOI Cookham Wood HNA (published in 2015).[3] Because comparable data for a number of conditions was not included in this previous HNA, we have also used historical QOF data taken from SystmOne to provide past prevalence for some conditions. We took an average number of patients with a number of conditions covering the period April to June 2015 and used the population of the establishment as reported by the MOJ at June 2015 (173 residents) to calculate a prevalence rate.

1.4 Report Overview

In order to avoid the risk of reporting personally identifiable information, the report sometimes conforms to the convention of suppressing data where describing fewer than five patients. Where there are none, this is stated. One to four patients are usually described as <5.

Part A of this report describes the 'story' of the establishment, specifically looking at:

- Prisoner Demographics
- Healthcare Overview
- Physical Health
- Mental Health
- Substance Misuse Needs
- Screening, Immunisations and Vaccinations
- Safeguarding, Self-Harm and Self-Inflicted Deaths
- Wellbeing and Health Promotion
- Social Care Needs
- Overview and Recommendations

There is a rationale and evidence base for the predictions we have used throughout Part A of the report, these are discussed and outlined in full in Part B, following the same themes and in the same order as those in Part A.

[3] Therapeutic Solutions (2015) HMYOI Cookham Wood: Health Needs Assessment

Chapter Two – Overview of HMYOI Cookham Wood

2.1 Establishment Overview

HMYOI Cookham Wood was originally built for young male offenders in the 1970s. In 2007/8 the site was converted to a Juvenile Centre accommodating 15-18 year old male offenders. Cells are single occupancy, and most have integral sanitation and telephones. The operational capacity (op cap) is 188.

The most recent published HMIP inspection of HMYOI Cookham Wood took place in December 2018.[4] The HMIP inspection was carried out in partnership with the Care Quality Commission (CQC) and OFSTED. It was broadly positive about the establishment and very positive about the health provision:

> *The quality of child-focused health services was very good. Partnership working remained good and clinical governance had improved and was impressive. Access to services had improved but there were still issues in getting children to health appointments and to therapy groups. There was age-appropriate health screening, primary care and vaccination services. Open Road delivered impressive substance misuse services which centred on the needs of the population. The mental health and wellbeing team continued to provide a very good child and adolescent focused multidisciplinary mental health service. Secure Stairs (sic) had started and was being rolled out across the establishment. Medicine management was very effective, with some good pharmacy practices. Dental provision was also very good and the waiting list had been eradicated.*

Most of the young people are held in the main houseblock: three floors with two landings each. A3 tends to be reception/induction and B1 is the Bridge, a step down from Phoenix (the segregation unit) and for those with more complex needs. There is also the separate Cedar Unit, a small enhanced unit of up to 17 young people focused on resettlement. Staffing levels reflect the different levels of need, e.g. the 'standard' level is three officers per landing, with two on Cedar and five on the Bridge.

2.2 Turnover Rate

The following table shows annual numbers of receptions and discharges as reported by the offender management unit (OMU). The governor felt that lack of resource (e.g. CAMHS) in the community was contributing to young people being admitted to custody who would have been more appropriately managed within the community, and that offences were more extreme and sentences longer. It is not clear whether this may be affecting the turnover.

[4] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

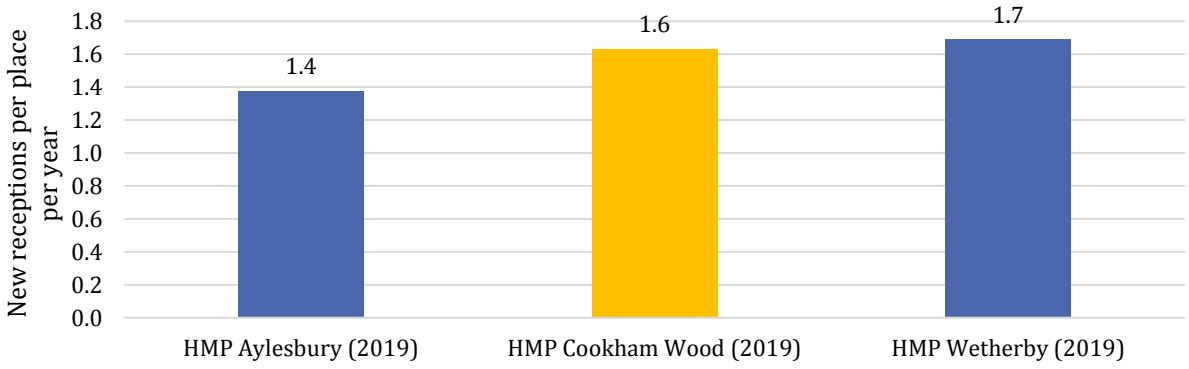
Figure 3 – Receptions and Transfers/Releases

Total numbers	2017/18	2018/19	2019/20 (to date)
Receptions in from the community	427	331	113
Receptions in from other establishments	20	50	13
Transfers out to other establishments	83	95	40
Discharges/releases to the community	275	231	67

The numbers of young men arriving should equal the number departing; as is often the case, in the data supplied the numbers do not appear to add up.

The turnover rate based on new patients recorded on SystmOne was 1.63 for 2018/19 (1.63 new receptions per place per year). This rate is mid-range of comparators as shown in the chart below.

Figure 4 – New Receptions per Place Per Year



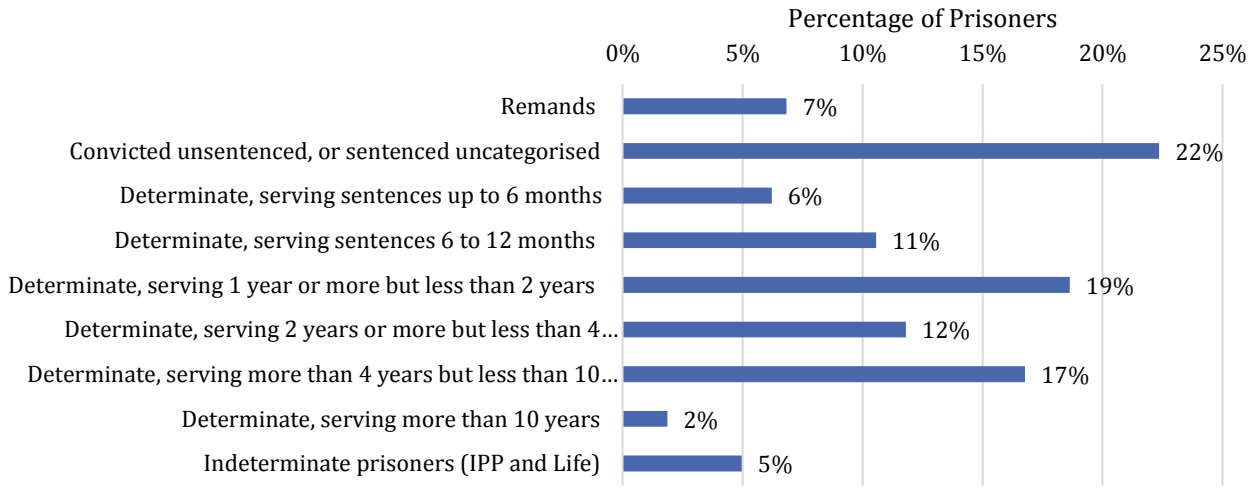
The implication of this low rate of turnover is that there should be more time available within which to screen, assess and treat residents before they move on or are released.

2.3 Offender Demographics

2.3.1 Sentence Status

The young people in HMYOI Cookham Wood have a wide variety of sentencing statuses as shown below. Almost half the population (49%) are serving sentences of a year or more. This reinforces the assumption that there should be time during the person's stay in custody to screen, assess and treat most conditions.

Figure 5 – Population Status (OMU data)



As said, the governor reports a trend towards longer sentences. This may lead to a rise in mental health issues in response to the prospect of a long period of custody. Staff and services recognise this risk and support those concerned accordingly.

Of more relevance to healthcare delivery in HMYOI Cookham Wood than the length of someone's sentence, is how long they spend in the establishment. The length of stay is shown in the table below. Sixty percent have been in HMYOI Cookham Wood for less than six months, and 46% for less than three months. Whilst this should still allow time for most initial screens and assessments, it may not allow time for reviews and to deliver substantial packages of care and other interventions, e.g. a course of psychological therapies.

Figure 6 – Length of stay (OMU data)

Length of Stay	Number of Residents	Percentage of Residents
Less than 1 month	38	23%
1 month to 3 months	37	23%
3 months to 6 months	23	14%
6 months to 1 year	40	24%
1 year to 2 years	25	15%
2 years to 4 years	1	1%
More than 4 years	0	0%

2.3.2 Age

The establishment accommodates young male offenders between the ages of 15 and 18 (inclusive). The current age profile is illustrated in Figure 7 below. Almost two thirds of the population of HMYOI Cookham Wood are aged 17. The youngest is aged 15, and the oldest is 18.

Figure 7 – Age Profile of Population at HMYOI Cookham Wood

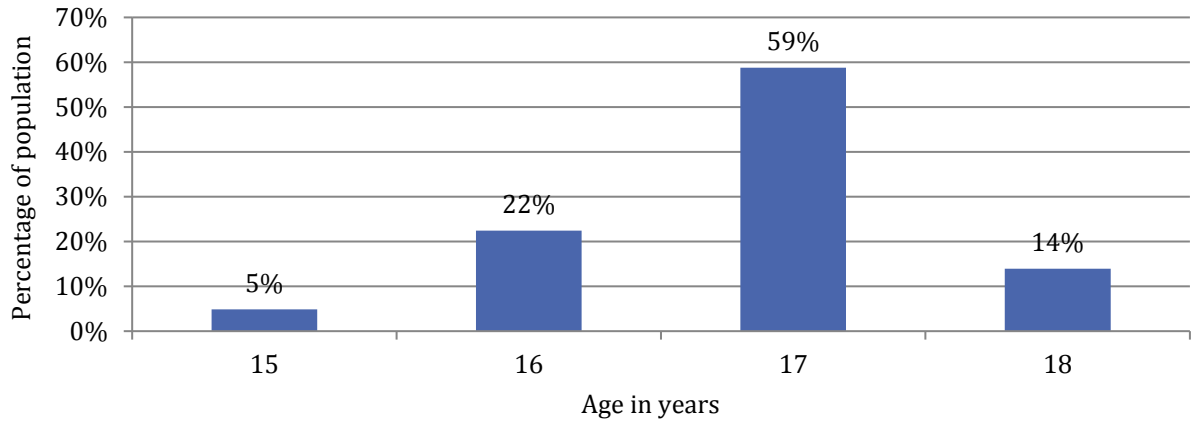
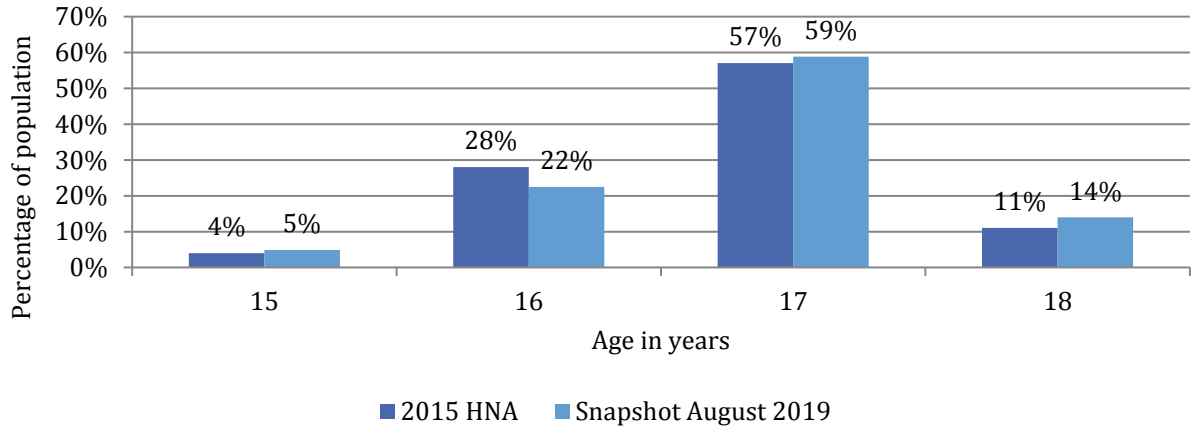


Figure 8 compares the age profile of the current and previous (at the time of the 2015 HNA) populations. This shows little change in the age profile.

Figure 8 – Age Profile of Current and Previous Populations



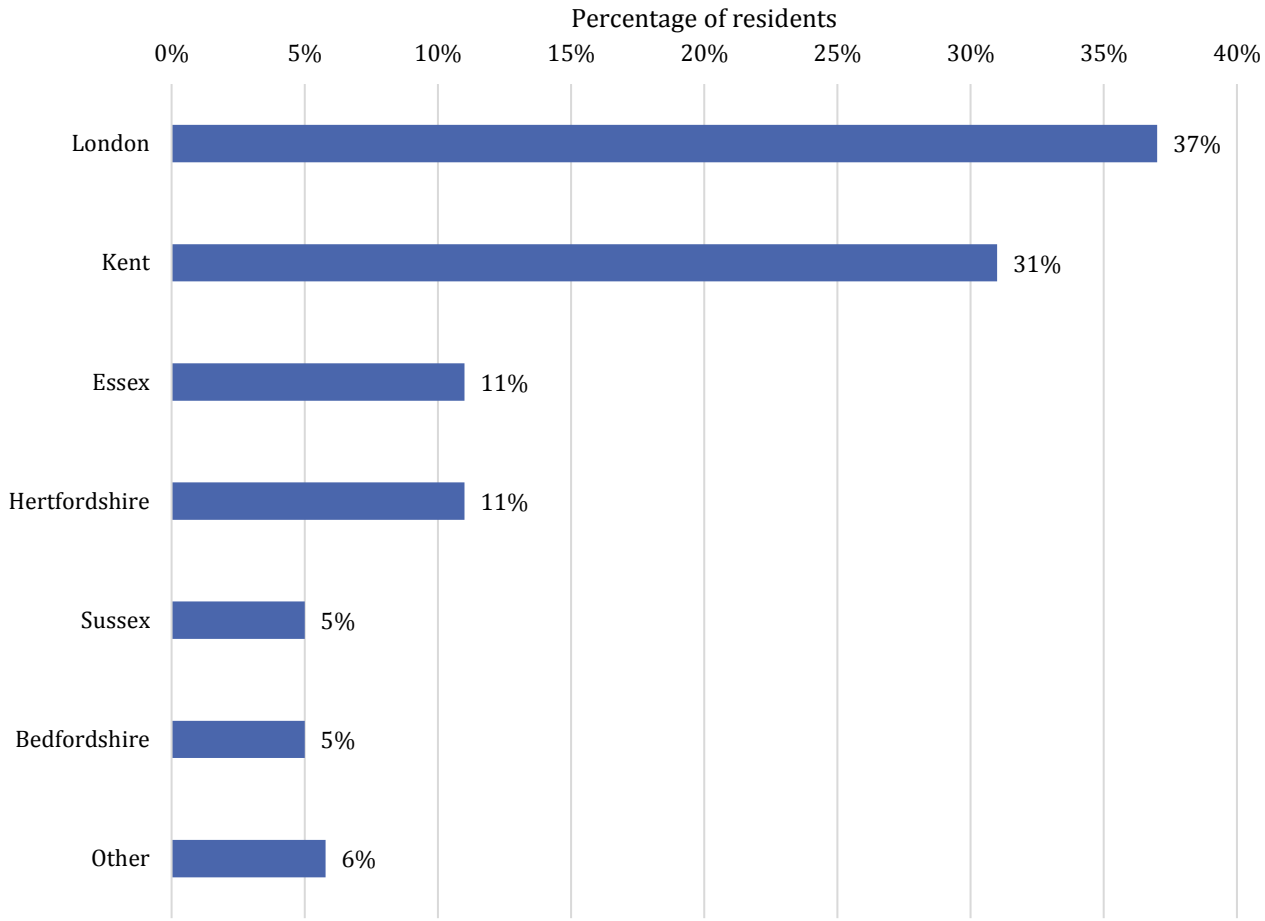
2.3.3 Area of Home Residence

Understanding distance from home is important. For example, in an investigation for the YJB, HM Inspectorate of Prisons notes the negative impact of being held a long distance from home, citing that every 26 miles of additional distance results in one less professional visit to a child.[5] This is particularly relevant for looked after children who may not have family to visit. Staff interviewed for the HNA reported that looked after children in general received fewer visits, presumably even more so if their home authority was some way away.

Data supplied by the OMU showed that 68% of the population of HMYOI Cookham Wood came from London or Kent, with most coming from the south east. This relative proximity should help support family links and the potential for continuity of care, though this is made more difficult where London is concerned by the large number of areas, and hence services involved.

[5] HMIP (2016) Thematic Report by HM Inspectorate of Prisons: The Impact of distance from home on children in custody

Figure 9 – Area of Home Residence

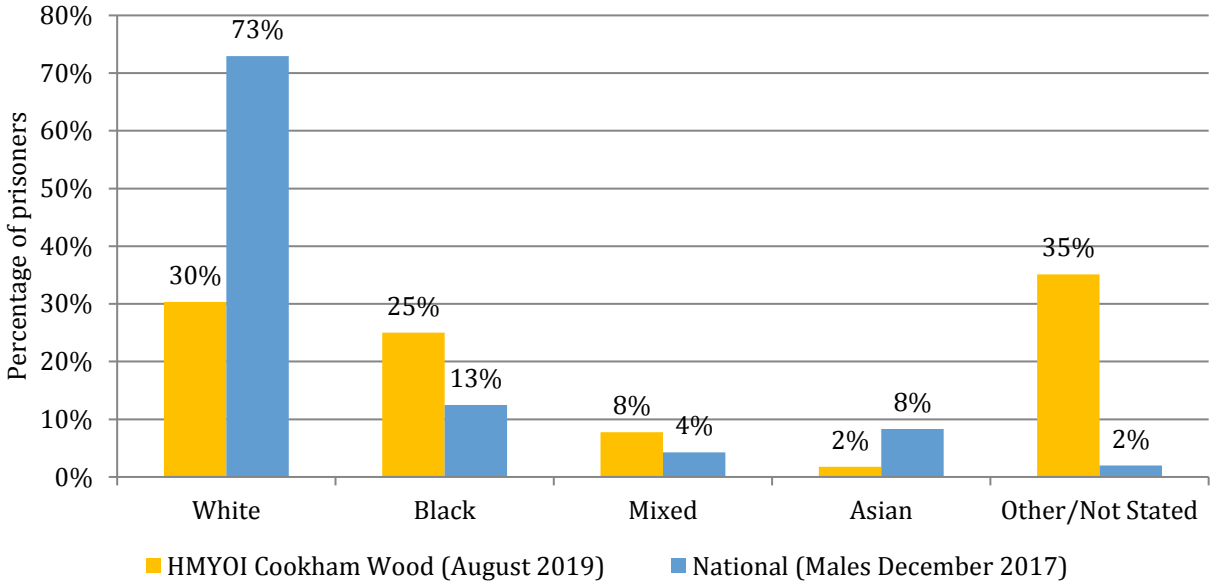


2.3.4 Ethnicity and Nationality

The chart below shows the ethnic profile of the residents at Cookham Wood. From the data supplied it would appear that Cookham Wood is very ethnically diverse with lower rates of residents with white ethnic backgrounds than the national average for males (all ages), however, the ethnicity of 33% of the population is unknown. The recent HMIP inspection[6] noted that two-thirds of the young people at HMYOI Cookham Wood were from a BME background, suggesting that most of the 'unknowns' were in fact BME (although the data we were given had this large category of 'other/not stated', we assume HMYOI Cookham Wood does in fact know the ethnicity of most, if not all, of the residents). Recent moves from HMYOI Feltham may also mean that the current profile is atypical, but it is apparent that a significant percentage of the HMYOI Cookham Wood population is from BME backgrounds.

[6] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

Figure 10 – Ethnicity (equalities data, snapshot June 2019)



HMPPS state that across the prison estate nationally, 11% of the prisoner population consists of foreign nationals.[7] The same data showed that at March 2019, 12.1% (n=21) of the population at HMYOI Cookham Wood were foreign nationals. Data provided by the equalities team showed that, as of an August 2019 snapshot, 13% of the population (n=22) were recorded as being foreign nationals. In the population profile supplied by the establishment for the HMIP inspection in December 2018, that percentage was 10.2%. Staff reported that the foreign nationals all had good, or at least functional, use of English, and the need for translation was rare.

Part B contains references to reports and guidance about the needs of young BME prisoners.

2.3.5 Disability

In this age group, most disabilities will be 'hidden', e.g. learning disability, autism, hearing or communication difficulties and so on. There are few young people with physical disabilities. In the most recent HMIP report prisoner survey (late 2018), 15% of respondents described having a disability, this is lower than the HMIP comparator figure of 20%.

The equalities team supplied data indicating a rate of identified disabilities of 10.8%. SystmOne reports a rate of 8.4%. HMYOI Cookham Wood stated that no residents have a current personal emergency evacuation plan (PEEP).

Figure 11 – Residents with a Disability

HMYOI Cookham Wood	HMIP 2018 Self-Report Survey	Equalities Data (snapshot August 2019)	SystmOne Data (snapshot August 2019)
Residents with disabilities	15% (n=18)	11% (n=18)	8% (n=14)

In relation to mobility issues, there is a stair lift that can be used to access primary care, and the houseblock has lifts.

[7] This figure is from the MOJ Prison Population Data Tool for December 2018 and March 2019.

SystmOne data indicated the following numbers of patients with recorded diagnoses of learning disabilities (LD) or autistic spectrum disorders (ASD). These are discussed in more detail later in the report. It is important to note that this is not an accurate reflection of learning disability at HMYOI Cookham Wood, i.e. there are young people identified with learning difficulties. This is discussed further in the relevant section of the report.

Figure 12 – Learning Disability and Autistic Spectrum Disorder

HMYOI Cookham Wood	Population During 2018/19	Residents at Snapshot August 2019	Patients at Snapshot August 2019 (QOF Register)
Learning Disabilities	0	0	0
Autistic Spectrum Disorders	3.3% (n=17)	4.8% (n=8)	N/A

2.3.6 Sexuality and Gender

Data from the equalities team as of August 2019 reported 100% of the population as heterosexual. In the December 2018 survey distributed by HMIP there were no questions about sexuality, although HMIP reported that the young people were very unlikely to be open about their sexuality for fear of adverse responses from their peers.[8]

The establishment reported that in August 2019 there were no transgender residents, although the relevant policies were in place. The average adult prison rate is 1.6 per 1000[9] (as described in Part B). This would suggest that transgender residents would be infrequent at HMYOI Cookham Wood.

The evidence base suggesting transgender individuals have a significant range of health needs and inequalities is robust and is summarised in Part B. Whilst the health services likely to be needed by this cohort are no different, the likelihood of accessing these services is greatly reduced.

2.3.7 Homelessness

Homelessness is one of many factors that negatively impacts on health. SystmOne data indicated that at August 2019, 4% (n=11) of the residents at HMYOI Cookham Wood were recorded as having disclosed being homeless during the year prior to imprisonment. Of more relevance perhaps is how many may be homeless on release. In most such cases the home authority is responsible for housing the young person, although several of the people interviewed for this report drew attention to how difficult this can be to ensure and that accommodation is often only resolved at the last minute, causing stress and making it more difficult to ensure the suitability of the accommodation and to establish throughcare and post-release support.

2.3.8 Armed Forces Veterans

Given the young age of the residents, we would expect few veterans and for none of them to have seen active service. OMU data reports 9% (n=15), SystmOne reports 0% (n=0). The HMIP survey did not include a question on veteran status. As noted in Part B, veterans who are imprisoned are more likely to be convicted of sexual or violent offences.

[8] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/
[9] *Ibid.*

2.3.9 Parents and Carers

This information is currently not recorded by offender management units (OMUs). The 2018 HMIP self-report survey contained one question regarding caring responsibility for children (*"Do you have children?").* The proportion of residents in HMYOI Cookham Wood who reported being parents was 10%, very close to the average for other YOIs of 10%. Data from the young people's national drug treatment monitoring system (NDTMS) quarterly establishment assurance report for 2018/19 showed a figure of 6% being a parent.

There had, in the past, been some specific provision for this group, but this had been discontinued due to lack of take up. Whilst it may be difficult to ensure the numbers for a viable group, it is important that attention is given to healthy parenting and relationships, particularly for those young people who are already parents. This should be addressed within the formulation plan.

Recommendation 1 – Support young parents in healthy parenting and relationships.

There is further context to this issue in Part B.

2.4 Care Experienced

As described in Chapter Ten and also Part B, there is an enduring responsibility placed on the care leavers' home children's service to support young adults leaving care. During 2018/19, there were 510 residents in HMYOI Cookham Wood (the whole of the population) aged under 21. As described in Part B, it is estimated that 40% of residents under the age of 21 will have been in care. Taking these figures, we estimate that during 2018/19, approximately 204 will have been care experienced, and many will be eligible for leaving care support, albeit from their home local authority area. In our survey, 22% (n=15) of patients said they were or had previously been in care (identical to the 22% at HMYOI Aylesbury). This issue is discussed further in Section 10.5.

2.5 Chapter Summary

- HMYOI Cookham Wood is a relatively small establishment holding 188 young male offenders aged 15-18. Most are 17.
- The turnover and length of stay mean that it should be possible to ensure all the necessary screens and assessments.
- The lengths of sentences mean that it should be possible to ensure most treatment needs are met, but the length of stay at HMYOI Cookham Wood is such that it may not be possible to ensure this whilst the young person is at HMYOI Cookham Wood.
- The recording of ethnic profile is inexact, but it appears that a significant percentage of the population is from a BME background.
- Most residents are from the south east, particularly Kent and London, hopefully helping to maintain family links and to support throughcare.
- Most disabilities are hidden, although screening should identify most. Physical disabilities are rare.
- Few of the young people are parents, but these could benefit from targeted support and interventions. See Recommendation 1.

Chapter Three – Healthcare Provision

3.1 Overview of Healthcare

NHS England has overall responsibility for the commissioning of healthcare in secure settings. HMYOI Cookham Wood is a part of the Children and Young Person's (CYP) Secure Estate and, as such, is considered separately from the adult prisons in Kent and south east England. The relevant commissioner is focused solely on CYP needs in the criminal justice system in the south east.

Oxleas NHS FT has been the lead healthcare provider since 2014. Some aspects of healthcare are delivered by other organisations as listed below. Some are sub-contracted, others are directly commissioned. HMIP noted in their recent report[10] that the healthcare arrangements were complex, although they also noted that these arrangements worked well. When healthcare services at HMYOI Cookham Wood are next recommissioned this will be separate from the nearby adult prisons and as a single integrated service. This is in line with current policy and what happens elsewhere; it would be welcomed by the establishment.

Figure 13 – Healthcare Providers

Element	Provider
Primary care & pharmacy	Oxleas NHS FT
GP	Maidstone Medical Centre (sub-contract)
Dental	Ayub Pangarker (sub-contract)
Optometry	John Rose (sub-contract)
Psychosocial SMS	Open Road (sub-contract)
Clinical SMS	Forward Trust
Mental health	CNWL NHS FT

There is no governor with specific responsibility for health. The main governor oversees this area and SECURE STAIRS. There are the usual partnership, strategic and coordination meetings, and the governor and commissioner also meet. There is a range of meetings specifically focused on SECURE STAIRS. The size of the establishment and the relatively small number of people involved make these processes easier. The Head of Healthcare at HMYOI Cookham Wood is also the Head of Healthcare at next door HMP/YOI Rochester, a very different prison.

Primary care and the establishment both feel that front line health and landing staff get on well, helped by the fact that most of the health staff are on the landings in the main houseblock much of the time. Primary care are seen as accessible by both staff and the young people and are considered to be good at their jobs.

[10] HMIP (2019) Report on an unannounced inspection of HMYOI Cookham Wood 10-20 December 2018

3.1.1 Healthcare in HMYOI Cookham Wood

Healthcare at HMYOI Cookham Wood operates seven days per week. Cover is provided between 7am and 9pm Monday to Friday, and between 7am and 7.30pm on weekends and bank holidays. There are no dedicated healthcare beds. The service is focused on the needs of young people and therefore differs in several ways from healthcare provision in adult prisons.

Healthcare's offices are in the same area near the establishment gate as most of the other departments' offices; the degree of informal and regular contact involved helps to support liaison and partnership working. Healthcare's office space is currently adequate but will be increasingly pressured as the new SECURE STAIRS staff are recruited, although the extra staff should be spread over the establishment and predominantly based where they will be working. There are sufficient SystmOne and Quantum computers. This should still be the case even with the extra SECURE STAIRS staff as they will be mostly on the residential units where there are also SystmOne and Quantum PCs.

Note that SECURE STAIRS staff are in fact part of the mental health team (or vice versa), but throughout this report they are often referred to as SECURE STAIRS in order to highlight the impact of the programme and to make it clearer what is additional to the previously existing mental health provision.

Health have various rooms on the main houseblock, including a large dispensary on the second floor. This is accessible from each landing and carries a fair amount of stock. There is a fully equipped treatment room, office space and a room for 1-1s as well as a room for the optician. There is also a room in reception and a treatment room/office on the Cedar Unit. All cells are single cells, and all the health services can, and do, see residents in their cells on occasion, with officer support.

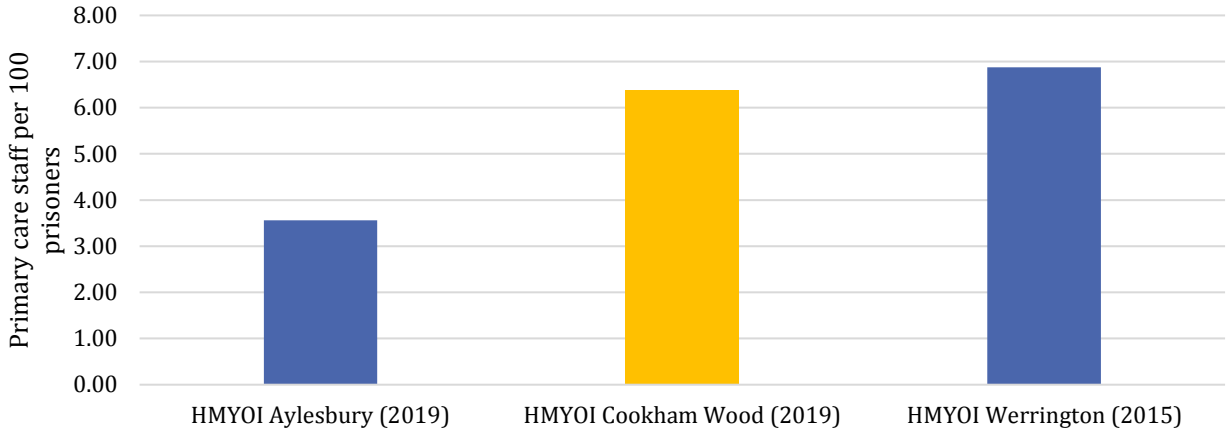
3.1.2 Out of Hours Cover

The Healthcare Operational Manager provides out of hours (OOH) cover for receptions after 21:00 (this is not contracted). Everything else is directed to NHS 111 service or 999 as appropriate, although on occasions staff will ring the Healthcare Manager at home (this is not in his job description or role). Many out of hours presentations end up going to A&E (see discussion below on escorts). NB note that OOH cover is not an NHS England responsibility, rather it is the responsibility of the local CCG.

3.1.3 Primary Care Staffing

Primary care staffing in HMYOI Cookham Wood is a little above average compared to similar establishments where this information is available.

Figure 14 – Primary Care Staffing HMYOI Cookham Wood and Similar Establishments



Note that the above is the *theoretical* staffing model and does not account for vacancies (in any establishment).

The head of healthcare at HMYOI Cookham Wood is currently also the head of healthcare at neighbouring HMP & YOI Rochester. In the current model of provision, if this post was full-time for HMYOI Cookham Wood this might help consolidate the strategic partnerships there as well as other senior functions. However, there may be insufficient need for such a management role to be full-time in a relatively small service, particularly if the funding for the 'extra' half came out of the existing resource. Such a role may end up getting drawn into clinical work as a result, potentially compromising their managerial duties. Looking towards the future on the other hand, an integrated prime-provider model of provision would likely need a full-time post just for HMYOI Cookham Wood to head up the health provision.

The following table describes the current primary care staffing complement (dental, pharmacy, mental health and substance misuse staffing are discussed in the relevant chapters/sections). The emphasis on Band 6 and Band 4 staff makes sense with respect to the difficulty employing Band 5s to work in prisons.

Figure 15 – Staffing HMYOI Cookham Wood Primary Care

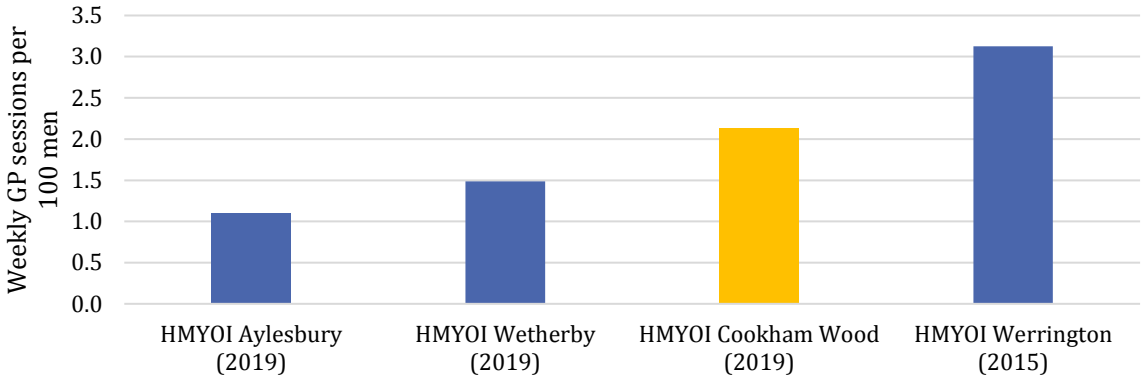
Role	Band (or equivalent)	Full-Time equivalents	Comments
Operational Manager	8	0.5	The other half of the post manages HMP/YOI Rochester
Clinical Nurse Lead	7	1	
Senior Nurse	6	4	
HCA	4	4	
HCA	3	2	
Admin	3	1	

There are also nursing students on placement.

3.1.4 GP Provision

GP availability comprises four sessions weekly: Monday, Wednesday and Thursday afternoons, and Saturday morning (for urgent cases only), indicating a ratio of 2.1 weekly sessions per 100 residents. This is average next to similar establishments.

Figure 16 – GP Cover Comparison



3.2 Clinics, Waiting Times and Did Not Attend (DNA) Rates

There is a wide range of primary healthcare clinics in HMYOI Cookham Wood as summarised below. Escort to appointments is particularly important and challenging at HMYOI Cookham Wood due to the need to ensure various young people are kept apart from each other, e.g. due to gang affiliations. This can take considerable organising and adversely affect clinic usage and attendance at appointments, as also noted by HMIP in their recent inspection.[11] All movement in the establishment is escorted, and primary care have an officer allocated to ensure that movement. They report that there is rarely a problem with patients getting to primary care, although other practitioners (e.g. the dentist) reported that this was sometimes a problem.

The benchmark we use for GP appointments is the Royal College of General Practitioners (RCGP) community average of no more than a two week wait for a routine GP appointment.[12] For all other appointments where any specific time limit is described, both NHS England specifications[13] and HMIP describe six weeks.[14] Each clinic below is reported as red, amber or green informed by this guidance.

Note that a lot of the 'unknowns' in regard to waiting lists in the table below are because these are not separate clinics but categories of health provision that are, in practice, delivered through the general daily clinics or the frequent GP clinics, as the demand is insufficient for a dedicated clinic. As such, most of those categories of waits will be a few days at the most, often less. The DNAs will also be similar, e.g. the 11% for GP clinics.

[11] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/
[12] Pulse (2017) Average GP waiting times remain at two weeks despite rescue measures.
[13] NHS England (2017) Specification Pack. Health Care Services Prison Estate.
[14] See for example: HMIP (2016) Report on an unannounced inspection of HMP Frankland by HM Chief Inspector of Prisons, 22 February - 4 March 2016.

Figure 17 – Clinic Frequency, Waiting Times and DNAs

Clinic	Reported Frequency or FTE	Waiting time (current wait, working days)	DNA Rate (Feb-Jul 2019)	Observations	Needs Assessment (RAG)
Reception	Daily as required.	Minimal, hours at most.	4%	See 3.3.1 Issues can be caused by late arrivals.	
Secondary screening	Daily as required.	Unknown, though 98% within 3 days.	N/A	See 3.3.1 Court appearances can delay this.	
G.P.	4 sessions: Monday PM; Wednesday PM; Thursday PM; Saturday AM (urgent only).	2 days (estimated; no clear waiting list on SystmOne).	11%	See 3.3.1 Court appearances can delay this.	
Non-Medical Prescriber	No set sessions.	N/A	N/A	There is no NMP role in the service, although the Operational Manager is an NMP and sometimes fulfils this function in an emergency.	
Nurse Triage	Daily.	1 day max	No DNAs as small prison and staff will go and find them.	Applications usually seen next day, everybody involved in any incident seen next day.	
Dentist	1 session per week.	6 days	3%	Will add extra session if waiting list increases.	
Optician	1 session per month	Unknown, though reported few on waiting list.	30%	Court can cause delays if clashes with appt. Urgent need rare. Few waiting, will do additional session if waiting list increases.	
Physiotherapy	As required basis.	10 days	14%	Shared resource with HMP Rochester, attending as required (rarely).	
Podiatry	As required basis.	Unknown	Unknown	Shared resource with HMP/YOI Rochester, attending as required (rarely). Urgent need very rare.	
Phlebotomy	As required.	Unknown, though likely days at most.	Unknown	Covered in daily general clinic.	

Clinic	Reported Frequency or FTE	Waiting time (current wait, working days)	DNA Rate (Feb-Jul 2019)	Observations	Needs Assessment (RAG)
ECG	As required.	Unknown, though likely days at most.	Unknown	Covered in daily general clinic.	
Tissue Viability	As required.	Unknown, though likely days at most.	Unknown	Covered in daily general clinic.	
Vaccinations	Weekly clinic.	2 days	13%	Weekly clinic for vaccinations and immunisations though can be done in general (daily clinic) if necessary.	
Immunisations	Weekly clinic.	Unknown	Unknown	Weekly clinic for vaccinations and immunisations though can be done in general (daily clinic) if necessary.	
Sexual Health	As required.	Unknown, though likely days at most.	Unknown	Covered in daily general clinic.	
Asthma	As required.	49 days (disputed by primary care)	Unknown	GPs lead on LTCs, so waits etc. reported as same as for GPs above (i.e. not 49 days). Amber solely due to data concern.	
Diabetes	As required.	Unknown, though likely few days at most.	Unknown	Rare. GPs lead on LTCs, so waits etc. reported as same as for GPs above.	
Epilepsy	As required.	Unknown, though likely few days at most.	Unknown	Rare. GPs lead on LTCs, so waits etc. reported as same as for GPs above.	
Other LTC clinic	As required.	Unknown, though likely few days at most.	Unknown	Rare. GPs lead on LTCs, so waits etc. reported as same as for GPs above.	
Pre-Release	As required.	Unknown, though likely days at most.	Unknown	See 3.3.2 Covered in daily general clinic.	
Smoking	As required.	Unknown, though likely days at most.	Unknown	See 9.2 Covered in daily general clinic.	
Sleep Hygiene	As required.	Unknown, though likely days at most.	Unknown	1-1 as needed, covered in daily general clinic.	
Weight/Healthy Eating	As required.	Unknown, though likely days at most.	Unknown	Rarely an issue, 1-1 as needed, covered in daily general clinic.	
SchoolScreener/DBST/Oral Health Screening.	As required	Unknown, though likely days at most.	Unknown	Mostly done as part of reception process (see 3.3.1),	

Clinic	Reported Frequency or FTE	Waiting time (current wait, working days)	DNA Rate (Feb-Jul 2019)	Observations	Needs Assessment (RAG)
				sometimes again later.	

There are several categories of health interventions that do not have their own clinics and are seen ad hoc in the daily general clinic. As such, the specific waiting times are unknown but are assumed to be one or two days at the most. Similarly, the DNAs are unknown, although the DNAs for the daily general clinic in the table below are a low at 6%. In most cases these interventions are graded green as the need appears to be being promptly met.

Some of the young people spoken to for the HNA described some very long waits including six months for the dentist, a year for the optician and months for a secondary (hearing) appointment, although the last may be at least partly due to primary care taking multiple tests over time to ensure a secondary referral was indicated. Even allowing for some misapprehension of the actual length of time involved, such long waits stand out in comparison to the SystmOne averages. The data suggests, however, that it is likely that long waits are rare (with those currently on waiting lists having waited no longer than six days to be allocated a dental appointment and two months for an optician appointment), and at least partially a product of other factors than waiting lists, e.g. the young person having to go to court instead.

Primary care should monitor any outliers to see where there may be room to reduce these waits. If these are as rare as the data suggests it may be useful to audit them and see how they may be avoided in the future. If it turns out that there are an unacceptable number of long waits, then a more active approach may be needed to bringing these down.

3.2.1 Optometry

Primary care screen for the optician. The optician reported that needs were low as would be expected with young people, and there were few on the waiting list, although the monthly clinic meant that they might have to wait a few weeks until the next clinic to be seen. This could be problematic in certain situations, e.g. if glasses had been broken during a fight. Provision for HMYOI Cookham Wood and HMP/YOI Rochester were a single contract and a single budget, due to run out very soon, i.e. long before year-end. Oxleas normally pick up any deficit, although it might be sensible to review the optician contract and budgets.

Recommendation 2 - Review the optometry budget.

3.2.2 Effective Use of Appointments

The capacity of healthcare services to meet needs is, in part, dependent on the number of patients booked into each clinic, and then also on the proportion of booked patients who actually present to a clinic. Patient non-attendance can impact waiting times for a service and thus its ability to meet needs. As noted above, issues with keeping residents apart from each other can adversely affect clinic attendance. In relation to this, some of the young people spoken to said that concerns about violence sometimes put them off seeking or going to

appointments. Patient feedback from a range of establishments indicates that this dynamic is far more of an issue in YOIs than in adult settings.

Across the range of HNAs conducted by our team, we found that the average DNA rate across primary care clinics has dropped from 20% to 13%. HMYOI Cookham Wood reported an average DNA rate across primary care clinics of 10%, which is both lower than the average and meeting the maximum acceptable rate of 10% determined in the current NHS England specification.[15] However, the DNA rate exceeds 10% in some of the clinics below. Although some clinics have relatively high DNA rates, none have any appointments recorded as 'No access' (patients unable to attend due to factors outside their control, such as prison enablement). It is possible that all non-attended appointments are recorded as DNA.

The average proportion of booked appointments fulfilled at HMYOI Cookham Wood was 90%; this varies between clinics as shown in the table below.

Figure 18 – Regular Clinics, Average Numbers Seen[16]

Feb-Jul 2019	Average clinic sessions per month	Average appointments booked per clinic session	Average seen per clinic session	Percent DNA	Percent 'no access'	Percent actually seen
CHAT 3 (SMS section)	35	4	2.5	39%	0%	61%
Health and Wellbeing Team	6	6	3.8	31%	0%	69%
PC (General Daily Clinic)	31	13	12.2	6%	0%	94%
PC - CHAT 2	27	3	2.5	4%	0%	96%
PC - Dentist	20	6	5.9	3%	0%	97%
PC - External Hospital Appointment	13	1	0.9	10%	0%	90%
PC - Health Promotion	31	4	3.9	1%	0%	99%
PC - HOTEL 1	3	21	21.3	0%	0%	100%
PC - Nurse Led Clinics	42	8	8.1	0%	0%	100%
PC - Sexual Health	18	5	5.0	0%	0%	100%
PC - GP Medication Review	17	8	8.0	0%	0%	100%
PC - GP Surgery	28	2	1.8	11%	0%	89%
PC - Segregation Round	12	11	11.2	0%	0%	100%
PC - Vaccination	4	3	2.8	13%	0%	87%
PC - Physio	1	3	2.7	14%	0%	86%
PC - HCAs	22	6	5.4	12%	0%	88%
PC - Optician	1	6	4.0	30%	0%	70%

Key to RAG rating on above table:

	% patients seen < 70%		% patients seen between 70% & 80%		% patients seen > 80%

[15] NHS England (2017) Specification Pack. Health Care Services Prison Estate.

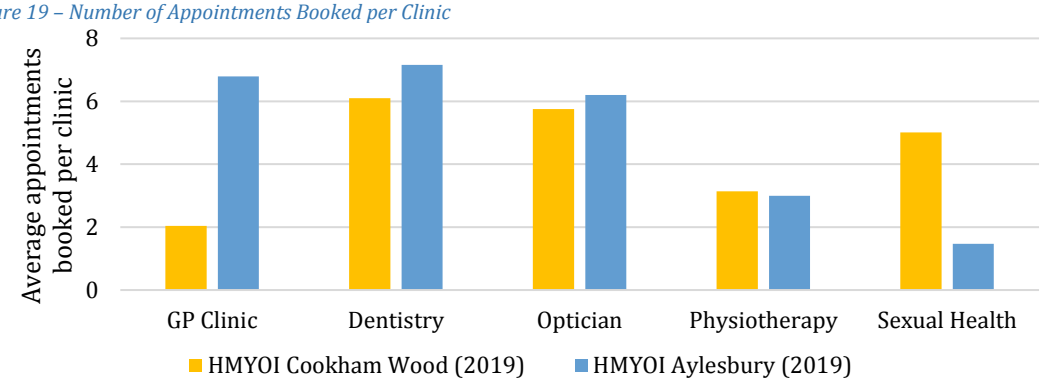
As noted above, all movement in the establishment is escorted, and primary care have an officer allocated to ensure that movement, so primary care DNAs are generally low. Note that the two red-graded areas are not primary care; the first is the substance misuse component of the CHAT, the second is mental health services. The optician was not clear why the DNA rate was so high, though felt that it was likely as the need was not considered pressing by those who did not attend. Primary care report that 'health promotion' as a code can cover a wide range of interventions, though not all might normally be considered health promotion.

Reporting on the number of clinics presents a partial picture. A supplementary issue is how many patients are booked or seen per clinic. The chart below illustrates the average number of appointments booked (planned) per clinic session at HMYOI Cookham Wood and HMYOI Aylesbury (the only similar establishment for which we have comparable data; this data was not available for any MOJ-specified comparator prisons).

At HMYOI Cookham Wood, much lower numbers of patients appear to be booked per GP clinic compared to HMYOI Aylesbury. Primary care felt that this was largely as their GPs worked in a different way than many other prison GPs. They worked more intensively with patients than was perhaps common practice in other establishments where GPs may be more focused on reviews, and they carried out some functions that in other establishments may be carried out by other professions, e.g. the nurses. As shown above, the level of the GP resource is average amongst comparators, suggesting that the resource is about right, although the comparison in clinic use with HMYOI Aylesbury at least, suggests that the GPs could see more patients per session.

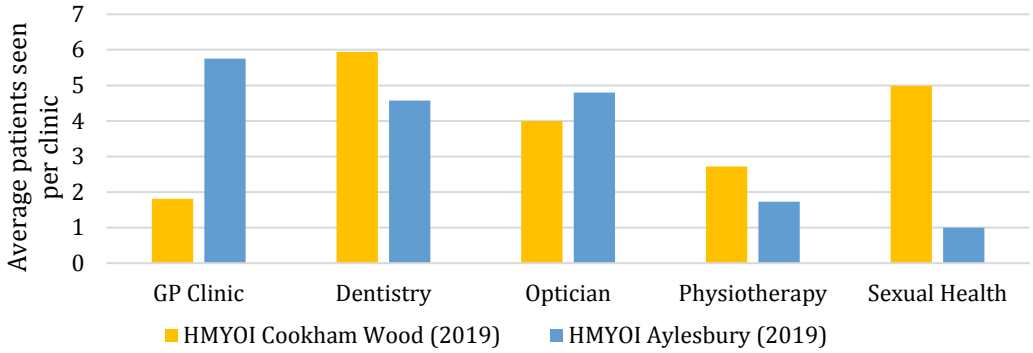
Slightly lower numbers than HMYOI Aylesbury are booked per clinic for dentistry and optician appointments, while higher numbers of appointments are booked for sexual health. Primary care felt the latter difference may be because HMYOI Aylesbury receives from other establishments, i.e. some will have already been tested and treated for sexual health concerns.

Figure 19 – Number of Appointments Booked per Clinic



The chart below shows the average numbers of planned appointments that were fulfilled per clinic session at HMYOI Cookham Wood and HMYOI Aylesbury. The chart shows a similar pattern to booked appointments above; the greatest drop-off from booked to seen is in the optician clinic.

Figure 20 – Number of Appointments Seen per Clinic



3.2.3 Booking Appointments

There are two main ways for potential patients to book appointments themselves. One is the traditional paper application process, the other is a digital approach via a screen (known as the ATM) available on each landing. All applications are screened twice a day by primary care.

We do not have a breakdown of the use of the different methods, although the young people themselves said they would prefer to use their in-cell phones (all cells have a phone except on the Phoenix Unit (segregation)). Currently young people cannot contact health services through these phones, but that is being considered. This could be for booking appointments or for conversations about health concerns, e.g. the call can function as a screen. This could perhaps be piloted on one landing first.

Recommendation 3 – Pilot access to healthcare through in-cell phones.

3.3 Other Aspects of Primary Healthcare Provision

3.3.1 Assessment tools

Children and young people in the secure estate are thoroughly and repeatedly assessed. As one member of staff put it, "*no-one gets missed, they're assessed to death*." The young people themselves reported finding the assessments irksome at times but largely understood and accepted the need for it.

Ideally there would be one single assessment tool or at the least a set of tools that did not repeat questions. This issue has been discussed many timers across youth offending and various attempts made to rationalise assessments, records, etc, but so far to little avail. It is difficult to see how any such simplification could easily be managed in any establishment in isolation as most paperwork is national.

The Comprehensive Health Assessment Tool (CHAT) was brought in across the children and young people's secure estate in 2012 in order to support a more consistent approach to screening and assessment. It is a large and detailed document that is normally completed over several days. It covers all the information normally found in a LAC (looked after child) assessment. At HMYOI Cookham Wood, the CHAT is digital and the templates are embedded in SystmOne. The other main record is Asset Plus – a shared (YOT and prison service)

information system that is focused on offending, though inevitably overlaps with health concerns. Like the CHAT, this can sometimes be a very large document.

Increasingly important and extra to the above is the formulation plan, a key part of the SECURE STAIRS approach. This is a multi-disciplinary plan intended to establish the child's needs and how these can most practically be addressed. This will be led by the Band 7 SECURE STAIRS lead for that landing, with involvement from everyone who has anything to do with the young person and from the young person themselves.

The development and review of this plan should always involve the young person themselves, their health and wellbeing worker, their CUSP officer, their case officer (where different) and the SECURE STAIRS lead for that landing, as well as anyone else potentially involved with them. Once SECURE STAIRS is rolled out this will become the main plan for all aspects of the young person's care and custody. The formulation should cover all aspects of health, not just mental health, e.g. health promotion and any physical health concerns.

The SBAR (Situation, Background, Assessment and Recommendation) screen is carried out by the designated social workers within the first few days. Amongst other things, this screens for trafficking, criminal and sexual exploitation and looked after child (LAC) status.

Lastly, the CUSP (custody plan) is similar, though with more of an emphasis on offending and other behaviour.

3.3.2 Arrival/Reception

There are roughly 30 young people a month passing through reception, as well as those going to and from court (NB any medicines for court are pre-packed and are dispensed in the main houseblock). Receptions are largely Monday to Friday, though there are some received from Saturday courts. HMIP reported that too many receptions were arriving late at night and that this undermined assessments.[17]

There is no health promotion material or media in the reception area (e.g. the waiting rooms). There are televisions in the holding cells, so these could be used to show health promotion or other relevant materials.

Recommendation 4 – Display health promotion and other relevant media in reception.

Primary Care (Hotel 1) cover reception and go there to start the CHAT assessment (CHAT 1) and to use the SchoolScreener (a template designed to help schools assess vision, hearing and basic health needs as well as automating immunisation programmes). This reception screen usually takes place within a few hours of arrival and aims to establish immediate need and risk. The room in reception used by primary care has SystmOne and Quantum PCs and a sink but no couch, although this is not considered a problem by primary care.

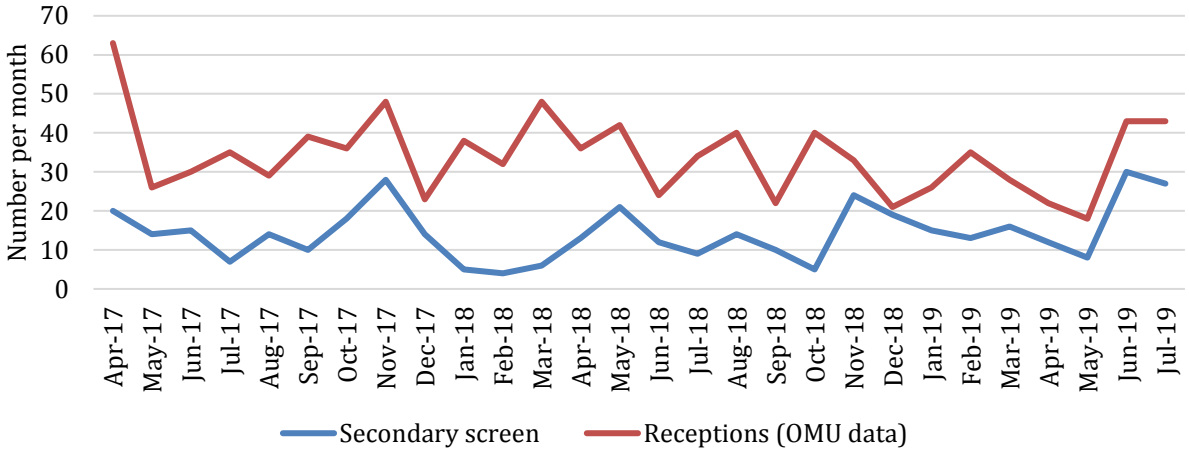
Primary care complete CHAT 2 (health) when the young person has moved to the houseblock. This functions as the secondary screen. Opt-out DBST is also offered as part of the initial

[17] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

screen. One of the young people described being 'made' to do the DBST, and whether this is strictly accurate or not, it does indicate an active opt-out approach. The comprehensive CHAT and full health assessment are usually completed within the first ten days,[18] although court appearances can delay this. The comprehensive assessment may highlight areas for further, more detailed, assessment. The GP assessment takes place within the first seven days, usually within the first few days. Mental health, Open Road and Barnardo's see all new receptions as part of the induction process.

SystmOne data shows that during 2018/19, fewer than five newly-registered patients had a read code on SystmOne explicitly stating a first or secondary reception screening had been carried out. Using read codes indicative of a comprehensive reception screen (including codes relating to BBV screening offers), 51% of newly-registered patients were recorded as likely having received a secondary reception screening. In the chart below, numbers of patients screened appear to follow the same pattern as the monthly number of new receptions to the establishment, although consistently lower.

Figure 21 – Receptions and Reception Screenings (SystmOne data)



In contrast, the CYPIPs (Children and Young People's Indicators of Performance) report for the establishment showed 100% of new receptions having received a reception screen, and 97% a physical health screening within three days of reception between July 2018 and June 2019. This discrepancy in the figures is almost certainly down to the use of the CHAT and the SchoolScreener not being coded on SystmOne in the way primary and secondary screens are in the adult estate. Whilst it would be helpful if the SystmOne coding matched the CYPIPS report, it is not essential. The CYPIPS data and the comprehensive nature of the screens shows that reception screening is comprehensive and timely, suggesting that most risk and need will be being promptly identified.

3.3.3 Release

Primary care see all young people prior to release. Sexual health risks are discussed. Each young person is provided with a GP contact letter and a copy of a template that acts as a summary of their health record, i.e. any current conditions, and interventions received. This

[18] RCPCH Standard 4.5 All children receive a timely full secure CHAT assessment, which includes an assessment of physical health (within three days of their arrival), mental health (within three days of their arrival), substance misuse (within five days of their arrival) and neurodisability (within 10 days of their arrival).

has a section for primary care, substance misuse and mental health. This is good practice that should help ensure continuity of care and reduce post-release risk, although primary care believe the template could be further improved. The young person will also be provided with an appropriate amount of their current prescription and/or FP10s.

Ideally primary care would (with permission) share records with the home GP where this is known, although this may not be clear to very close to release, and on occasions not even then. This could be an opt-out question on the initial assessment, or as part of the pre-release appointment. The rollout of SECURE STAIRS may provide a revised context and reason for reviewing what health information is passed on to community services and it is suggested this takes place.

Recommendation 5 – Review what health information is passed on to community services on release

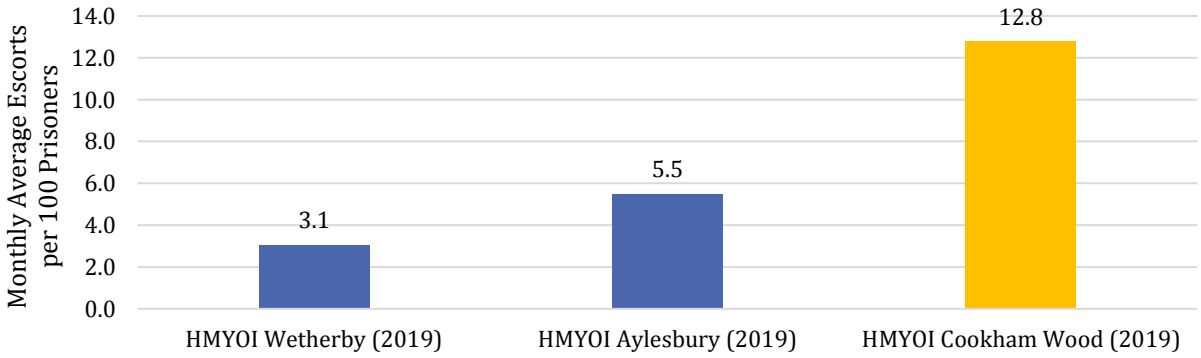
The resettlement team and the relevant youth offending teams (YOTs) work closely on sentence planning and on resettlement. The latter is planned from the time of reception. The YOTs report that it would be helpful if relevant community services were involved in the resettlement planning, particularly CAMHS, but this is rare (largely due to limited resources). The Kent CCGs share a Band 7 CAMHS specialist to support the YOTs, but this role is largely used up in supporting the YOTs in their community provision, often in a consultancy role. The community forensic CAMHS provision is very limited.

There are many challenges in ensuring an effective transition to community services. These are discussed in more detail in the relevant section in the chapter on mental health (as this is when the most difficulties manifest) and in the chapter on social care. Overall, the transition where physical health is concerned is probably good and needs are met, but this is considerably less certain where mental health is concerned.

3.4 Secondary Care, Escorts and Bedwatches

Two escorts per weekday are profiled. There was an average of 24 escorts and less than one bedwatch per month during the most recent twelve months (August 2018 to July 2019). This is less than profiled, although the rate of escorts per 100 residents is high compared to other similar establishments.

Figure 22 – Escorts per Month per 100 Residents Comparison

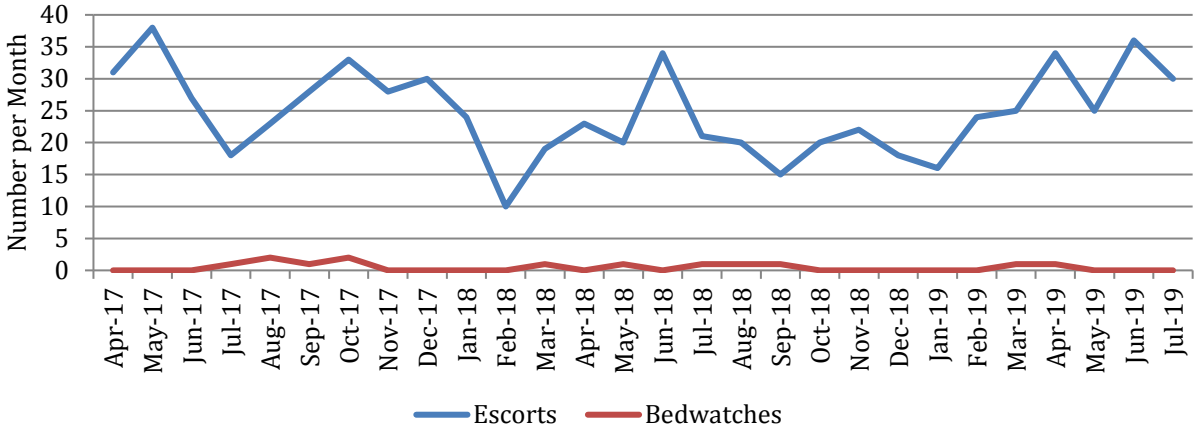


The establishment is keen to lower the number of escorts, and felt that the comparatively high number may be partly because primary care were unnecessarily risk averse. Reducing the profiled number of escorts may act to lower the usage. The establishment also questioned whether some of the outside interventions could be carried out on-site instead. An X-ray machine had been considered but was concluded (appropriately) to not be cost-effective, largely as in many cases the person would still need to attend A&E. Note that the dental nurse is currently undertaking radiography training. Whilst the capacity for facial X-rays would be helpful, it would not be likely to have much impact on escorts for secondary care.

The number of escorts for orthodontics was also questioned, although it was acknowledged that many of these were continuations of treatment begun in the community. A dental van was also considered and rejected for not being cost-effective. There have been several discussions on how escorts might be further reduced, and primary care are seen as willing in this respect, although there has been little further progress made.

As the chart below shows, the monthly number of escorts has reduced gradually over time but appears to have increased somewhat in recent months. Numbers of bedwatches are very low and do not appear to have changed.

Figure 23 – Escorts and Bedwatches

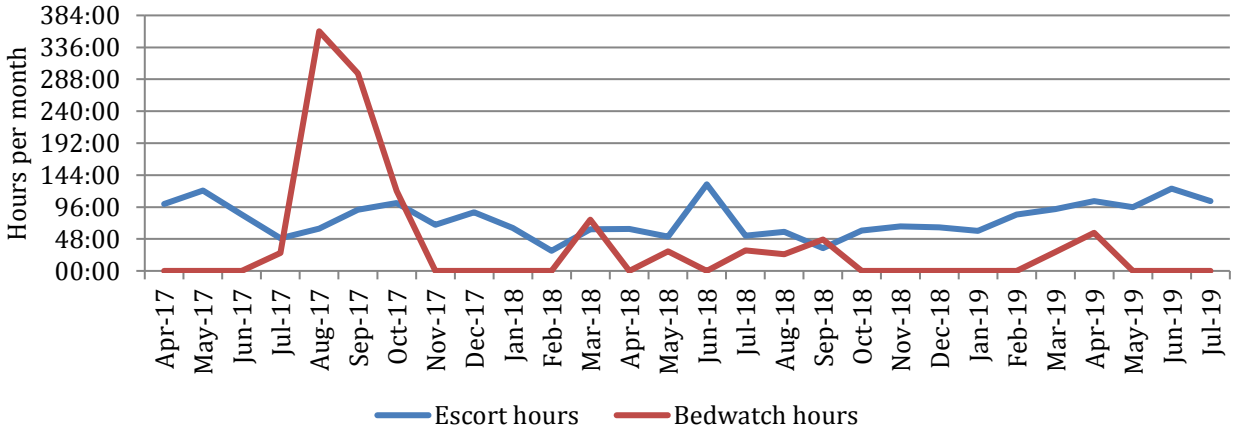


Although the number of bedwatches is much lower than numbers of escorts, the number of hours taken up can be hugely variable, and often much higher than for escorts, with one bedwatch episode potentially lasting several days. There have been no significantly lengthy bedwatches in the last year.

There have been several discussions about reducing the demand for escorts, but it is suggested that there is a formal review of the use of escorts at the strategic level involving the prison, healthcare and NHS England with the aim of agreeing actions to reduce this demand.

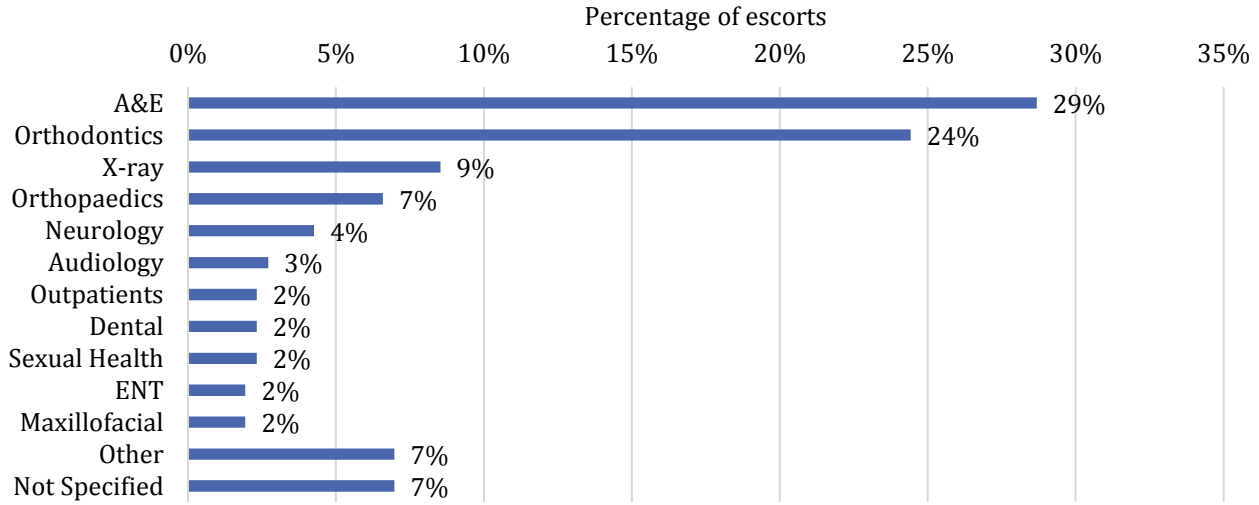
Recommendation 6 – Review the use of escorts for secondary care.

Figure 24 – Escort and Bedwatch Hours



Recorded hospital departments visited on escorts and bedwatches during 2018/19 are shown below – the most common reasons appear to be emergency visits to A&E and orthodontic treatment.

Figure 25 – Escort and Bedwatch Reasons (healthcare data, 2018/19)

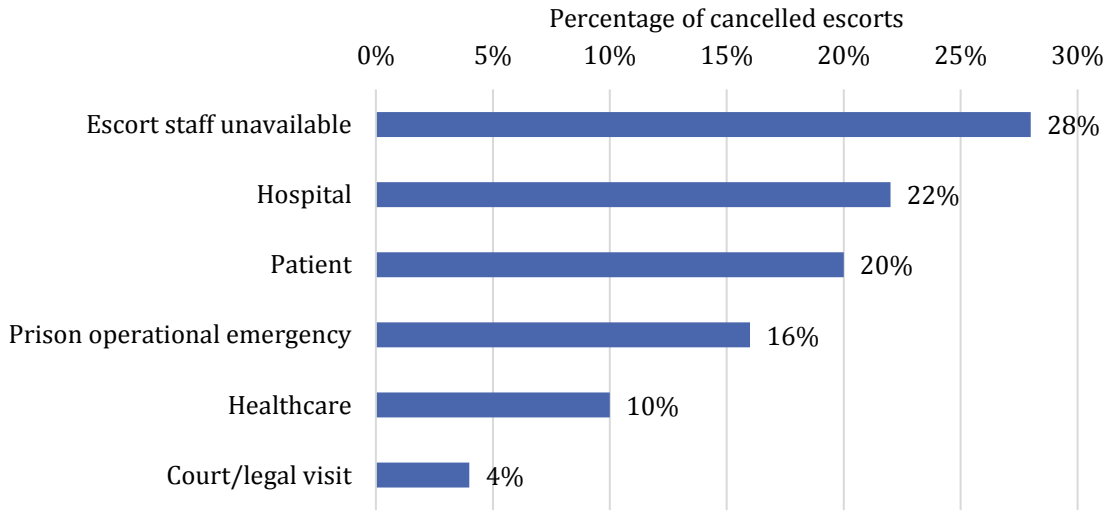


A&E admissions account for 29% of escorts (note that Medway has a separate children's A&E). In common with male young offenders everywhere, violence is exacerbated by gang-related issues. Most of the A&E admissions are related to violence, which can potentially occur at any time when the young people are not locked up for the night.

With respect to child safeguarding in such circumstances, Medway Council raised a point about equity between community and custody related to child safeguarding where injuries are concerned, i.e. that in the community serious injuries would lead to an examination within a safeguarding context by a paediatric consultant, and they were concerned that this was not always happening with the young people from HMYOI Cookham Wood. This could be discussed and reviewed as part of the overall review of social care and safeguarding recommended in Chapter Ten.

Data provided by healthcare showed the following reasons for 50 cancelled escort appointments during the twelve months August 2018-July 2019:

Figure 26 – Escort Cancellation Reasons (healthcare data)



There is an agreed process for establishing priorities when escorts need to be cancelled due to staff not being available, and primary care are always consulted. The establishment and health felt this worked well. One or two of the young people had examples of cancelled appointments they were unhappy about, but most were not that concerned, presumably as in most cases the matter was not urgent.

Telemedicine is not currently available in HMYOI Cookham Wood. Other prisons have used this facility with varying degrees of success. It is not clear that this would significantly impact on the use of escorts considering the reasons normally involved, but this could still be considered.

3.5 Oral Health

Part B explores dental care need amongst younger patients.

The one dental suite is clean and modern and has all the necessary equipment, although the dentist reports that it can take too long to repair malfunctioning equipment (e.g. the compressor), resulting in cancelled appointments and increased waits. There isn't a separate sterilisation room although the dentist did not see this as a problem. There is a SystmOne PC in the room but no phone. Whilst the dentist can access nearby phones – e.g. to arrange translation or to follow up missing patients – this would all be easier if there was a phone in the room.

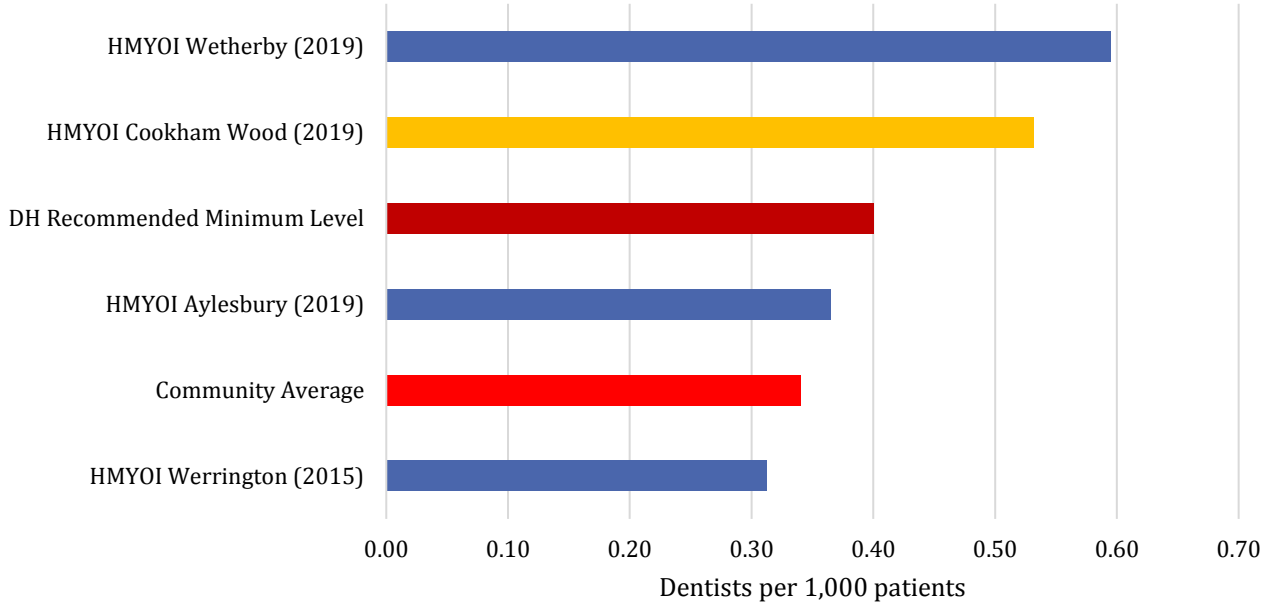
Recommendation 7 – Install a phone in the dental suite.

Oral health is part of the reception screen. The referral pathway is: application ⇒ triage by the dental nurse ⇒ dentist check-up ⇒ treatment. Urgent cases are prioritised and seen in the next available clinic.

The dentist can deliver all the interventions normally available in the community. Other than for orthodontics, only a small number are sent out to secondary care, e.g. for general anaesthetic. Orthodontics is the second largest reason for escorts to outside hospital, accounting for nearly a quarter of all escorts, and the establishment would like this to be reduced. The dentist reports that the dental nurse has an orthodontic background and that between them they are good at triaging such that only appropriate referrals are made, and these are at least category 4 or 5. As such it may be difficult to reduce the demand for orthodontic escorts whilst still meeting the established need.

The chart below shows the level of dental cover in HMYOI Cookham Wood compared to similar establishments where data was available (dentists per 1,000 patients). Cover at HMYOI Cookham Wood is above DH recommended minimum level for a prison.

Figure 27 – Dentist Cover Comparison (dentists per 1,000 patients)



There is one dentistry session provided per week. Healthcare and the dentist reported that further sessions could be added if required to meet need, and that this was used as a way of keeping the waiting list down. SystmOne showed the average wait for the dentist as six days, although one of the young people spoken to for this report said that they had waited six months for an appointment. It is difficult to see how the wait could have been that long. The dentist (and primary care) felt it would help if the uniformed staff supported them in pointing out to the young people that the waits were not long compared to the community.

Effective use of clinic capacity is compromised by some of the challenges involved in keeping some young people apart from others. The dentist felt that this could all be better managed if they had an officer dedicated to the escorts of their patients, similar to primary care.

Recommendation 8 – Ensure dedicated escort of dental patients.

It is likely that most need is met, although some of the young people reported not having had a check-up beyond the basic initial healthcare screen. One said that there "*should be a computerised system for check-ups*", similar to those sometimes used in the community. The dentist reported that the young people's teeth were in generally good condition, particularly young black men, whose parents were often strong on dental hygiene. The dental nurse and the dentist both promote dental hygiene and report that the young people are generally receptive to these messages.

3.6 Pharmacy and Medicines Management

Medicines are dispensed off-site at HMP Rochester. Nursing staff receive, store and administer the dispensed medication. Most medication is named. HMYOI Cookham Wood holds a fair amount of stock but report that the pharmacy is generally reliable, and that if necessary, they will collect the order themselves rather than wait for delivery (HMP/YOI Rochester is next door).

Administration is through several dispensaries across HMYOI Cookham Wood. There is a large, appropriately equipped dispensary serving the main house block on the second floor with hatches serving each landing. Any medicines for young people going to court are administered there (rather than in reception). Forward Trust have their own drugs cabinet in this dispensary, although it hasn't been used for a long time and is likely overdue for a check. There is a small treatment room on the Cedar Unit that can function as a dispensary and has its own secure cabinets; medicines are administered through the gate of that room. Segregated residents are given their medicines through the cell door.

The primary care team in the establishment takes on the role of medicines management and do their own weekly checks, although HMP/YOI Rochester's pharmacy carry out audits as well. Medicine reviews will usually be carried out by the GPs, sometimes by an ANP. Pharmacy are not usually involved unless there is an unusual pattern of prescribing. The recent HMIP report was very positive about medicines management and the pharmacy provision at HMYOI Cookham Wood.[19]

There are no dedicated pharmacy staff at HMYOI Cookham Wood. This is similar to most other establishments for which data was available: HMYOI Aylesbury (2019) also reported no pharmacy staff as did HMYOI Werrington (2015). Although HMYOI Wetherby's most recent HSCNA (2019) does state there is a dedicated pharmacy team, the number of staff is not specified.

3.6.1 In-Person Possession

SystmOne data indicated very few patients having been assessed for suitability for in-possession (IP) medication at HMYOI Cookham Wood, with fewer than five residents at a snapshot in August 2019 having an in-possession risk assessment on record. This is very different to the 100% with a recorded assessment at HMYOI Aylesbury (in 2019), the only similar prison for which comparable data was available.

[19] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

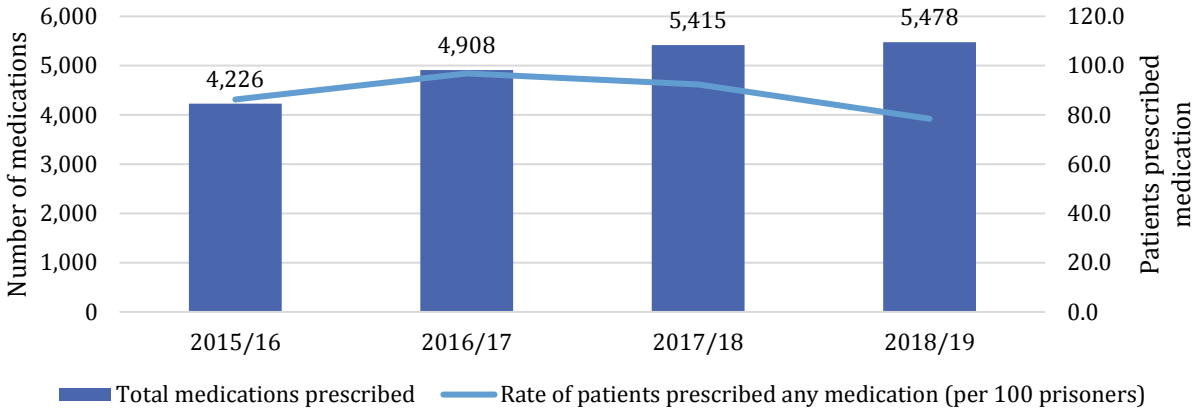
However, the actual rate of in-possession prescribing (during 2018/19) was 5% of medications according to SystmOne data, only a little lower than the 8% at HMYOI Aylesbury. These low rates are broadly appropriate considering the risk profile of the young people and mostly involve things such as acne cream. The young people spoken to about this didn't seem to have a problem with the lack of IP prescribing for other medications.

It is apparent that the default approach at HMYOI Aylesbury is to risk assess even when it is unlikely that the person would be considered appropriate for IP, whereas the default at HMYOI Cookham Wood appears to be the opposite, i.e. to assume that the person should not even be risk assessed for their medication unless it is something completely harmless. Whilst this approach saves work it may mean that some potentially safe IP prescribing is overlooked. Primary care are considering increasing the use of IP, particularly on the Cedar Unit.

3.6.2 Levels of Prescribing

Prescribing data from SystmOne shows a rise in the number of medications prescribed over the past few years, although this has been stable for the last two years. However, the rate of patients receiving medication during the year has reduced slightly.

Figure 28 – Total Prescribing (SystmOne data)

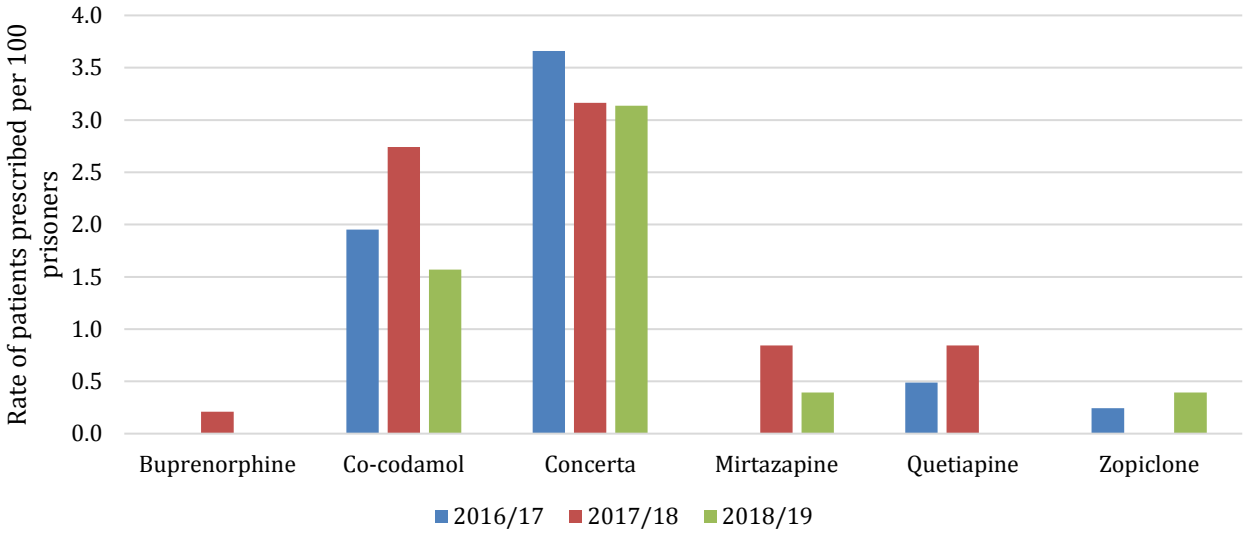


3.6.3 Tradable and Controlled Drugs

At present there are very few controlled drugs prescribed (mostly Concerta) and these are all supervised. Data from CYPIPS reporting for the establishment showed that between July 2018 and June 2019, an average of 2% of patients receiving supervised medication did not attend to collect their medication. Primary care report that this was usually ADHD medication.

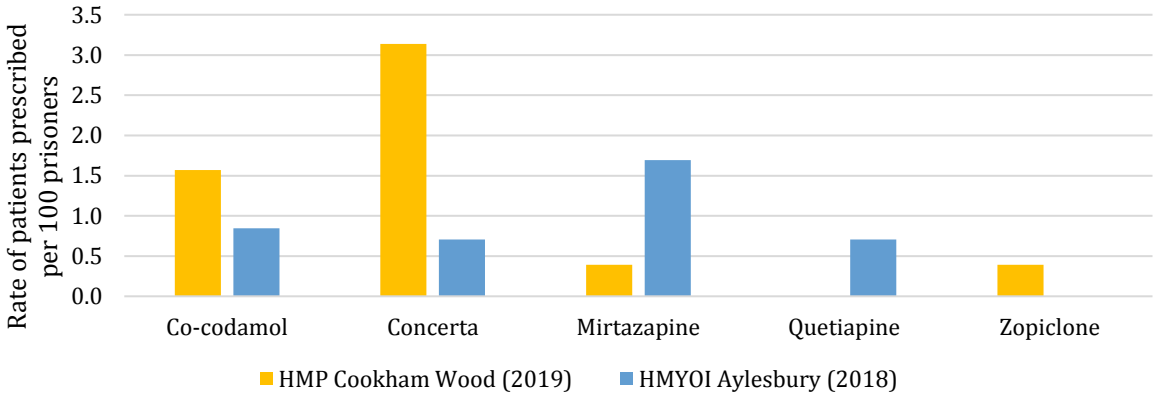
The amount of prescribing of the most potentially tradable medications has always been low, though SystmOne shows this has declined further over the last few years. In contrast to adult prisoners, the young people didn't have any views on this, perhaps at least partly as they were quite negative about some drug misuse, particularly of system depressants.

Figure 29 – Rate of Prescribing of Tradable Medications



In comparison to HMYOI Aylesbury, the only similar prison for which comparable data was available, HMYOI Cookham Wood had higher prescribing rates of Co-codamol, Concerta and Zopiclone, but lower rates of patients being prescribed Mirtazapine and Quetiapine. The numbers involved are quite small however and not necessarily significant of unmet need or over-prescribing. The assessment, treatment and pharmacy processes discussed in this chapter suggest that most need is likely being appropriately met.

Figure 30 – Tradable Medications Comparison



There are no homely remedies available from the canteen. Primary care did not see the necessity of supplying these occasionally as problematic, and none of the young people interviewed for this report felt that it mattered particularly where they got homely remedies from.

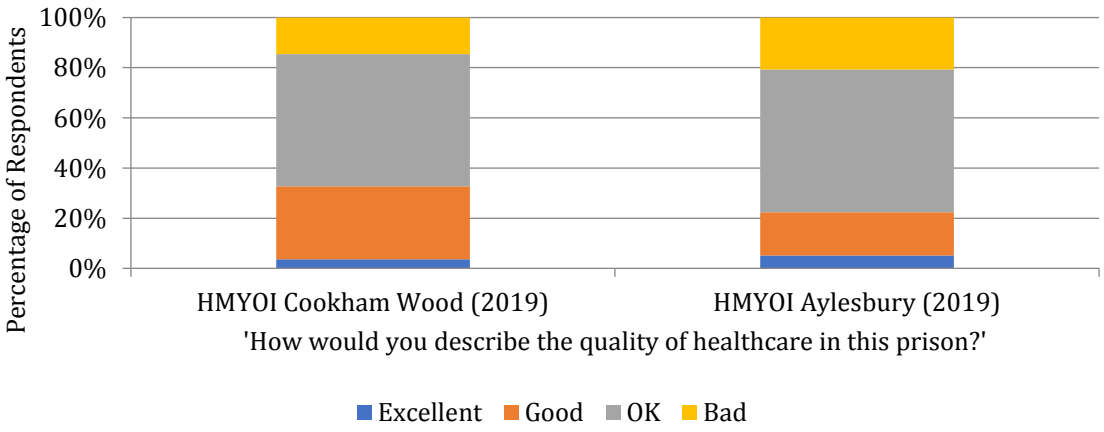
Of those received into the establishment in receipt of prescribed medication, 68% were received with at least seven days' medication.

Looking at to take out (TTO) medication, CYPIPS data showed low numbers of patients leaving HMYOI Cookham Wood while in receipt of prescribed medication, with just 16 patients over the most recent available twelve months needing an FP10 prescription (of whom 15 received one). This is likely reflective of need, e.g. ADHD prescribing.

3.7 Survey Views on Healthcare at HMYOI Cookham Wood

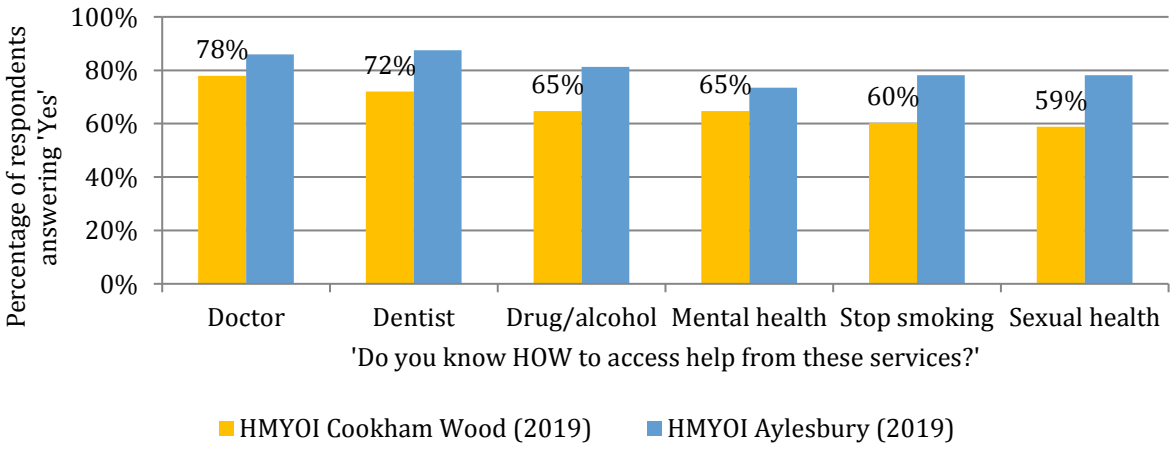
In the resident consultation, the percentage with positive views on healthcare was slightly higher than HMYOI Aylesbury (the only similar establishment we have recently surveyed), with 26% of patients reporting that they thought healthcare was 'excellent' (3%) or 'good' (23%). This concurs with the recent HMIP report[20] where there was a high level of satisfaction with health services expressed. Several of the young people spoken to for this report felt that most of the health staff were approachable: "*the nurses and doctors are good.*"

Figure 31 – Opinion of Healthcare Overall (survey data)



However, in contrast to the slightly higher reported satisfaction with healthcare services, reported confidence in accessing most services was lower than at HMYOI Aylesbury. Patients were most likely to say they were aware of how to access primary care services, and least likely to be aware of how to access sexual health services. Participants in the focus group felt that most people did in fact know how to access primary care and, if they didn't, they would know how to find out. Similarly, they would go through primary care to access other services if necessary, or ask the landing staff.

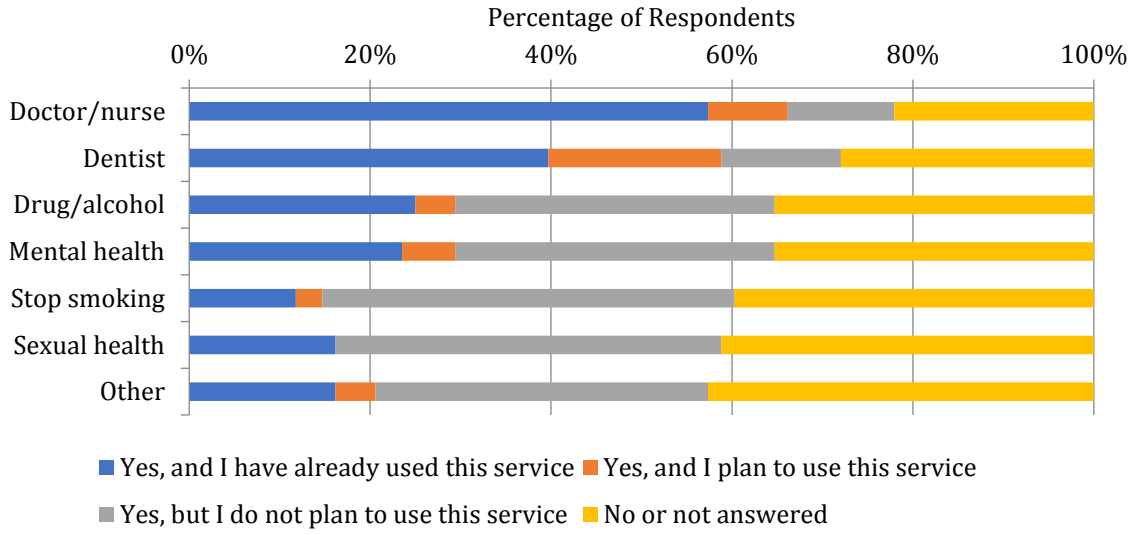
Figure 32 – Confidence in Accessing Services (survey data)



[20] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

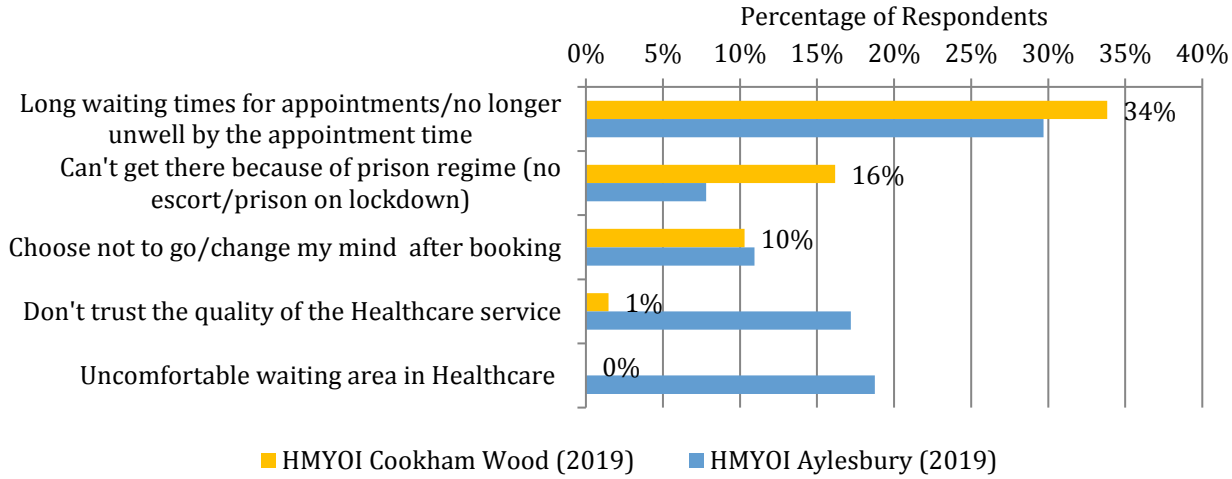
For a number of services, there was a high proportion of patients who reported knowing how to access the service but did not plan to use it, as can be seen in the chart below. This was particularly true for smoking cessation and sexual health services, indicating that these services may be well-promoted but not perceived as required by many patients. This was borne out by the young people spoken to for this report, specifically that some health issues were only relevant when they were pressing, e.g. they had toothache, were withdrawing from nicotine or were being asked about their sexual history at reception.

Figure 33 – Patient Access to Healthcare Services (survey data)



Patients were asked *"What stops you going to healthcare?"* – the most common reason cited was a long waiting time for appointments, followed by access problems due to the establishment regime. Patients were considerably more likely than those at HMYOI Aylesbury to report being put off by problems relating to the establishment regime (see earlier discussion on internal escorts). There were no free text comments to elaborate on the concern about waits, although comments from the young people interviewed suggested a low tolerance for almost any length of wait.

Figure 34 – Reasons for Avoiding Healthcare Visits (survey data)



3.8 Chapter Summary

- There are several different health providers, although they work well together and with the establishment. The staffing is adequate to meet most of the health needs.
- Health provision is appropriately child-focused, and it is likely most need is identified and met as much as it can be whilst people are at HMYOI Cookham Wood. The young people have generally positive views of most aspects of healthcare.

- SECURE STAIRS is being implemented and will change the way most prison and other staff work.
- There is an appropriate range of clinics, access is straightforward, and waits are low, however the need to keep some young people apart from each other wastes resources and undermines efficiency.
- The optometry budget needs review. See Recommendation 2.
- Ninety percent of health appointments are attended.
- Most cells have phones, though these cannot be used to communicate with health. See Recommendation 3.
- Young people are comprehensively assessed.
- There is no health promotion or other relevant material in reception. See Recommendation 4.
- There can be considerable challenges in ensuring throughcare into the adult estate or the community, particularly with mental health. See Recommendation 5.
- Levels of escort and bedwatch are higher than comparators and the prison are keen to reduce them. The most common reasons are A&E and orthodontics. See Recommendation 6.
- The dental suite is adequately equipped though lacks a phone. See Recommendation 7.
- Dental provision is good, and waits are low. DNAs might be improved if there was dedicated escort profiled. See Recommendation 8.

- Pharmacy and medicines management are good.

Chapter Four – Physical Health

4.1 Long-Term and Chronic Conditions (LTCs)

Throughout this chapter, we have estimated the prevalence for each condition for HMYOI Cookham Wood, weighted for the age profile of the current resident population. Often the predictions are for very low numbers, so one or two patients can make a disproportionate impact against the prediction. The separate Part B report includes more general background context, prevalence estimates and commentary on methodology including age-weighted estimates.

Although we seek to include comparator data as a benchmark wherever possible, because there are only two MOJ-specified comparators for HMYOI Cookham Wood it has not been possible to include a large volume of comparative data. Where possible, we have also included data from HMYOI Aylesbury, although this is not specified by the MOJ as a comparator. Our comparison also includes some data from less recent HNAs (namely HMYOI Werrington (2015)).

The previous HNA included only limited data on long-term conditions; to supplement this data, we have used historical QOF data taken from SystmOne. We took an average number of patients across a range of conditions covering the period April to June 2015, and used the MOJ-reported population of the establishment at June 2015 to calculate a prevalence rate.

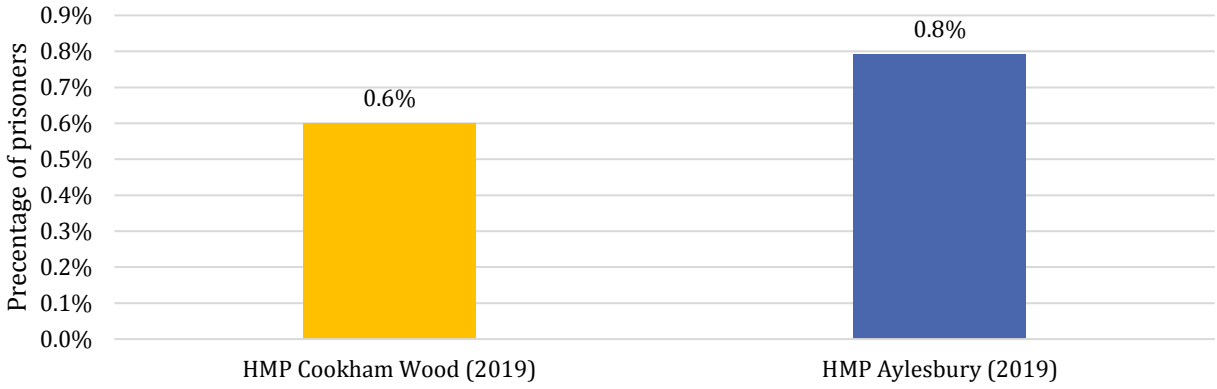
There is a strong correlation between LTCs and social inequalities. In wider society, compared to the highest social class, those in the lowest social class have a 60% higher prevalence of LTCs and a 30% higher severity of conditions.[21] Typically, disproportionate numbers of prisoners are drawn from the most deprived areas. However, being a young offenders' institution, HMYOI Cookham Wood is expected to have a low prevalence of most long-term health conditions.

4.2 Comorbidity

The recorded prevalence of comorbid physical health conditions at HMYOI Cookham Wood would be expected to be very low, even zero at times, and rarely involving the more serious LTCs such as cancer or heart disease. The figures for physical comorbidity at HMYOI Cookham Wood are slightly lower than those at the one similar prison for which data was available, but conclusions cannot be drawn from this due to the very low numbers involved. This data was not available from the previous HSCNA or for either MOJ-defined comparator. There is no reason not to assume that when there are comorbid conditions these are identified and responded to appropriately.

[21] The Kings Fund quoting from Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition.

Figure 35 – Comorbidity Comparison (two or more long-term physical health conditions)



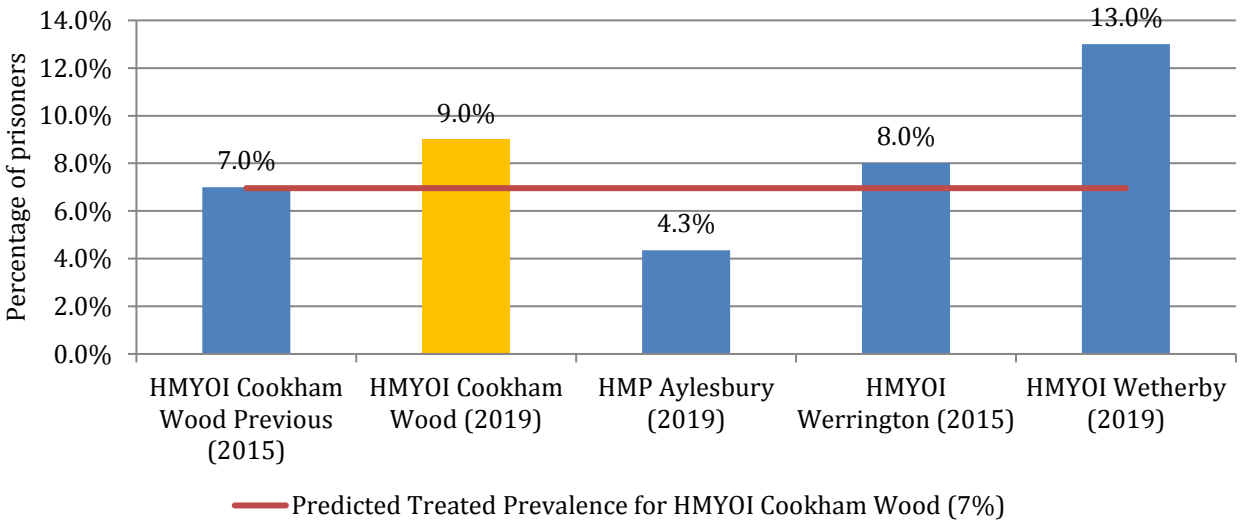
4.3 Asthma

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology with respect to asthma.

Asthma is by far the most significant long-term physical health condition to be found at HMYOI Cookham Wood and amongst young people in general. The Band 7 clinical nurse lead leads on asthma.

Based on the age-related prevalence of asthma and the current snapshot population, we would expect to see 32 residents (19%) diagnosed with asthma and 12 young people (7%) treated. Both the diagnosed and treated rate are slightly higher in HMYOI Cookham Wood than would be expected, with 35 (21%) having a recorded diagnosis on SystmOne and 15 (9%) recorded on the QOF register as being currently treated. The difference between expected and actual prevalence is not large enough to be significant but does suggest that the use of QOF and the approach to long-term disease management is effective and that the need is being identified and met. The disparity between the diagnosed and treated numbers is likely due to historical diagnoses which have not yet been reviewed and/or removed from SystmOne. The rate of treated asthma in HMYOI Cookham Wood has increased slightly since the time of the last HSCNA and is a little higher than the comparator average of 8.4%.

Figure 36 – Asthma Prevalence Comparison (QOF data)



4.4 Chronic Obstructive Pulmonary Disease (COPD)

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

Based on the prevalence of COPD and the current snapshot population, we found that the rate of residents in HMYOI Cookham Wood identified with COPD was lower than the predicted estimate of 1.3% (two patients) which, because of the age group, was likely to be too great. At the April 2019 snapshot, there were no residents with a recorded diagnosis on SystmOne. This was the same as at HMYOI Aylesbury, and the same as at the time of the last HNA. In all cases, the numbers involved are between zero and two and therefore highly vulnerable to fluctuation.

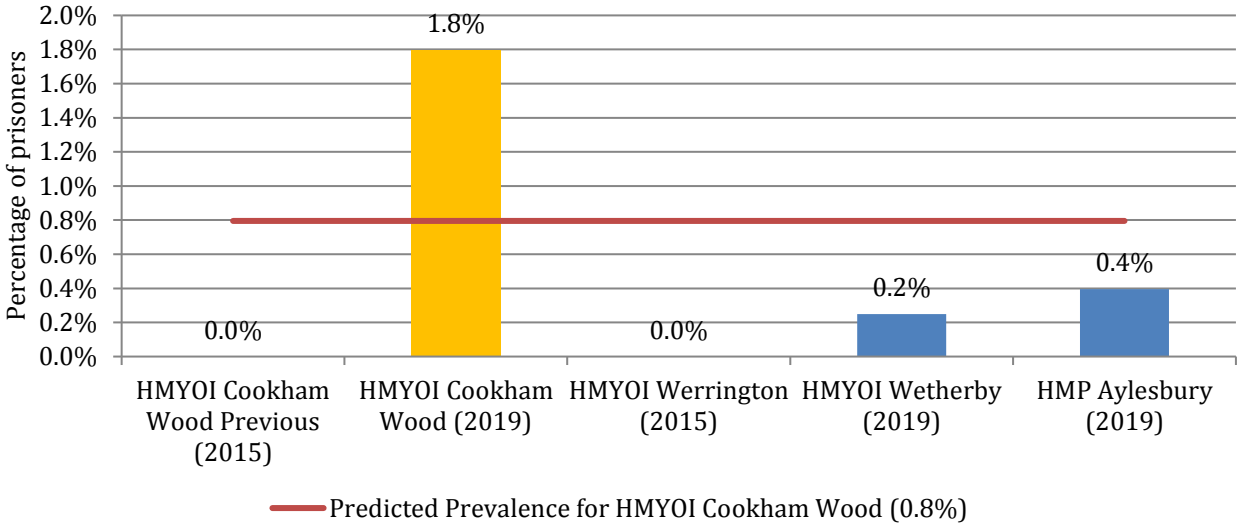
The data and the effectiveness of the management of asthma at HMYOI Cookham Wood suggests that when there is a case of COPD this would likely be identified and responded to appropriately.

4.5 Diabetes

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

The predicted prevalence of diabetes, based on age-specific prevalence data, and the current age profile at HMYOI Cookham Wood, is one resident (0.8% of the population). The identified and treated prevalence in HMYOI Cookham Wood is slightly higher (n=<5) than the predicted prevalence. Diabetes prevalence is higher than comparators and has increased since the time of the last HSCNA; this reflects the rise of diabetes amongst young people in the community, as described in Part B.

Figure 37 – Diabetes Prevalence Comparison (QOF data)



This level of variation is not likely to be meaningful where such small numbers are concerned, but does reinforce the view that any need at HMYOI Cookham Wood is likely to be identified and met. Primary care report that diabetes is rare, and that there is rarely a need for retinal screening. However, when there is need, this is done through secondary care, i.e. the young person is taken to an outside hospital.

4.6 Epilepsy

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

Identified rates of epilepsy are below the predicted prevalence, with two predicted and no patients being treated. There were also no treatment patients at the time of the last HSCNA and this is similar to comparator establishments, with none identified at HMYOIs Werrington or Wetherby and 1.2% at HMP Aylesbury.

The treated prevalence (no patients) refers to those on the QOF register as being prescribed medication for epilepsy, and thus should only include cases that have been medically verified (and will exclude those who might be thought to have epilepsy because they are prescribed anti-seizure medication for unrelated conditions e.g. bi-polar). There are fewer than five young people recorded on SystmOne as having an epilepsy diagnosis (not necessarily current or confirmed). At the time of interview (September 2019) primary care reported that one of these was queried and was being assessed. The variation between expected and actual prevalence is not significant where such small numbers are involved, and the ongoing assessment suggests that need is being identified and met.

4.7 Hypertension and Coronary Heart Disease (CHD)

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

The identification rate for hypertension is much below the expected prevalence for diagnosed and treated patients based on the population age profile – we would expect eight patients with hypertension (5.0%), while none were diagnosed or treated. This is the same as at HMYOI Aylesbury, the only similar establishment with available data.

Identification for CHD is close to the predicted rate of 0.1%, with 0% of the population diagnosed and treated. This is the same as at HMYOI Aylesbury.

There were also no patients identified with CHD and hypertension at the time of the previous HSCNA.

The gap in the hypertension figures is significant and suggests that possible need is not being identified (or met). This is surprising, as assessments are very thorough, although it is possible that some of the anticipated hypertension may manifest later, i.e. after the initial reception assessments. It is possible that there is currently no unmet need, but the existing procedures should be reviewed to ensure that all need would be identified.

Recommendation 9 – Primary care to review hypertension screening to ensure best practice.

4.8 Sickle Cell Disease

Part B describes sickle cell and possible interventions. Fewer than five patients at an August 2019 snapshot were recorded as having the condition. Need will have already been identified in the community and the young person themselves will also be aware of it, so it is likely that all such need is identified and met.

4.9 Cancer

The separate Part B report includes more general background context, prevalence estimates and commentary on methodology.

As of August 2019, there were no residents in HMYOI Cookham Wood on the QOF register for cancer. This is below the expected prevalence (0.7% or one resident) based on current evidence. Cancer prevalence was also zero at HMYOI Aylesbury. This variation in numbers is not significant and does not necessarily indicate unmet need.

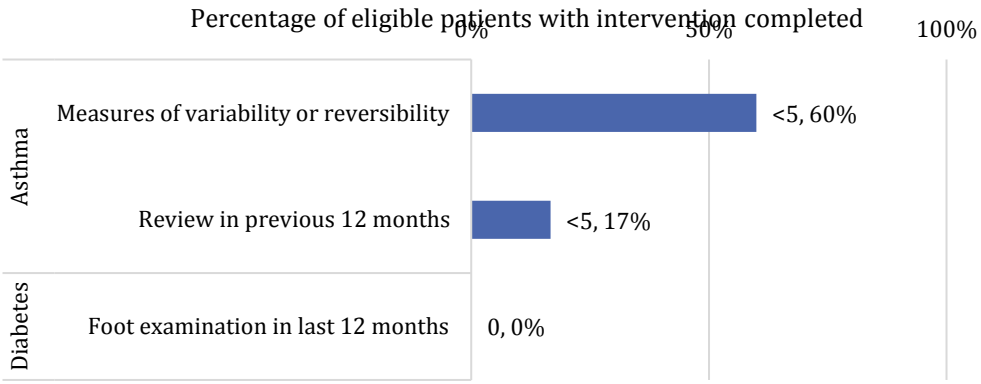
4.10 Skin Conditions

Skin conditions such as eczema and acne are common long-term conditions. Whilst these are rarely serious in health terms, they can be very troubling for the young people concerned. Healthcare report that skin conditions are relatively common and there are several young people with low level acne, although few require a clinical treatment. Note that one of the GPs is a dermatology GPwSI.

4.11 Management of LTCs

The 'How Am I Driving' QOF report states the number of patients eligible for various interventions related to the management of their health conditions (such as patient reviews and diabetic foot checks) and then numbers for whom a record of these interventions exists on SystmOne. The only conditions with eligible patients reported were asthma and diabetes. The figures below suggest a lot of reviews are being missed.

Figure 38 – QOF How Am I Driving Data



The long time period over which some of these indicators are tracked (usually 12 months) means that some patients will have been in the community or in a different establishment for some of that time. The data above reflects activity at HMYOI Cookham Wood only, since if a patient has an intervention recorded at a previous establishment, they will not be considered eligible at the current establishment. Full data and explanations of each indicator can be found in Appendix B.

It is possible that the appropriate checks or reviews were carried out elsewhere, although there can be a difficulty in confirming previous reviews, particularly those that took place in the community. The young people cannot be relied upon to know whether they have been reviewed or not and when that might have been. However, primary care need to be assured of any recent checks and, if there is doubt, should ensure the review themselves.

Recommendation 10 – Ensure QOF reviews for LTCs.

GPs lead on all the LTCs except asthma, which the Band 7 clinical nurse lead leads on, although some of the monitoring may be carried out by nursing staff in regular clinics. Primary care aim to ensure the QOF interventions, although the QOF data in the chart above suggests that this can be difficult. Primary care report that this is at least partly due to the short stays of some of the young people, i.e. that some are not yet due a review and for others it is not possible to fit one in.

4.12 National Screening Programme

As noted in Part B, there are few elements of the National Screening Programme which are relevant to the young offender prison population, as most are aimed towards those aged 35 and over. Only retinal screening for patients with diabetes may be applicable to younger

residents. CYPIPS does not report on these screenings; SystmOne showed no records of retinal screenings for any patient over the last three years (see above).

4.13 Deaths from Natural Causes

The Prison and Probation Ombudsman (PPO) reported no deaths from natural causes at HMYOI Cookham Wood since 2015, although the time lag involved in producing the final report can be as much as two years. Healthcare and the establishment reported one recent death from natural causes; this is noted below. At the time of interview (September 2019) there had not yet been an inquest, and the PPO investigation was still in its early stages and yet to formally report.

Figure 39 – Deaths Due to Natural Causes

Initials	Date Deceased	Comments (including whether the person passed away in prison or hospital/hospice)
CS	27/07/2019	Deceased in hospital (Kings)

Self-inflicted deaths are discussed later in the report.

4.14 Chapter Summary

- Many of the long-term conditions associated with adults are rare amongst young people such that there may be few or no cases at HMYOI Cookham Wood.
- The most prevalent LTC is asthma. Figures are slightly higher than expected with 15 (9%) on the QOF register. Asthma (and COPD) need is likely being identified and met.
- Numbers with diabetes, epilepsy, CHD, sickle cell disease and cancer are very low or zero, within expected range. It is likely that any need is identified and met.
- The expected prevalence of hypertension is eight, though none were reported on SystmOne, perhaps indicating unidentified and unmet need. See Recommendation 9.
- Long-term skin conditions are relatively common.
- Whilst historical data may be hard to access, the QOF register suggests some LTC reviews may be being missed. See Recommendation 10.
- Deaths by natural causes are uncommon. The cause of a recent death has yet to be confirmed but is expected to be of a natural cause.

Chapter Five – Mental Health

5.1 Strategic Framework and Approach to Mental Health

In common with mental health in much of the children and young people's secure estate, HMYOI Cookham Wood have a broad view of what concerns are included, i.e. as well as the more 'traditional' mental health diagnoses such as anxiety and depression, there is a range of emotional and conduct disorders that generally do not receive the same level of attention or resources in the community. The more common conditions, such as depression, are generally less prevalent than attachment and trauma-related disorders. This is recognised by both the health providers and the establishment. The mental health team at HMYOI Cookham Wood are known as the 'health and wellbeing team' to reflect this more holistic approach. There is inevitably considerable crossover between health/behaviour/offending problems and interventions, recognised in the SECURE STAIRS approach.

HMYOI Cookham Wood is in the process of changing its approach to mental health and the operational and clinical frameworks and pathways involved. The previous approach was broadly a stepped-care tiered approach, where the intensity of intervention increased in line with the intensity and complexity of the mental health problem. This was often with reference to the wider context and to the young person's behaviour and attitudes, although the extent to which this more psychologically informed approach was possible was always limited by insufficient resources, particularly of psychologists.

The stepped-care approach will still apply in the new model, but within the wider context of SECURE STAIRS (and CUSP). This is discussed further throughout this chapter, but can be summarised as a multi-agency approach within a psychologically (and trauma) informed environment. The key components of the revised provision will be:

- The formulation (plan of care) meeting
- Direct interventions with the young people
- Facilitated group reflective practice for staff
- 1-1 supervision/guided reflective practice for staff
- The therapeutic milieu

This will complement the CUSP (custody plan) approach also being rolled out across the establishment (essentially a sentence planning/personal officer scheme). The transition to the SECURE STAIRS approach is currently (September 2019) in the initial stages of a phased implementation that may take another year to establish and potentially another year or two beyond that to become thoroughly and effectively embedded.

Progress so far has been slower than anticipated and most involved are concerned that progress may continue to be slow, although the senior management team are keen to progress. Several of those interviewed felt that the custodial managers would be key to the long-term success of SECURE STAIRS.

There are other initiatives competing for staff training time and attention, and there is a shortage of appropriately qualified staff nationally, and a shortage of appropriate physical space for meetings and sessions, although plans are in place to address these and other issues. There is already consistent staffing on each landing ready to act as the core of the multi-

disciplinary team as the roll-out continues. Senior staff believe that the officers so far involved in SECURE STAIRS like the approach, although initial views were mixed. NB a key role for the Band 7 staff currently being recruited for SECURE STAIRS is to lead the project on their landing and to help and support landing staff in that transition to a different way of working.

To date, HMYOI Cookham Wood is the largest establishment and the only public YOI to implement SECURE STAIRS. It is likely that there is more to implementation than simply scaling up what has been tried elsewhere, particularly as there will be even bigger YOIs moving to SECURE STAIRS in the future. There is considerable scrutiny, support and cross-establishment networking already in place that should help with this process.

SECURE STAIRS has so far (September 2019) only been implemented on the Cedar Unit (17 beds), which is an enhanced unit where the young people are close to release and/or on enhanced privileges. This was an unfunded pilot with eight or nine young people to help maintain momentum and enthusiasm for SECURE STAIRS and to scope and try out some of the plans involved. This is generally considered to have been a success by staff and by the young people. As one young person said, "*it helps us get our point across*…" something they felt was much more difficult on the main houseblock. There is also a comments book on the Cedar Unit that has dozens of comments from family members praising the progress that the young people are making on the unit.

Mental health services report that most interventions are (and will be) trauma-informed, usually involving talking therapies, although individual practitioners may have differing approaches within this. The young people are matched with the most appropriate practitioner for their needs where possible. Services report that it is often difficult to fit the required interventions into the time that the young person is at HMYOI Cookham Wood. Interventions are delivered 1-1 and in groups. Examples of the latter include groups for managing emotions, sleep and for those with long sentences (10 years plus), as well as ad hoc groups as indicated.

In terms of clinical interventions, the most common prescribing is for ADHD. There is some limited prescribing of anti-psychotics and for depression, and there is some prescribing of Melatonin to support sleep.

5.1.1 Transition, Continuity and Throughcare

All transitions can be difficult for young people, destabilising them and threatening to undermine progress made. Changes to a different establishment or release back to the community can be times of risk, and all of this can be exacerbated by the transition to adulthood, specifically to adult services. In many cases this may mean a reduction or even complete loss of support and interventions.

Roughly a third of the young people at HMYOI Cookham Wood will transition to the adult estate at some point, often directly from HMYOI Cookham Wood. The prison and health services are aware of the importance of supporting this transition, and where relevant this will be a key focus of the young person's formulation plan.

Release back into the community is particularly problematic for looked after children where there is uncertainty about their placement, not least as some of the young people involved can be very difficult to place (see Chapter Ten). The placement may not be clear until close to release, making it impossible to know what services to liaise with to ensure continuity of care, sometimes at very short notice. This was as much a concern for the community services spoken to (e.g. YOTs) as it was for those in HMYOI Cookham Wood.

A further issue is that of accommodation, and staff report consistent difficulties resulting from the relevant local authority's tardiness in ensuring accommodation.

Foreign nationals over 18 are usually deported on release, making it extremely difficult to ensure any kind of throughcare.

In terms of release into the community, the local youth offending teams (YOTs) are key to supporting transition. Services report having to deal with almost a hundred different YOTs over the course of the year and how this makes it harder to ensure continuity and a smooth transition for the young people involved, particularly when there is such a range of provision in the community, in some cases very little. The safeguarding team face similar challenges in terms of all the different home authorities to liaise with. Even within the CPA context, transition often proves challenging due to the high bar involved in many of the community services.

For some young people, the emphasis is inevitably as much on how to manage with little or no specialist support as it is on connecting them with the relevant services. Both the establishment and health services reported concerns about ensuring continuity due to the lack of community resources, particularly appropriate mental health provision.

Services report that some of the YOTs and local authority children's teams (e.g. Kent and Medway) are more willing and able to meet and liaise effectively around sentence planning and resettlement, however the community mental health resources are invariably sparse and it can be very difficult to ensure a smooth transition and continuity of care. This deficit in resources and the associated unmet need can only realistically be met in the community through the community services and their commissioners.

The young people report that, for many of them, resettlement and other transitions are considered from the start. There appeared to be some ambivalence and anxiety about returning to the community and the risks involved, more so than in any transition to the adult estate or to adult service provision.

5.2 Service Delivery

In HMYOI Cookham Wood there is a mental health service provided by CNWL NHS FT. This is an integrated team, with no distinction between primary and secondary mental health needs. The core of this is the health and wellbeing team, who have traditionally focused on direct support and provision to the young people. The implementation of SECURE STAIRS is bringing several extra staff whose roles are focused as much on supporting SECURE STAIRS as they are on providing direct interventions to the young people (described as a roughly 50/50 split of their time).

These new staff are being recruited widely across the professions; this is necessary because of the shortage of staff nationwide with the appropriate skills who are keen to work in a secure establishment. Whatever the professional background, the new posts are expected to lead on the development of SECURE Stairs on their landing and on the organisational change and professional development involved. In terms of direct work with the young people, they are mostly a resource for their landing, but potentially for the whole establishment, so a wide skill set will be valuable.

HMYOI Cookham Wood also directly employ several psychology staff working on offending behaviour. These staff, pathways and interventions are expected to be integrated with the SECURE STAIRS context. Note that CNWL currently cover problematic sexual behaviour.

The health and wellbeing service operates six days a week, 8am to 8pm, although in practice most provision is in normal office hours of Monday to Friday 9-5. This meets the new NHS England requirements for a service which operates into the evenings, but not for one that operates seven days per week.[22] SECURE STAIRS will eventually mean that all staff will have a degree of psychological understanding and competencies, however this may not always be sufficient to respond to presenting need outside of normal working hours. Consideration should be given to how support can be provided on Sundays.

Recommendation 11 - The mental health service should meet the requirements of the current NHS England specification for an integrated service operating seven days per week.

The health and wellbeing team see all new receptions as part of the induction process. In terms of accessing services after reception, some young people reported having to wait a while, but that there was a prompt response where there was urgent need. Health and wellbeing prioritise where necessary, and it is assumed that the enhanced levels of staffing under SECURE STAIRS will make it easier to meet need promptly.

The young people consulted for this HNA were largely positive about mental health provision. Examples of provision the young people valued included support with trauma and with sleeping problems.

In the 'old' model of the service, mental health was a separate department that any young person might have been referred to if they had (or were suspected of having) one or more of the mental health conditions discussed in this chapter. In the new SECURE STAIRS model, mental health – or more specifically psychology – will be involved with all the young people (diagnosed mental health condition or not) as well as with all the resident-facing staff. In the current transitionary phase, the new model only applies to the Cedar (enhanced) Unit.

[22] NHS England (2018) Service specification: Integrated mental health service for prisons in England.

The establishment and mental health are both aware of how useful it would be to have more psychology input across the whole establishment, particularly for the Phoenix Unit (segregation) and the Bridge (step-down from Phoenix - B1 landing), but there are currently not the specialist roles in place to deliver this, although recruitment is under way. In the meantime, much of the 'behavioural' assessment and planning that takes place when considering how best to support a young person in moving on from the Bridge or the Phoenix Unit is carried out by prison staff, as is most planning around managing any attitudinal, conduct or behavioural problems. This will be very different when SECURE STAIRS is fully up and running, when there will be a distinct psychology role in leading on the formulation plan and supporting all staff in the delivery of that plan.

An important element of the roll-out of SECURE STAIRS will be training for all the staff involved. This will take some time to ensure as even the basic training is three full days, and operational delivery needs to be ensured throughout. Staff are trained in mixed groups (four to six at a time), in line with the SECURE STAIRS ethos of multi-disciplinary partnerships. Primary care have begun the training of their staff.

5.2.1 Mental Health Staffing

The table below outlines the mental health staffing complement for HMYOI Cookham Wood in the revised SECURE STAIRS model:

Figure 40 – Mental Health Team Staffing HMYOI Cookham Wood

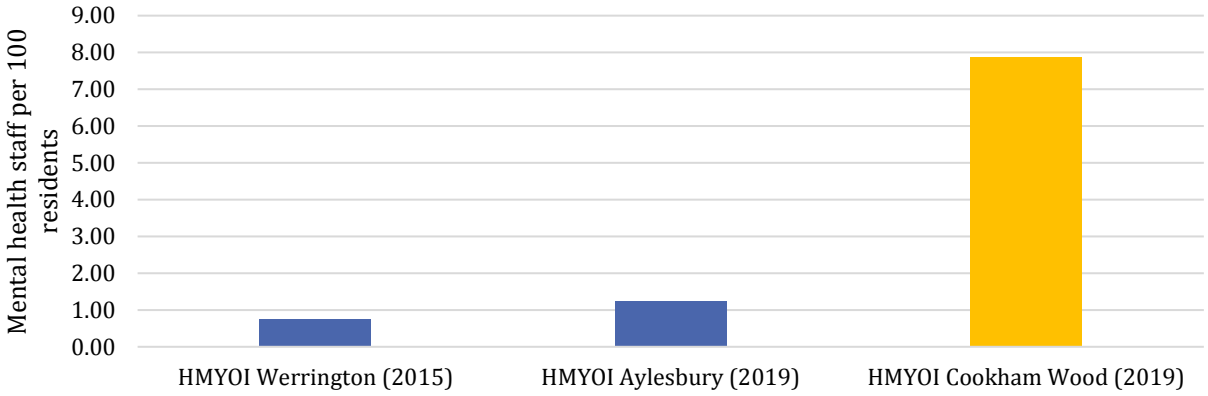
Role	Band (or equivalent)	Full-Time Equivalents	Issues
Service Manager	8B	0.50	Other half of post at Medway STC
Consultant Psychologist	8C	0.60	Currently 0.80 – leading on the implementation of SECURE STAIRS
Consultant Psychiatrist		0.60	
Staff Grade Doctor		0.50	Currently being adjusted to NMP
Senior Psychologist	8A	1.0 WTE	
Senior Art Therapist	8A	0.60	
Speech and Language Therapist	7	0.50	
Mental Health Practitioner (RMN)	6	1.0 WTE	
Senior Assistant Psychologist	5	1.0 WTE	
Administrator	4	1.0 WTE	
Secure Stairs Posts			
Senior Psychologist	8A	1.0 WTE	Advertised -Secure Stairs Post
Clinical Team Leader	7	1.0 WTE	In vetting
Specialist SECURE STAIRS Practitioner	7	4.0 WTE	2 in vetting, 1 interview stage, 1 advertised stage
Art Therapist	7	1.0 WTE	In vetting
Assistant Psychologist	4	1.0	
Data Performance Administrator	5	0.50 WTE	Start date 9th Sept 2019

In addition to this there are three full-time staff working on *Most Valuable Player*, a CBT-based approach to address offending. These staff focus on supporting the young people in the transition back into the community. They have not been counted in the above figures, although they will be part of the SECURE STAIRS context, as will the establishment's own forensic psychology staff working on behavioural and offending programmes.

There is also a range of students on placement from various disciplines including nursing, psychology and arts therapies.

The team at HMYOI Cookham Wood is very well staffed next to other similar establishments for which comparable staffing information was available, although none of these have yet to implement SECURE STAIRS. The team felt that they were adequately staffed for their usual work before SECURE STAIRS, although most of the work of the new staff will be extra to what currently takes place.

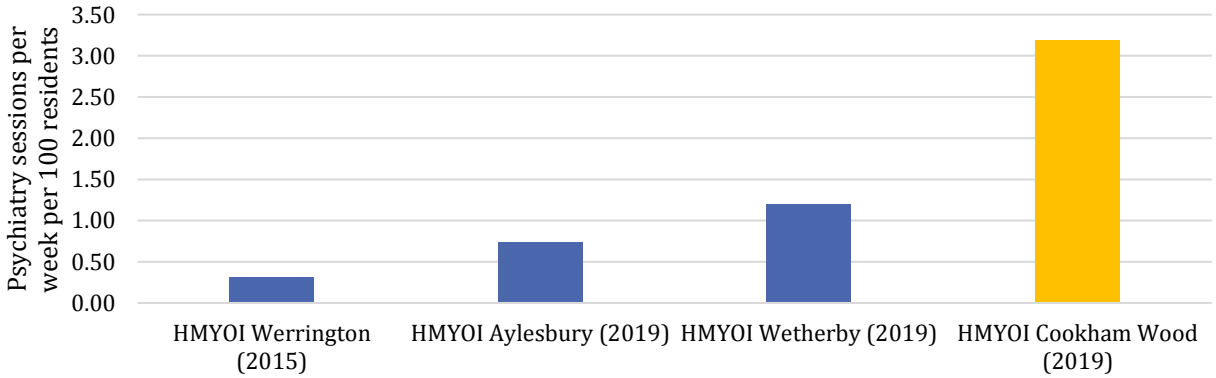
Figure 41 – Staffing HMYOI Cookham Wood and Similar Prisons



5.2.2 Psychiatry

There are six psychiatry sessions provided per week by a consultant psychiatrist. When compared to similar prisons for which we had data available, this is a high rate of sessions in proportion to the establishment's population size. Services recognise this and make good use of the resource, with the psychiatrist involved across the establishment and even attending ACCT reviews sometimes. There was also a 0.5 WTE specialist doctor, although this post is due to be replaced soon by an NMP in a similar role. This new role has been counted into the general mental health staffing.

Figure 42 – Psychiatry Provision Comparison (mental health team data)



There is little guidance about the number of staff a mental health team should have, but a 2007 benchmark is the Royal College of Psychiatrists (RCPsych) guidance.[23] Applying its formula to HMYOI Cookham Wood, it recommends 0.2 FTE consultant psychiatrist, supported by 0.2 non-consultant grade. It is unusual for the resource to be higher than the RCP recommended level. Being dated, this standard does not take account of the enhanced nursing and other roles now available.

5.2.3 Access and Waiting Times

SystmOne showed a waiting time of one day to access psychology services, 38 days for the psychiatrist, and 78 days for SALT. Services reported that the large figures were inaccurate, and the healthy levels of resource involved suggest that they are correct to say this and that this is a data issue.

5.2.4 Did Not Attend (DNA) Rates

SystmOne data showed clinic occupancy and DNA rates for psychiatry clinics and health and wellbeing team clinics over the last six months. In both cases the DNA rate was high. No other mental health appointments were recorded on SystmOne in a way that allowed reporting of DNA rates. At least some of this DNA rate may be due to the lack of a dedicated escort to support appointments (as primary care have), and the difficulty of ensuring these appointments due to the need to keep various young people apart from each other. It is hoped by both prison and health staff that SECURE STAIRS may help with this.

Figure 43 – Mental Health DNA Rates (SystmOne)

Feb-Jul 2019	Average clinic sessions per month	Average appointments booked per clinic session	Average seen per clinic session	Percent DNA	Percent 'no access'	Percent seen
Consultant Psychiatrist	1	4	2.5	38%	0%	63%
Health and Wellbeing Team	6	6	3.8	31%	0%	69%

There should be dedicated staff to escort for mental health in the same way as for primary care, particularly when the need for this expands as SECURE STAIRS is rolled out.

Recommendation 12 – Review the use of escorts for secondary care.

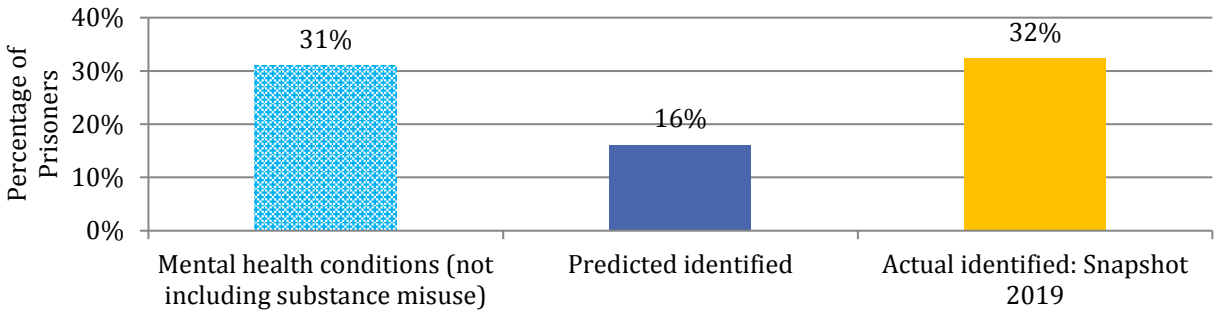
5.3 Proportions of Residents with Mental Health Issues

The prevalence estimates in this chapter are based on a study that is almost two decades old but that remains the most relevant prevalence study, conducted in all the (then) 131 prisons in England and Wales, and involving in-depth clinical interviews with a large sample of prisoners.[24] The resulting expected prevalence figures are compared to the actual rates of identification in HMYOI Cookham Wood throughout this chapter. Specifically considering mental health problems other than substance misuse disorders, a number of studies cite

[23] RCPsych (2007) Prison Psychiatry: adult prisons in England and Wales.
[24] Singleton, N. *et al.* (1998) Psychiatric Morbidity among Prisoners in England and Wales. ONS and DH.

prevalence rates of between 30-50%.[25] A comprehensive 2006 study found that 31% of young offenders (both in custody and in the community) had mental health-related needs (not including substance misuse).[26]
Based on the above, and the assumption that 52% of those with a mental health condition are likely to be identified,[27] it can broadly be estimated that 16% *should be* identified with mental health problems. This is compared to the actual rates of identification in HMYOI Cookham Wood below, with the SystmOne snapshot at August 2019 describing a higher than predicted rate of identification in both cases. This data was not available from the last HNA.

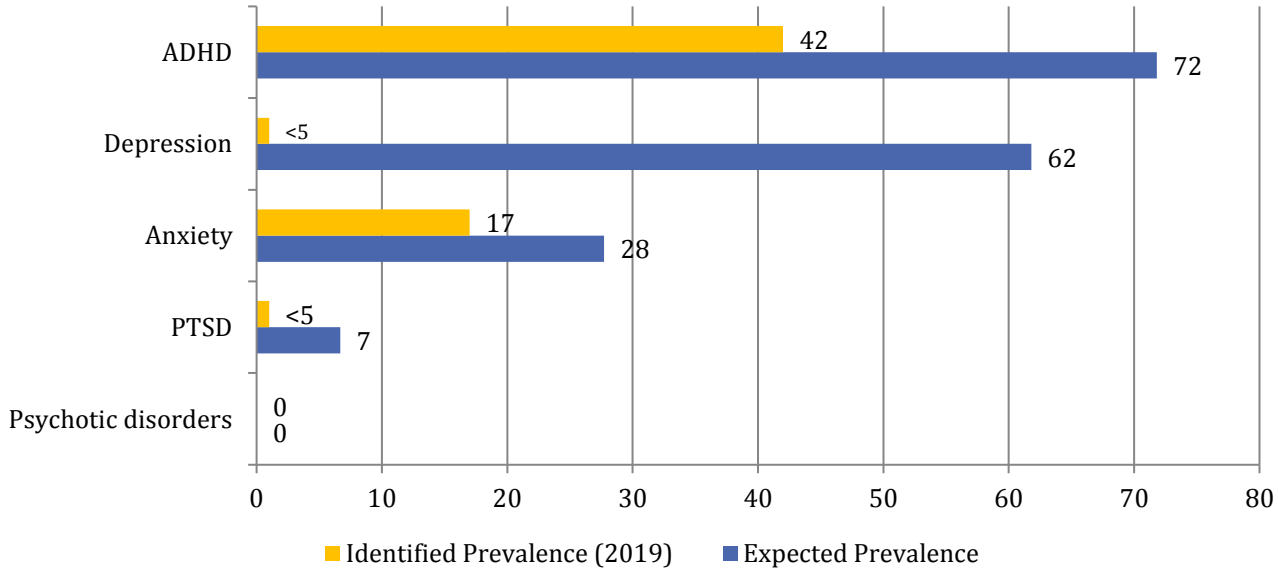
Figure 44 – Expected and Actual Mental Health Prevalence (including and excluding substance misuse)



SystmOne indicates that of the 54 patients (32% of residents) at the 2019 snapshot recorded as having any type of mental health issue, 49 had one or more of their conditions recorded at HMYOI Cookham Wood. The SystmOne mental health records for the remaining five men had been entered at other establishments. This shows that HMYOI Cookham Wood are not relying on community services, and in many cases may be the first to clearly identify a mental health concern.

[25] Mental Health Foundation (2002) The Mental Health Needs of Young Offenders: An Update; Prison Reform Trust (2012) Turning Young Lives Around: how health and justice services can respond to children with mental health problems and learning disabilities who offend.
[26] Chitsabesan, P. et al (2006) Mental Health Needs of Young Offenders in Custody and in the Community.
[27] Sainsbury Centre for Mental Health (2003*)* Primary Solutions: an independent policy review on the development of primary care mental health services. From a table prepared by Muijen, M. after Goldberg, D. and Huxley, P. (1992) *Common Mental Disorders: A Bio-Social Model.* London: Routledge.

Figure 45 – Expected and Actual Prevalence of Individual Conditions



The proportion of those with the conditions specified above does not reflect predicted levels. However, mental health report that their caseload varies between about 70 and 90 at any one time. This is roughly half the establishment, i.e. more than the overall expected prevalence (higher than both the expected prevalence of 31% in Figure 44 above and much higher than the likely number presenting of 16%). It is also higher than the 32% (54 people) recorded on SystmOne, suggesting that some of the young people on the mental health caseload are not coded on SystmOne under one of the mental health categories. The various conditions and conclusions as to the meeting of need are discussed in more detail in the following sections.

Part of the reason for the discrepancy between actual and estimated prevalence can be where a mental health concern is recognised but there is a reluctance where young people are concerned to diagnose and label too rigidly, leading to a lack of a clear code on SystmOne. The young person may well be getting the support and interventions they need, but this may not be coded or recorded the way it might be if adults were involved and the person's mental health status was more established.

5.3.1 Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is sometimes picked up from the primary screen and sometimes from a later referral. Mental health report that many of the self-reported ADHD cases prove not to have ADHD when formally assessed. They also report some of the young people refusing the medication as they don't like the effect.

The predicted rate of ADHD among young offenders is around 43%; at HMYOI Cookham Wood 25% were identified. Though lower than predicted, the identified rate is higher than that at HMYOI Wetherby, the one comparator for which this data was available (12% identified in 2019) and also HMYOI Aylesbury (19% in 2019). Of the 42 patients with a recorded diagnosis of ADHD at the August 2019 snapshot, 36 of these had had their diagnosis recorded at HMYOI Cookham Wood, indicating robust identification processes. It is likely that most of the need is being identified, and SECURE STAIRS should ensure this even further.

SystmOne indicates five patients with a recorded diagnosis of oppositional defiant disorder (ODD) in the establishment during 2018/19; at the August 2019 snapshot there were fewer than five. This is noted as there can be crossover in diagnoses.

SystmOne prescribing data in August 2019 showed that during 2018/19, 16 patients had been prescribed Concerta (similar to previous years) and five were currently prescribed at an August snapshot. There are several other prescribing records for medications that may have been used to treat ADHD during the same period, but the recording involved means it is not possible to ascertain the total number of patients prescribed each medication.

5.3.2 Anxiety and Depression

Mental health reported that anxiety problems at HMYOI Cookham Wood were often about the adjustment to prison life. The numbers recorded on SystmOne with diagnoses of anxiety (equivalent to 10.2% of the population of HMYOI Cookham Wood) are somewhat lower than the predicted 17%; this is also low next to the 16.6% identified at HMYOI Aylesbury. Of the 17 patients with a record of anxiety or stress-related conditions, 16 had been recorded at HMYOI Cookham Wood.
Mental health reported that depression was often treated as low mood and rarely prescribed for, so was often not coded as depression, and it is likely this applies to some extent to anxiety too. Most interventions involved 1-1 talking therapie;, currently only two young people were being prescribed anti-depressants. Severe depression was reported to be relatively rare.

The <3% of patients (fewer than five) identified with depression and related disorders is considerably lower than the expected 37%. HMYOI Aylesbury (again, the only similar prison with comparable data available) also had very few patients recorded with depression, with 4.7% of residents having a recorded diagnosis on SystmOne. During the full year 2018/19, 1.4% of all residents (n=7) had a recorded diagnosis of depression at HMYOI Cookham Wood.

QOF data from 2015 showed that, around the time of the previous HNA, 0.6% of the population was on the QOF register as having depression.[28] At August 2019, this was still very low with fewer than five patients (<3%), lower than the 3.2% reported at HMYOI Aylesbury. No patients appeared to have a recorded diagnosis on SystmOne but not be on the QOF register as currently receiving treatment.

The very low numbers coded or treated for depression suggest that the need relating to depression is not being identified and met. However, if the young person's concerns are recognised and being responded to, as appears to be the case, then it perhaps matters less what these concerns are called then that their needs are recognised and met. The young people spoken to for the HNA emphasised how thoroughly they were assessed and how they generally felt that they could talk to many of the people responsible for their care, including mental health, and this does suggest that their health and wellbeing needs are by and large identified and met. This was also the consistent view across the staff groups involved. This level of recognition and support for health and wellbeing is likely to be further enhanced as SECURE STAIRS rolls out. Accordingly, whilst there may be difficulties in precisely

[28] The previous HSCNA for HMYOI Cookham Wood did not supply QOF data for most mental health-related registers. To provide a benchmark for change over time, we used historical Quality and Outcomes Framework (QOF) data taken from SystmOne, taking an average number of patients during the period April to June 2015, and calculating the prevalence rate based on this and the MOJ-reported population of HMYOI Cookham Wood at June 2015.

categorising and coding the young people's conditions and associated interventions, it appears that need is generally being identified and met.

5.3.3 Severe and Enduring Mental Health Issues

QOF data showed that at August 2019, no residents at HMYOI Cookham Wood were identified as having severe and enduring mental health problems (the measure includes schizophrenia, bipolar affective disorder or other psychoses). This is the same as was reported in 2015, and lower than the 2% reported at HMYOI Aylesbury. Mental health reported that severe and enduring issues were rare, but did happen, though could be transferred out under the Mental Health Act.

5.3.4 PTSD and Trauma-Related Conditions

Mental health report that much of the presenting concerns and their interventions are within the context of trauma. This view was echoed by the YOTs, who saw this as currently the largest area of unmet need. The governor also felt that that there was a big rise in mental health concerns across the young person's estate, and a growing recognition in response to this of the importance of trauma and ACEs (adverse childhood experiences). This was exacerbated by the paucity of community services. The extreme nature of some of the crime and the high sentences involved could also be traumatic.

The diagnosis rate for post-traumatic stress disorder (PTSD), is lower than the 4% predicted based on research, with fewer than five patients at an August 2019 snapshot having a recorded diagnosis. This is low compared to HMYOI Aylesbury, where 11% of residents were identified with the condition. A review of mental health-related read codes on SystmOne did not reveal any recorded sub-PTSD trauma-related conditions.

Part B discusses childhood trauma, including the concept of adverse childhood experiences (ACE) and how this may induce lasting trauma which may or may not reach the diagnostic criteria for PTSD.

Trauma and ACEs are covered in some depth in the SECURE STAIRS training (note that many of the resident-facing staff have already received mental health training). Numbers with diagnosed PTSD are a lot lower. Again, as with depression, it appears that a lot of the young people with trauma-related issues are being worked with by mental health (and substance misuse, safeguarding and other staff). They may not fulfil the diagnostic criteria for PTSD, but nevertheless their trauma-related needs are being identified and responded to. Meeting this need may be a long-term and intensive process that is hard to see through at HMYOI Cookham Wood. This identification and the resource with which to respond to trauma will increase as SECURE STAIRS becomes established.

5.3.5 Personality Disorder (PD)

Personality disorder is discussed in Part B. Mental health reported a lot of complex emergent personality disorder, not yet formally identified as personality disorder as people are still too young for such a diagnosis to be certain (and therefore not coded as such on SystmOne).

Conduct disorders were also described as common at HMYOI Cookham Wood. The governor also reported a trend towards more extreme behaviour.

Whilst the apparent identification of those with personality disorders is well under predictions, with no patients currently identified and fewer than five recorded during 2018/19 (compared to an estimated 88% of young offenders with the condition according to research), it should be noted that the predictions include a wide range of personality disorders (including anti-social personality disorder which could include criminal behaviour), whereas those identified in HMYOI Cookham Wood would have had a formal diagnosis. To put this in context, the rate of diagnosis at HMYOI Aylesbury (which has a PIPE programme) was also substantially lower than predictions at 2.4%.

This gap between expected and actual prevalence is to be expected where young people are concerned, and the same applies as for depression and trauma, i.e. needs appear to be being largely identified and responded to, just not categorised and coded on SystmOne in the way that they might be with adults and that is of use for comparing prevalence and assessing unmet need.

5.3.6 Sexually Harmful Behaviour

CNWL also provide the interventions focused on sexually harmful behaviour. The numbers involved are relatively low, usually in single figures at any one time. Where the young person has been sentenced for a sexual offence, there is an expectation that they will undertake the intervention. Where they are remanded on a similar charge then the provision is optional. Interventions are all on a 1-1 basis. Staff will work in situ in HMYOI Cookham Wood with the young person, and with just the family during the period of custody and after release. The need is being met.

5.3.7 Eating Disorders

At August 2019, no patients were recorded on SystmOne as having a diagnosis of eating disorders; in 2018/19 there were fewer than five (this is consistent with none diagnosed at HMYOI Aylesbury). Mental health reported that eating disorders were rare. However, in previous years there have been relatively high numbers of patients: seven in 2017/18, 36 in 2016/17 and 54 in 2015/16 (although 44 of these appear to have arrived at the establishment with their diagnosis). This suggests there may have been some changes in assessment and/or recording of eating disorders over the last few years, as some of the larger historical numbers seem unusual.

Eating disorders can often overlap, be symptomatic of, or be obscured by other conditions. They are increasing amongst young men, so it is possible that they are being missed as a concern or a diagnosis at HMYOI Cookham Wood, although as with other conditions discussed above, it is possible that any underlying or associated concerns are being identified and responded to. SECURE STAIRS is likely to further ensure this and to help ensure that any food issues are considered as part of the formulation, whether these are formally diagnosed as an eating disorder or not.

Note that the planned approach to meals at HMYOI Cookham Wood is for the young people to eat communally, however problems with having to keep some young people apart mean that this is not always possible, and some have to eat alone.

Precisely because eating disorders and food issues can easily be missed, it is important that these are considered alongside other issues as part of a comprehensive assessment of that young person's wellbeing, as it is possible there is unidentified and unmet need. In practice, the landing staff and other young people may often be the best placed to identify this.

Recommendation 13 – Consider eating disorders and other food issues when assessing/reviewing young people's needs.

5.4 Learning Disabilities/Intellectual and Development Disability

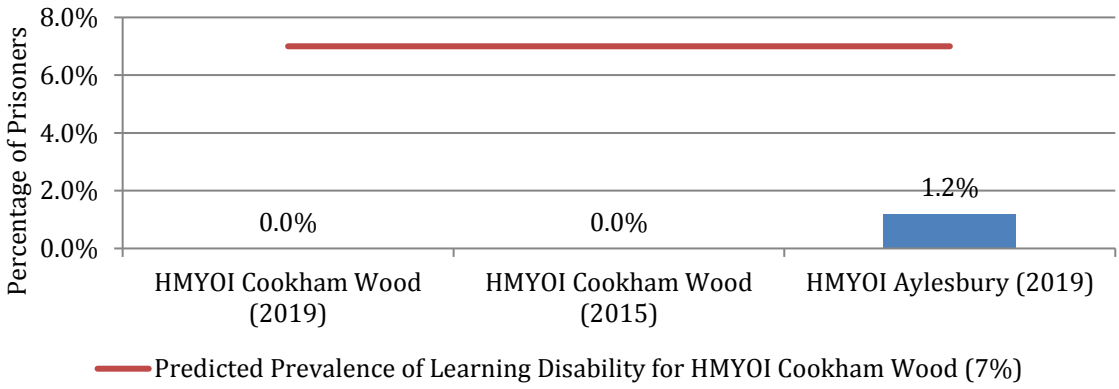
Mental health report that a lot of the young people have a low IQ and low levels of functioning – i.e. learning difficulties - and that this is identified at assessment. Currently this is usually only an issue for education who will develop an appropriate learning plan. Under SECURE STAIRS this will be one of the considerations in the formulation. Actual learning disabilities were rare. Mental health reported that, where necessary, it was usually relatively easy to transfer someone to the LD secure unit.

The local YOT reported that around a third of their clients in HMYOI Cookham Wood had special educational needs (SEN) and needed SEN support. The rates with education, health and care (EHC) plans were four times that of their peers in the community. In our patient survey, 16% of respondents (n=11) self-reported that they had a learning difficulty or disability, although did not distinguish between the two.

The boundary between 'difficulty' and 'disability' can be difficult to define. Good practice is generally to respond to the need holistically, particularly where young people are concerned, i.e. the definition matters less than that the need is identified and met. Where the distinction can become important is in who responds to that need, i.e. healthcare might be involved if there is a *disability*, whereas education (if anyone) will often lead if there is a learning *difficulty*. In many cases, education will identify a learning difficulty and develop a plan to support the person without necessarily informing or involving healthcare or mental health (as there is no reason to).

At an August 2019 snapshot, there were no patients with a recorded diagnosis of learning disability in HMYOI Cookham Wood, either on the QOF register or reported in broader SystmOne data. This is in contrast to the predicted 7% based on literature (the red line in the chart below) and the 1.2% observed at HMYOI Aylesbury. HMYOI Wetherby was the only MOJ-defined comparator for which any data was available and they did not report a QOF prevalence but reported 21% of patients having any recorded diagnosis in the 2019 HSCNA. There were also no patients recorded with a learning disability in the previous HNA at HMYOI Cookham Wood in 2015.

Figure 46 – Learning Disability (QOF)



Recorded prevalence appears to have decreased over time. Though no patients were recorded with learning disabilities on SystmOne during 2018/19, there were fewer than five in 2017/18 and nine in 2016/17.

The initial assessment is very thorough and almost certainly identifies learning difficulties that are then appropriately responded to, i.e. overall the need is identified and met. Learning disabilities are not being recorded on SystmOne as they do not appear to be coming to mental health's attention in the first place. Under SECURE STAIRS it will make little practical difference whether a learning difficulty is technically a disability or not if any need involved is being appropriately met, and this will likely be the case (and largely seems to be now). Nevertheless, there is some value in attempting to ensure formal diagnoses of learning disability, not least as these may be relevant post-custody in securing appropriate support.

Recommendation 14 – Establish diagnoses of learning disability where appropriate.

5.5 Autistic Spectrum Disorders

Neurological disorders are covered in Part Five of the CHAT assessment.

The identified prevalence of autistic spectrum disorders (ASD) at HMYOI Cookham Wood is a little higher than that predicted, based on research: eight patients identified (4.8%) against an expected prevalence of 1.5% (equivalent to three patients).[29] Comparable data was available only from HMYOI Aylesbury, which had a slightly lower prevalence with 3.2% of residents having a diagnosis recorded on SystmOne. At HMYOI Cookham Wood, prevalence appears to have been typically similar over time, with 3.3% of patients (n=17) identified during 2018/19, and 4.2% (n=20) identified during 2017/18. Of the eight patients with a record of ASD, all had been recorded at HMYOI Cookham Wood. This suggests that need is being identified.

5.6 Speech, Language and Communication Needs

As noted in Part B, there is evidence for a high prevalence of speech, language and communication disorders amongst offenders, particularly young offenders, with 60-90% of

[29] NHS (2014) Adult Psychiatric Morbidity Survey: survey of mental health and wellbeing, England, 2014.

young offenders having been shown to have below average communication skills, as compared to 10% of the general population. The local YOTs reported high levels of speech and language problems amongst their client group. Speech and language is a key issue considered in the CHAT assessment and in SECURE STAIRS.

SystmOne reported fewer than five patients with a recorded read code of 'speech or language developmental disorder' at an August 2019 snapshot, and fewer than five per year over the past three years. Mental health services reported that there were currently 10 young people on the caseload for speech and language difficulties and more receiving ad hoc interventions, i.e. numbers were considerably higher than reflected on SystmOne. The data mismatch was considered to be a coding issue. It would be helpful if this was resolved in the future.

Recommendation 15 – Ensure consistent coding of speech and language difficulties and interventions.

Other establishments (e.g. HMYOI Feltham) have found that as well as direct interventions to support the young people, speech and language expertise has been a useful resource for staff to help them more effectively understand and communicate with the young people. HMYOI Cookham Wood hope to make more use of the speech and language expertise in this way, and this will become more relevant within the SECURE STAIRS context. There are good links with education with respect to speech and language.

There are currently six speech and language therapy (SALT) sessions provided per week, as well as speech and language students on placement. It is likely that most need is being both identified and met.

5.7 Acquired Brain Injury (ABI)

Part Five of the CHAT assessment screens for ABI. Where this is diagnosed, primary care are usually also involved. Services report that the turnover can make it difficult to get very far with assessment and treatment in some cases.

ABI can be hard to identify and diagnose as distinct from other conditions, not least as it is often a question of degree of damage. Numbers are described by services as low, and fewer than five were recorded on SystmOne as having experienced a brain injury (with the read code 'brain injury NOS') at an August 2019 snapshot. All had been recorded at HMYOI Cookham Wood. There were also fewer than five patients recorded with brain injuries during 2019/20 to date, though none in 2018/19.

The lack of established prevalence data makes it hard to assess the extent to which need may be being identified and met, although the levels of violence in the histories of many of the young people suggest a heightened risk of brain injury. The existence of the screen and specific pathways shows that need can be identified and met, and the increased psychology input as SECURE Stairs develops should further enhance this.

5.8 Foetal Alcohol Spectrum Disorder

At an August 2019 snapshot, no patients were recorded on SystmOne as having a diagnosis of foetal alcohol spectrum disorder (FASD), nor had there been any in the past four years. This was confirmed by services. It is likely that there is some FASD at HMYOI Cookham Wood, although, as with ABI, there isn't an established prevalence baseline to support comparison. It is likely that possible need isn't being identified or met, although the increased psychology input as SECURE Stairs develops should improve this, and in many cases the formulation plan would appropriately address the implications of FASD even if it hadn't been explicitly diagnosed.

5.9 Mental Health Transfers

Mental health reported one MHA transfer during the twelve months August 2018 to July 2019, this took 55 days. They reported that though transfers were rare, they were generally quick, although complex personality disorders were more difficult to transfer under MHA, as was also the case if the young person was close to 18.

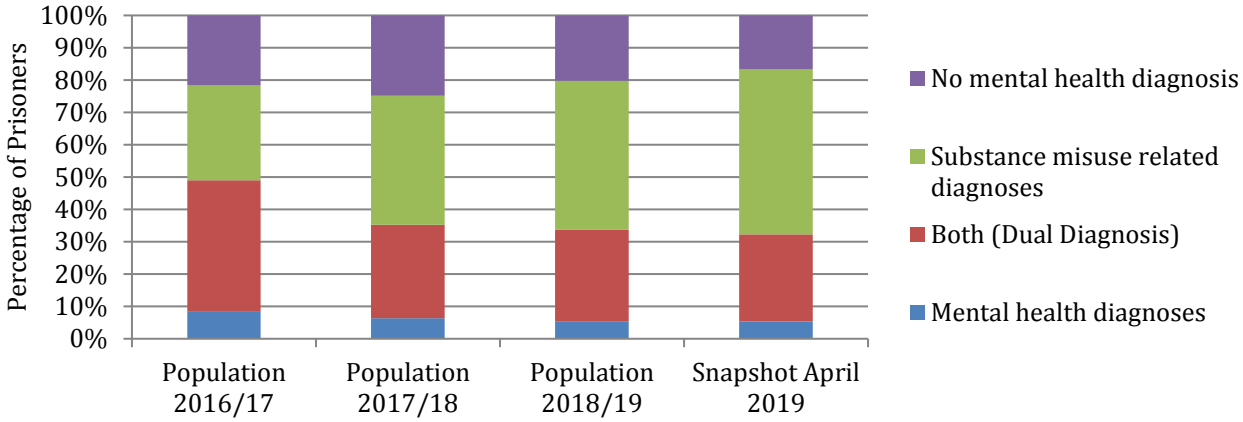
This is comparable to HMYOI Aylesbury, which also had fewer than five transfers in a recent twelve month period.

There is nowhere specifically designed to hold such patients whilst they await transfer, although in most cases it should be possible to manage the person within existing accommodation at HMYOI Cookham Wood and we believe that they could usually be supported appropriately. We are not aware of specialist in-patient facilities available in other establishments, as most do not take this age-group and are not national resources, so the options for transfer elsewhere whilst waiting would be very limited at best.

5.10 Mental Health and Dual Diagnosis

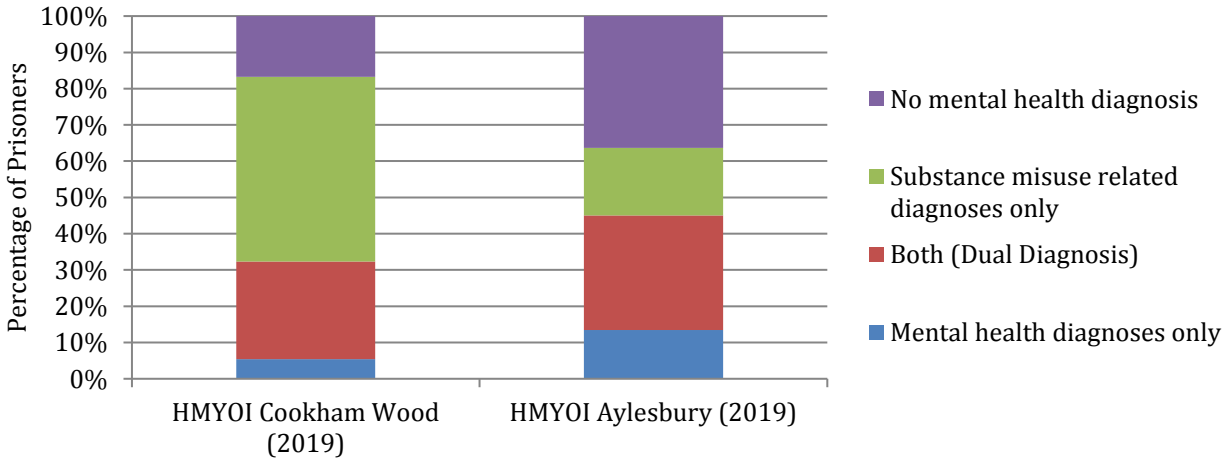
The chart below shows the proportion of the population recorded on SystmOne as having mental health and/or substance misuse problems over the past few years. This shows that there has been a decrease in patients with mental health diagnoses but increasing numbers with substance misuse diagnoses, possibly due to increased SystmOne recording of substance misuse issues. Note that very few of the substance misuse issues concerned are to do with substance dependency.

Figure 47 – Mental Health and Substance Misuse Prevalence Over Time



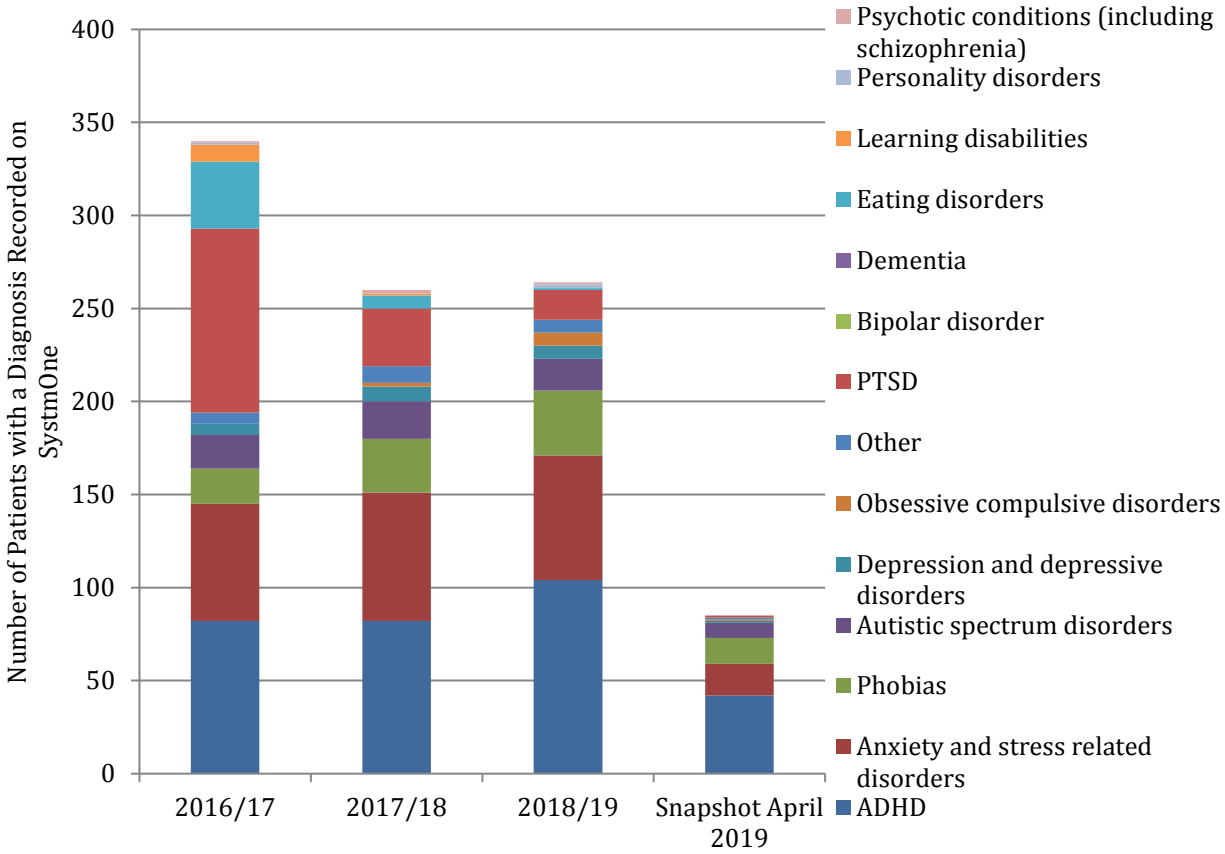
From the chart below, it is apparent that the overall identification of mental health disorders (including substance misuse) at HMYOI Cookham Wood is higher than HMYOI Aylesbury, the only similar establishment for which this data is available. This is due to the very high levels of recorded substance misuse diagnoses, while recorded prevalence of mental health conditions is lower than at HMYOI Aylesbury. This implies an effective assessment process at HMYOI Cookham Wood.

Figure 48 – Mental Health Diagnosis Comparison



The chart below shows the number of patients recorded on SystmOne as being diagnosed with various mental health conditions, during recent years and at a current snapshot. Note that one patient may be diagnosed with multiple conditions.

Figure 49 – Recorded Mental Health Diagnoses



This indicates that the numbers of recorded diagnoses have decreased since 2016/17 (note that this is unusual), with ADHD, anxiety and phobias being the most commonly diagnosed conditions. This decrease, particularly the recent drop, may indicate a move away from an emphasis on diagnostic criteria towards the more holistic and child-centred approach of SECURE STAIRS where the emphasis is more on clarifying the needs than the diagnosis. For the reasons discussed throughout this chapter, there is no reason to assume this lack of recorded diagnosis reflects unmet need.

Mental health report that dual diagnosis was relatively rare, presumably as significant substance misuse was rare. The necessary liaison between services was described as effective and easy as the services were close together. Mental health usually led in such circumstances.

5.11 Findings from Patient Consultation

In our patient survey, 65% of respondents said they knew how to access mental health services, and 24% said they had already done so. This is lower than at HMYOI Aylesbury, where 73% of patients reported knowing how to access mental health services. Under SECURE STAIRS this question will lose its relevance anyway as all young people will be involved with mental health.

5.12 Chapter Summary

- HMYOI Cookham Wood has an integrated health and wellbeing team covering mental health with a child-centred approach focused on the young person's needs rather than their diagnosis.
- SECURE STAIRS is slowly being rolled out across the establishment, increasing the mental health resource and moving the establishment towards being a psychologically and trauma informed environment.
- Transitions can be very difficult to ensure, whether into the adult estate or the community. Services in HMYOI Cookham Wood do what they can to support this and prepare the young person, but community resources and engagement with this group are patchy and often poor.
- Mental health provision is only six days a week. See Recommendation 11.
- Staffing levels are good and increasing. Waiting times are minimal. DNA rates are high though should improve under SECURE STAIRS.
- There should be dedicated staff to escort for mental health in the same way as for primary care. See Recommendation 12
- It is likely that most mental health need is being identified and responded to, though the recorded prevalence of most conditions is below what would be expected.
- Rates of depression on the QOF register are very low, though low mood is commonly identified and responded to. It is likely that need is being met.
- Severe and enduring mental health issues are rare, as expected.
- Trauma is common and appears to be identified and responded to, although diagnoses of PTSD are rare.
- Behavioural, conduct, attitudinal and other disorders are common, although personality disorder diagnoses are rare. Need is being identified and responded to.
- Eating disorders and food issues may be being overlooked. See Recommendation 13.
- Learning difficulties are being identified and needs met, though it would be useful if learning disabilities were diagnosed where appropriate. See Recommendation 14.

- Speech and language needs are identified and met, although this is not reflected in the data. See Recommendation 15.

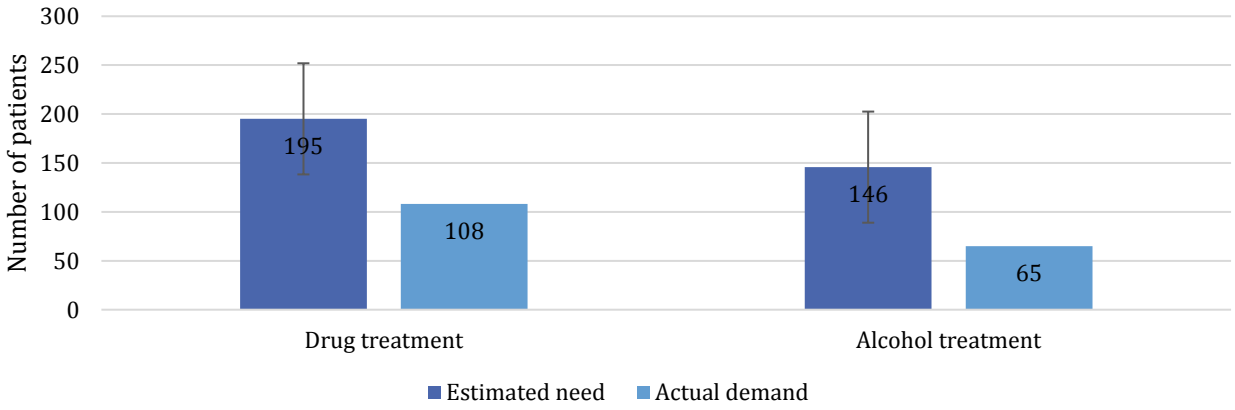
Chapter Six – Substance Misuse

6.1 Prevalence

There are no established prevalence estimates for young people in custody so estimated need has been based on research regarding substance use of males of all ages in secure settings. This data functions more as a guideline, e.g. illustrating trends in use and over time, and is only partially useful for assessing need and unmet need. Substance use in young people is very different from that of adults, including amongst those in custody. Substance dependency is rare, injecting is rarer, and use of illicit class A drugs such as heroin and crack cocaine is rare. The following data needs to be considered with these provisos.

The following charts compare the expected annual incidence of substance misuse among the population of HMYOI Cookham Wood to the actual demand for treatment, based on NDTMS data (estimated for drugs and alcohol based on the 108 patients receiving treatment in 2018/19 as reported to NDTMS). Calculations for the expected incidence can be found in Appendix C.

Figure 50 – Predicted Incidence and Actual Demand (per annum)

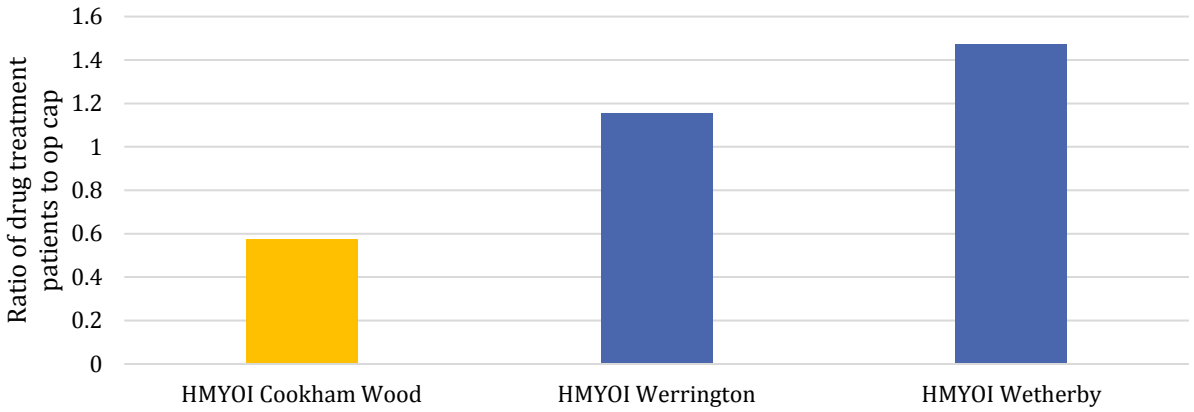


The demand for 'drug treatment' at HMYOI Cookham Wood is a little lower than that estimated based on the research. This is to be expected, due to the lower levels of use, the lower risks involved and the lack of dependent use. It is important to note that whilst NDTMS uses the term drug 'treatment', most of the interventions at HMYOI Cookham Wood are not 'treatment' as most people might understand it, i.e. interventions to help with dependency or the adverse effects of substance misuse. Rather the emphasis is on advice, education, prevention, harm-reduction and the risks involved in the drugs trade.

Data confirms that young people in drug treatment are less likely than those in older age groups to be opiate and crack cocaine users (OCUs). National drug treatment monitoring system (NDTMS) data indicates that, of the 108 patients in treatment in HMYOI Cookham Wood during 2018/19, only 6% (n=7) were recorded as using opiates, and 2% (n<5) as using crack cocaine. Services report that even this use was rarely dependent. The most commonly cited substances used by patients were cannabis (93% of those in treatment in 2018/19) and alcohol (60%). This substance use profile is similar to substance misuse treatment patients in YOIs in general.

One useful comparison can be with similar establishments. The number of patients recorded on NDTMS as receiving drug treatment in the last full year (taken as all substance misuse patients during 2018/19) in relation to the op cap is low at HMYOI Cookham Wood in relation to similar establishments.

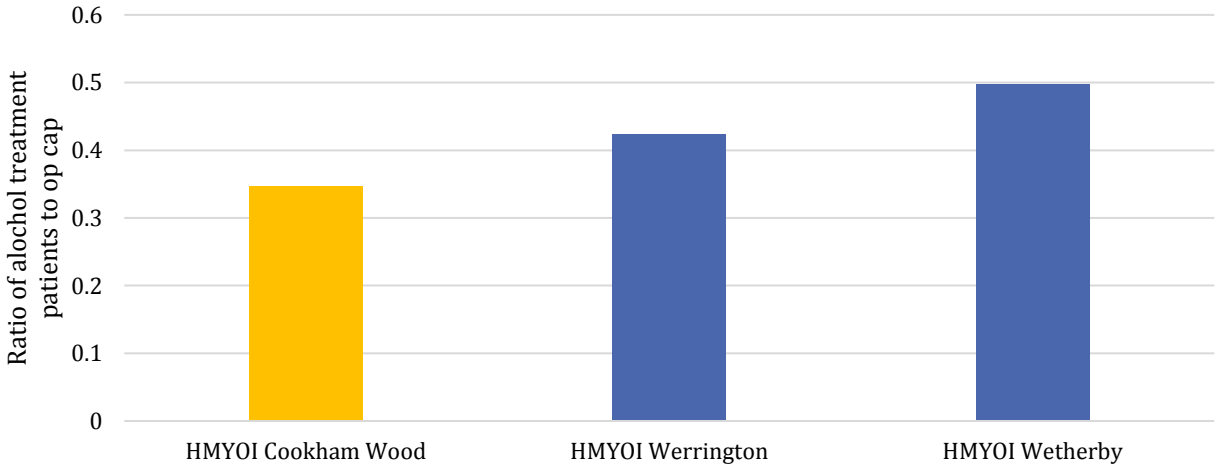
Figure 51 – Ratio of Drug Treatment Patients to Op Cap (NDTMS data, 2018/19)



The differences above may be due to differing criteria. The large ratios involved with substance misuse services at the comparator prisons may be because in some YOIs (particularly amongst juveniles) it is usual for all receptions to engage with the substance misuse services, or at least those who are even slightly at risk (which is nearly all). The assessments and engagement at HMYOI Cookham Wood are such that there is no reason to believe there is unidentified or unmet need, even in terms of education and advice.

For alcohol 'treatment', the observed demand at HMYOI Cookham Wood is also lower than predicted. The same comments apply as with drugs. The chart below shows engagement with alcohol treatment in similar establishments in relation to the op cap: the higher the number, the greater numbers engaging with alcohol treatment. As with drugs, note that 'treatment' simply means engagement with the services and is, in practice, mostly education and advice. Also, as with drugs, there is no reason to assume unidentified or unmet need.

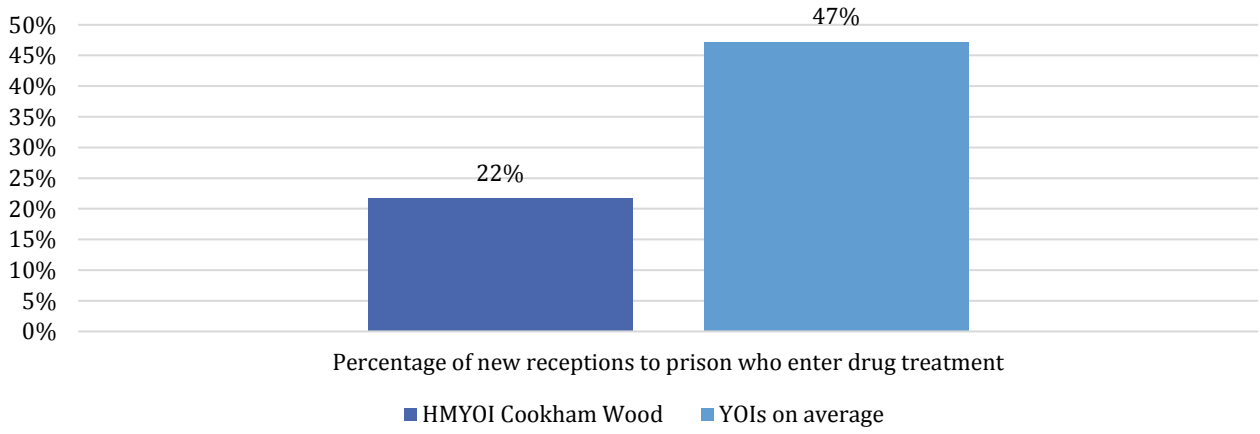
Figure 52 – Ratio of Alcohol Treatment Patients to Op Cap (NDTMS data, 2018/19)



NDTMS data on the AUDIT scores of those in treatment showed that during 2018/19, 26% of those with a score recorded (n=28) had AUDIT scores indicative of harmful or dependent drinking (compared to an identical 26% in all YOIs nationally). SystmOne data on AUDUT scores discussed below suggests none were dependent. Services report that dependency is very rare, and whilst some are drinking at potentially harmful levels, more of the concern in physical health terms is around heavy episodic ('binge') drinking and the risks of mixing some drugs and alcohol.

NDTMS data suggests below average levels of treatment engagement, though note that some YOIs have significant numbers in the 18-21 age group who tend to have markedly higher and riskier levels of drug and alcohol use than juveniles, and hence potentially higher needs for interventions. A lower proportion of new receptions to HMYOI Cookham Wood enter drug or alcohol treatment (note this is inferred from the number of patients with a substance misuse assessment reported to NDTMS as a percentage of patients reported to the YJB as receiving a reception health screening at the establishment).

Figure 53 – Treatment Entrants Data (NDTMS, 2018/19)



The SystmOne data on CHAT 3 (the SMS templates) shows a high DNA rate of 39%. This is considered by the health and substance misuse services to be because many young people don't think that they have a substance misuse concern and/or are unwilling to discuss this. The young people spoken to for this report were perhaps reticent to be fully open because of the presence of landing staff, but were generally not that concerned about their use of cannabis or alcohol (the main substances used) and dismissive of the use of 'harder' drugs (and the people who used them), although they were more interested in discussing some of the less used 'recreational' drugs such as ketamine and spice.

Whilst it is understandable why some young people may want to avoid a comprehensive substance misuse assessment, this is also an opportunity to provide harm-reduction advice and brief motivational interventions. Harm-reduction advice covering the more common risks (physical, mental and legal) involved in the use of drugs and alcohol (and the drugs trade) is of relevance to all young people involved in the criminal justice system and would ideally be covered multiple times, e.g. as part of induction, as part of universal screening by Open Road, by education, and to some extent as part of any assessment. This can also be effectively delivered within wider contexts such as risk-taking, criminal coercion, thinking skills, etc.

Open Road offer a substance awareness group to all young people within 5 days of induction, although it is not clear how many take up this offer. They also complete harm reduction sessions with all the young people on remand at the CHAT assessment stage. Whilst Open Road are appropriately coming at the issue from multiple directions, it is important that this is reinforced by other prisoner-facing staff and departments.

Recommendation 16 – Ensure harm-reduction advice on the main risks involved in substance use is provided to all young people at every opportunity, not just those engaged with substance misuse services.

6.2 Service Provision

The psychosocial element of the substance misuse service (SMS) is available five days per week between 9am and 5pm. This non-clinical element is provided by Open Road, sub-contracted to Forward Trust as part of their Kent and Medway-wide contract for substance misuse services in the prisons. The service is child-centred and appropriate to the needs at HMYOI Cookham Wood, as also recognised by HMIP, who were very positive about the service in their last inspection.[30]

The young people are normally seen in education, with their appointments booked in advance. There is increasing pressure on room space for interviews, and this pressure is likely to increase under SECURE STAIRS. The service has just started an evening drop-in during association; there had been two so far at the time of writing (September 2019). These were well-used (9 and 15 young people respectively) and are likely to continue.

Office space is adequate and there are enough SystmOne and Quantum computers. All Open Road's records are kept on SystmOne.

6.2.1 Clinical

Clinical substance misuse needs are very rare at HMYOI Cookham Wood. The current arrangement is that if any such needs were to occur, they would be seen to by Forward Trust's clinical staff from next door HMP/YOI Rochester who can be available seven days per week (as required). Clinical interventions should be in liaison with Open Road and HMYOI Cookham Wood's primary care, although this has rarely been put to the test. Clinical assessments would be provided via an on-call system with the out of hours GP if the Forward Trust staff were not available (e.g. late evening), although this is a very unlikely scenario. Since the start of the contract, the service reported that no patients have been prescribed OST (opioid substitution therapy, e.g. methadone). This fits with the expectation that this age group will have very few opiate users.

An alternative option for service configuration might have been to have any clinical need covered by primary care at HMYOI Cookham Wood, but Forward Trust's access to the relevant competencies argues for the existing configuration. In summary, any clinical need can easily be met, although this should always be in close liaison with the HMYOI Cookham Wood staff, particularly within the context of SECURE STAIRS and the formulation plan.

[30] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

At an August 2019 snapshot, the substance misuse team reported no patients currently receiving prescribed medication for substance misuse. A review of the medications data indicates no patients having been prescribed methadone for at least the last four years. The only need that clinical staff were able to recall was one young person who needed (on two separate occasions) to be supported with their dependency on Diazepam.
Naloxone is not provided on release. This is almost certainly appropriate.

6.2.2 Non-Clinical

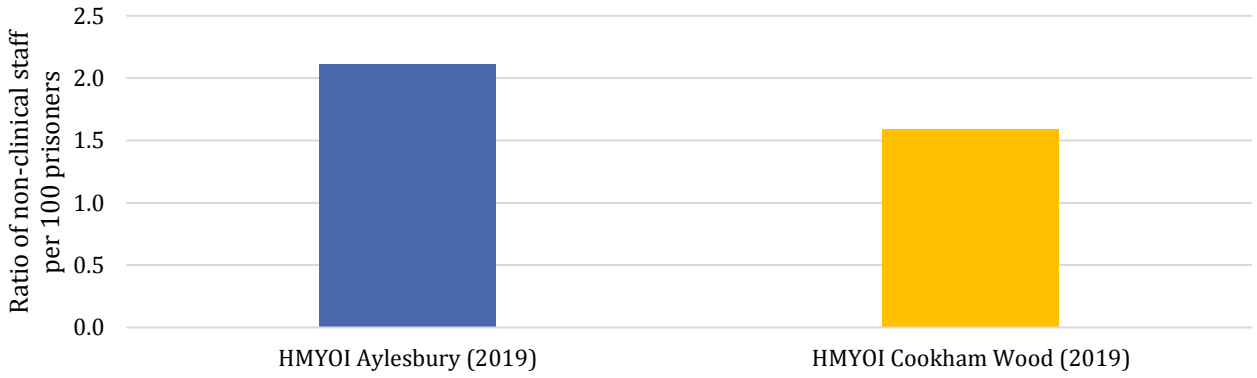
The staffing profile for the non-clinical substance misuse team is detailed below:

Figure 54 – Non-Clinical Substance Misuse Team Staffing

Role	Band (or equivalent)	Full-Time equivalents	Comments
Team Manager	Manager	1	
Substance Misuse Worker	Worker	1	
Substance Misuse Worker	Worker	1	
Substance Misuse Worker	Worker	1	
Admin	Worker	1	Forward Trust employee based at HMP/YOI Rochester, processes data for both establishments.

The chart below illustrates that HMYOI Cookham Wood has a lower ratio of non-clinical substance misuse staffing to the size of the resident population, compared to the only other similar establishment for which recent data was available. Open Road considered the staffing level at HMYOI Cookham Wood to be adequate, although more could usefully be done if the resource was increased. Considering that the young people already experience a wide range of support in areas that commonly overlap with substance use (e.g. risk-taking, emotional management) and will soon have more under SECURE STAIRS, it is unlikely that more substance misuse resources are needed.

Figure 55 – Psychosocial Substance Misuse Staffing Ratio (based on op cap)



At an August 2019 snapshot, the substance misuse service reported a total of 70 patients on the non-clinical caseload.

The service is supported by one peer mentor role (a trained resident who will have completed treatment with the service); this role can co-facilitate groups with an Open Road worker. The

role is paid via the prison. There are usually two young people in this role. Some have gone on to be peer mentors in the community post-release. They receive regular supervision and ongoing training.

In addition to 1:1 work, the service provides several groupwork sessions, though none are accredited. Available groups include the following:

Figure 56 – Substance Misuse Group Provision (service data)

Group/Programme name	Number of Participants	Duration (e.g. number of sessions)
Peer Support (peer-led)	Varies – up to 8	2 hours per week
Education (advice, awareness)	Varies – Up to 8	2 hours per week
Induction	Varies – Up to 15	2 hours per week
Family Day (monthly, substance misuse stall)	Varies – up to 30	4 hours per month
Evening Drop In	Varies – up to 20	2 hours per month

No fellowship groups (e.g. Alcoholics Anonymous) are currently provided. This is probably appropriate as young people rarely respond well to the 12-step approach to substance dependency, not least as they rarely have a dependency.

6.3 Service Activity

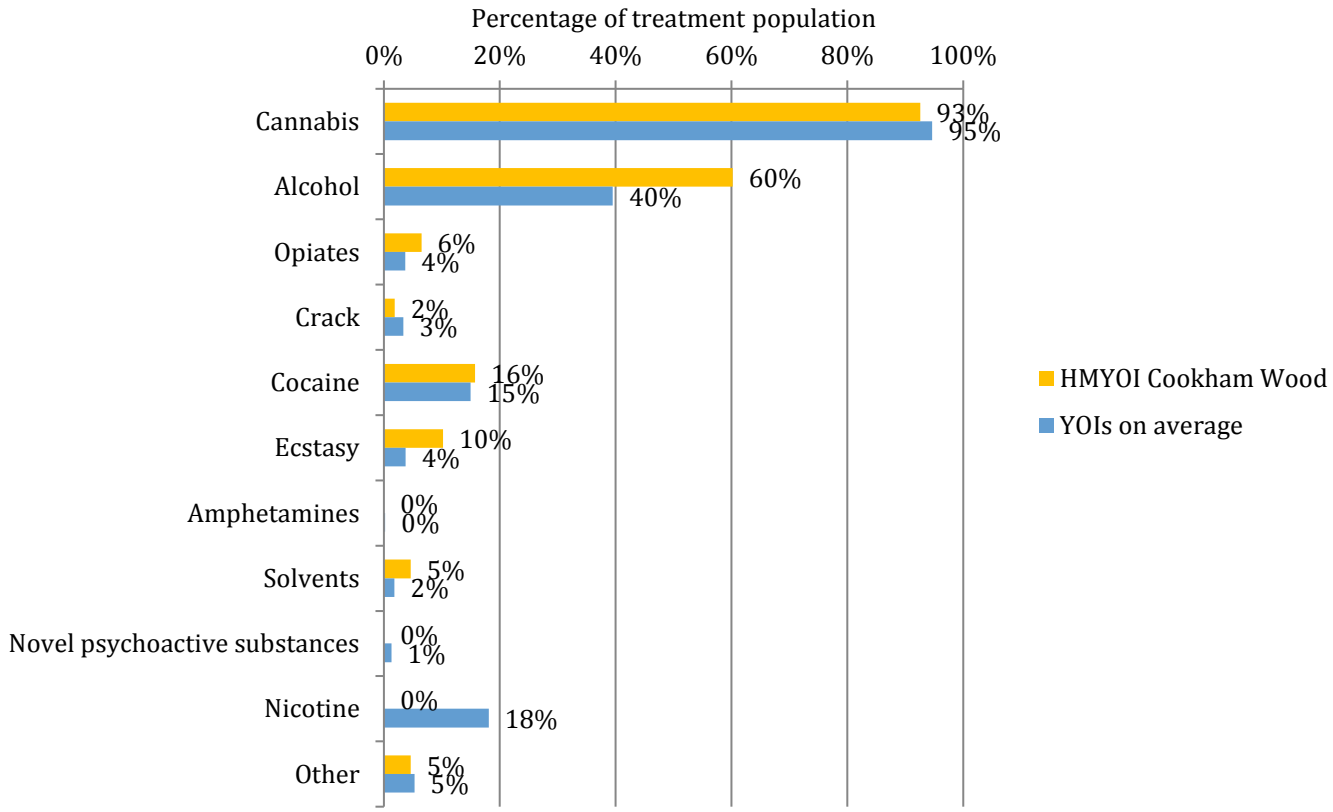
Open Road report that their overall approach is broadly educational, supportive and based on the young people's present and future experience and risks. They endeavour to place substance misuse within the wider context of that young person's life, attitudes, risks and behaviours. This is an appropriate approach to working with young people, who in the great majority of cases have not been dependent on alcohol or any other drug and who are not currently facing the same risks as their adult counterparts. This approach will also blend well with SECURE STAIRS and the formulation plans.

There is a lot of work done about drug dealing, mostly with those who are convicted of relevant charges, but also with those who have otherwise been identified as involved with dealing or at risk of the same. This includes the 'county lines' context. Note that criminal exploitation was a particular concern of the designated social workers and the safeguarding team. Sessions on the relevant legal issues are provided for both sentenced and remands.

In terms of substances, cannabis is the main concern, followed by alcohol and the range of so-called 'recreational' drugs. Substance use within the establishment itself is less of a concern than in the adult estate. The harm-reduction education covers all drugs.

The substance use profile, as reported on NDTMS, of those in treatment at HMYOI Cookham Wood is similar to YOIs on average, with few new patients reporting opiate use, and a high proportion being cannabis users; at HMYOI Cookham Wood an above-average percentage reported use of alcohol.

Figure 57 – Substance Use Profile of Treatment Entrants (NDTMS data 2018/19)

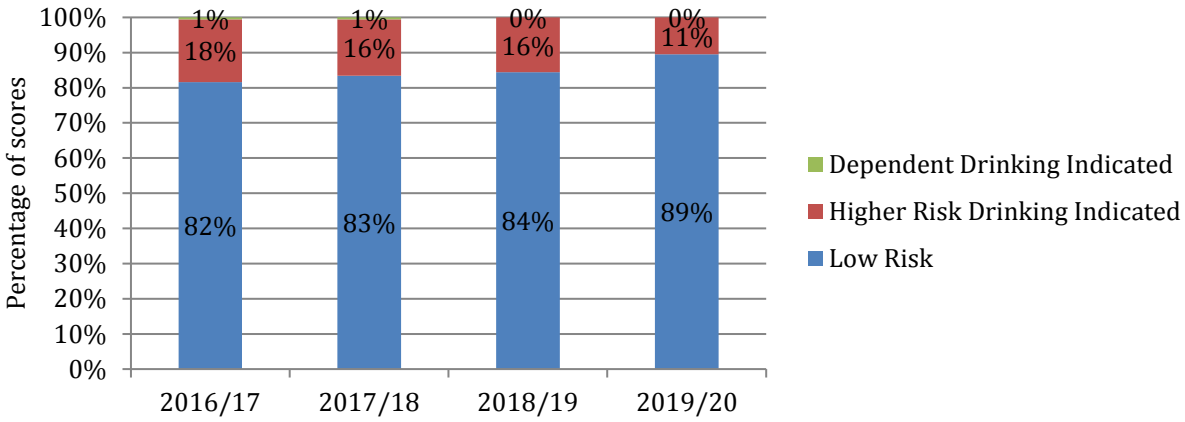


Data relating to the current in-treatment population was taken from NDTMS (current data relates to 2018/19), CYPIPS reporting where possible, and also supplied by the substance misuse service in HMYOI Cookham Wood.

CYPIPS data showed 20 young people receiving a brief intervention for substance misuse, and 26 receiving a specialist intervention during the three months April to June 2019. Between January and June 2019, all new receptions disclosing regular alcohol use were reported to have received an AUDIT screening.

SystmOne data indicated that 52% of newly registered patients during 2018/19 had an AUDIT score recorded. As can be seen below, the majority of scores did not indicate risky or dependent alcohol use, with 16% of scores in 2018/19 suggesting higher risk drinking, and none indicative of dependence. This is in contrast to the 26% of substance misuse treatment patients whose AUDIT scores suggested high risk or dependent drinking. There has been a slight decrease in higher risk drinking over time. Some staff felt that this might be a response to the increased risks of violence as gang culture has increased, i.e. that the young people sometimes preferred to be sober and have their wits about them.

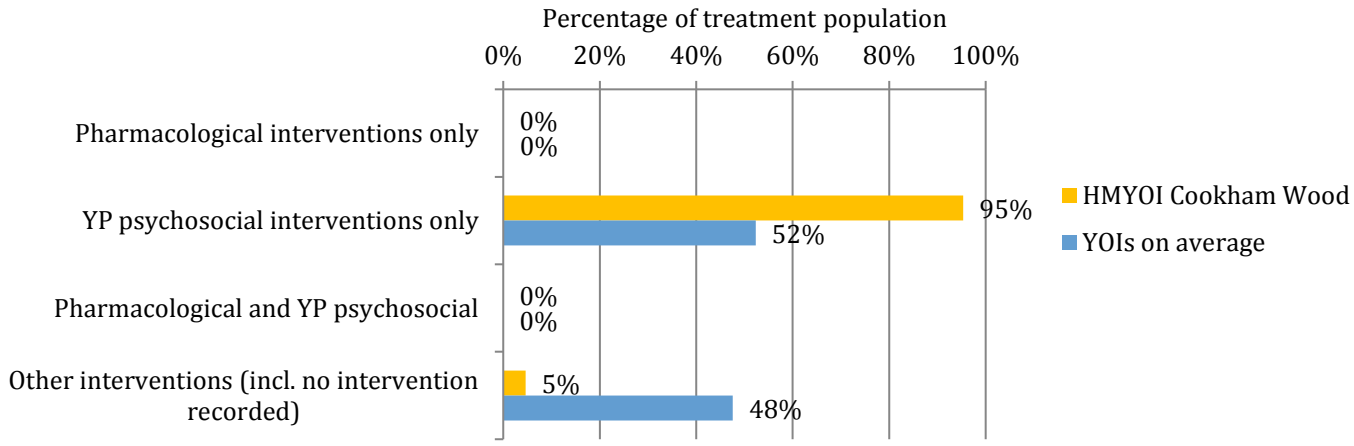
Figure 58 – AUDIT Score Data (SystmOne)



SystmOne data regarding treatment interventions was limited, with a total of 31 patients having a recorded substance use assessment in 2018/19, but very few other interventions recorded.

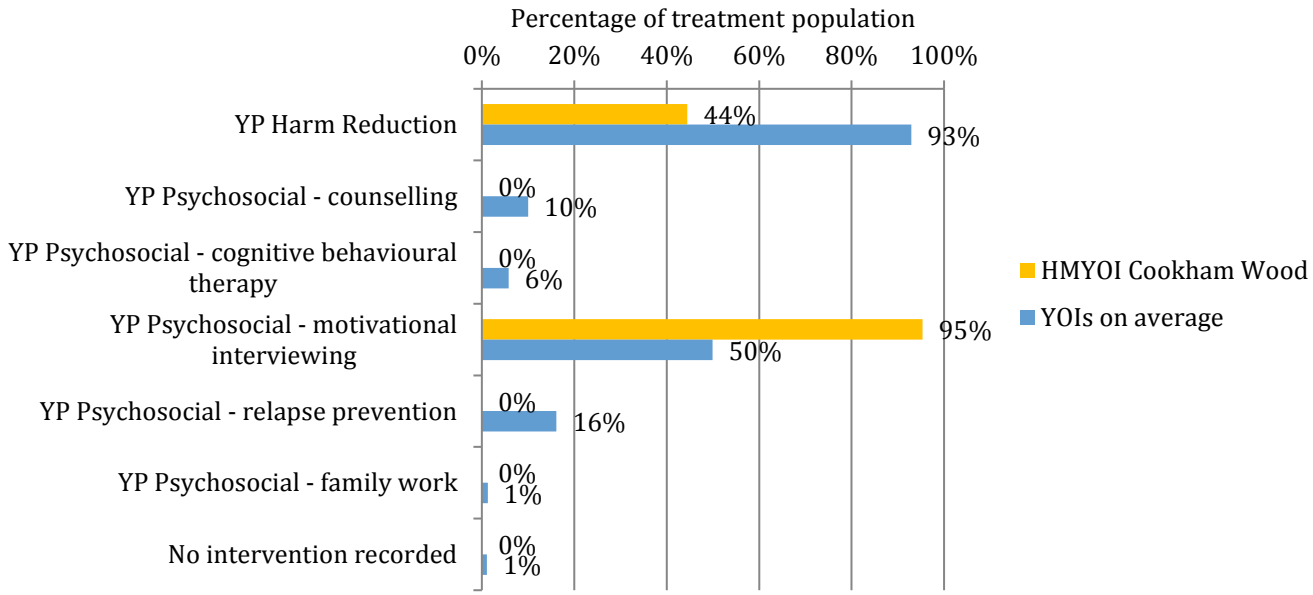
NDTMS data indicates that the profile of interventions provided to those in substance misuse treatment in HMYOI Cookham Wood is a little different to that offered in YOIs nationally. The establishment follows the national trend of no residents reported as receiving clinical treatment and with the vast majority receiving non-clinical treatment (psychosocial intervention) only; this is reinforced by snapshot data supplied by the service provider, indicating all current patients are receiving psychosocial interventions only. In contrast to the national average for YOIs, a low proportion at HMYOI Cookham Wood are reported as receiving 'other' interventions or having missing data. In practice most 'other' interventions are psychosocial anyway, so this makes sense, and the differences are likely down to conventions on recording across different services.

Figure 59 – Clinical and Non-Clinical Interventions (NDTMS, 2018/19)



A more detailed breakdown of treatment provision shows some differences between HMYOI Cookham Wood and YOIs on average, with a lower proportion of young people at HMYOI Cookham Wood receiving harm reduction interventions, and a higher proportion receiving motivational interviewing (note that patients may receive more than one intervention).

Figure 60 – Treatment Types Breakdown (NDTMS data 2018/19)



Open Road report that all their service users receive harm-reduction advice, explicitly and/or as part of other interventions, though this may not be recorded as such. Arguably most interventions also have an element of motivational interviewing, albeit with young people this may not be in the common sense of promoting abstinence.

The rigorous and multiple assessments and the breadth of support and interventions (substance misuse and others) suggest that most need is likely identified and met, although as in Recommendation 13 above, advice on reducing harm and risks should be covered from as many angles as possible.

6.3.1 Accessibility and DNA Rates

SystmOne data indicated a waiting time of one working day for substance misuse services as at August 2019. There was a reported DNA rate of 16% for substance misuse appointments.

In the patient consultation, 65% of patients said that they knew how to access substance misuse treatment (25% had already done so). This is lower than the 73% at HMYOI Aylesbury (the only similar prison for which survey data was available). Young people consulted for this report said that even those who didn't immediately know how to access a service could find out very easily.

6.4 Release Planning

As covered in 3.3.3 and 5.1.1, release can be a risky time for the young person and a challenge for services to reduce that risk. Release is planned from the moment of reception, but this planning is often limited.

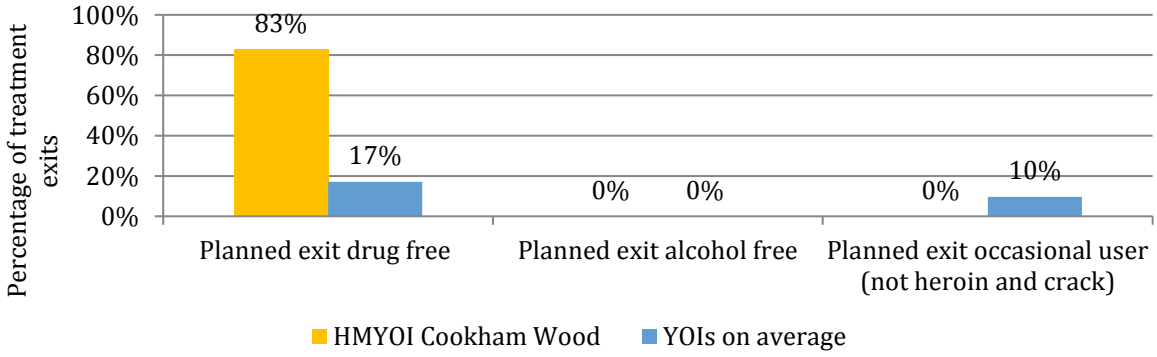
There has never been a need to ensure continuity of clinical intervention (e.g. OST). In most cases the young people would not see themselves as needing to continue to engage with substance misuse services so would be unlikely to, although where they are involved with YOTs and other services, these will almost certainly be considering substance use as well as other risk areas. Even if the young person did want to continue to engage with specialist support, this is a very limited resource for young people in the community, and in practice they are more likely to receive this from non-specialists such as YOTs or social workers if from anyone.

6.5 Treatment Outcomes

Caution needs to be taken when interpreting treatment outcome data as it relates solely to those who leave drug treatment (whether they choose to leave treatment, are released, or are transferred to another prison). A successful treatment outcome can include a discharge substance-free or with only occasional use, or an onward referral, for example to another prison or a community agency. This is even more the case with young people where the pattern of interventions and associated outcomes are not well reflected in the adult- and dependency-oriented NDTMS monitoring. As such it is difficult to draw useful or meaningful conclusions from much of the data in this section, but it is included for the sake of completeness.

NDTMS reported a high proportion (83%) of residents leaving treatment in HMYOI Cookham Wood drug-free in 2018/19 (much higher than the average of 17% across all YOIs).[31] This is not surprising considering the low levels of substance use in the prison and the brief nature of most interventions, and the higher age range of YOIs in general, though this is likely also another case of varying conventions around data. No patients were recorded as having left treatment alcohol free or as occasional users, although alcohol use is very rare in the establishment so in fact most probably have left treatment alcohol free in strict terms, especially as most exits are planned. The low figures involved are likely as so few only used alcohol, meaning many of the treatment exits are counted as drugs even if alcohol was also involved.

Figure 61 – Substance-Free and Occasional Use Treatment Exits (NDTMS, 2018/19)

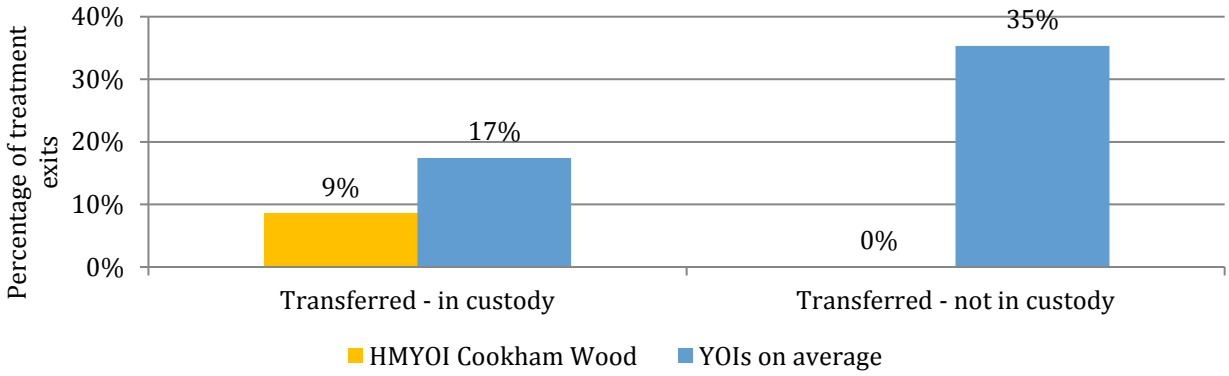


The total percentage of exits from treatment at HMYOI Cookham that were unplanned (9%) was considerably lower than the 21% of unplanned exits from treatment in YOIs on average.

[31] The establishments included in this average are HMYOI Brinsford, HMYOI Deerbolt, and HMYOI Feltham.

A relatively low proportion of treatment exits from HMYOI Cookham Wood (9%, n=7) were reported by NDTMS to be of individuals remaining in treatment and being transferred to a substance misuse service in another prison. Transfers to the community were expectedly low, though figures deferred between data sources. None were recorded by NDTMS as transferred to services in the community (most would not accept a need for this). Other NDTMS data shows that of 68 released patients over the course of the year, six were referred to a YOT and treatment provider; five of the referred patients are recorded as having started an intervention in the community. From the data it appears that all patients who were released from the establishment during the year were discharged as drug free. Most being substance free and few continuing to engage with specialist services is as expected and fits in with what was reported by Open Road and by the young people themselves.

Figure 62 – Transfers to Continuing Treatment (NDTMS, 2018/19)



6.6 Substance Use in the Establishment

The establishment report some drugs coming into the establishment through visits, but that their intelligence is quite good and they can keep supply to a minimum. There are low rates of positive test results from mandatory drug testing, roughly 4-5%, and these are mostly cannabis. Supply reduction is not a significant concern. Open Road and the young people themselves echoed this, although the young people are understandably likely to be reticent about discussing substance use in the establishment.

As substance misuse is not a big issue in the establishment, there is no separate strategy meeting, rather substance misuse concerns (supply or demand) are discussed in other meetings.

NDTMS data showed no substance misuse treatment patients recorded as reporting NPS use at HMYOI Cookham Wood during 2018/19, compared to 1% of patients at YOIs nationally. SystmOne showed no patients in recent years with a record indicating NPS/PS type drug use.

Part B of the report contains much fuller information in relation to the impact of new psychoactive substances (NPS/PS) in prisons and on prison healthcare teams in general.

6.7 Chapter Summary

- A lack of established baseline prevalence data for juveniles in custody makes it hard to assess the extent to which need is identified and met.
- The range of assessments, support and interventions available suggest most need and risk is likely identified and responded to, although there may be a need for more harm- and risk-reduction interventions. See Recommendation 16.
- Forward Trust are the contract holders and sub-contract psychosocial provision to Open Road.
- Dependent drug or alcohol use is very rare. As such, clinical need is very rare so, in practice, the service is essentially a psychosocial one.
- Provision is child-centred and appropriate to the needs of the young people. It is well regarded by other departments, by HMIP and by the young people themselves.
- Open Road also cover drug dealing and criminal exploitation (e.g. 'county lines').
- Staffing levels and resources are adequate. There are roughly 70 young people on the caseload.
- Cannabis is by far the most common drug (93%) used by those engaged with Open Road, followed by alcohol (60%).
- Most of the young people do not consider themselves to have a substance misuse problem.
- Substance use in the establishment is low, meaning supply reduction is not a big concern.

Chapter Seven – Screening, Immunisations and Vaccinations

7.1 Blood-Borne Viruses - Screening

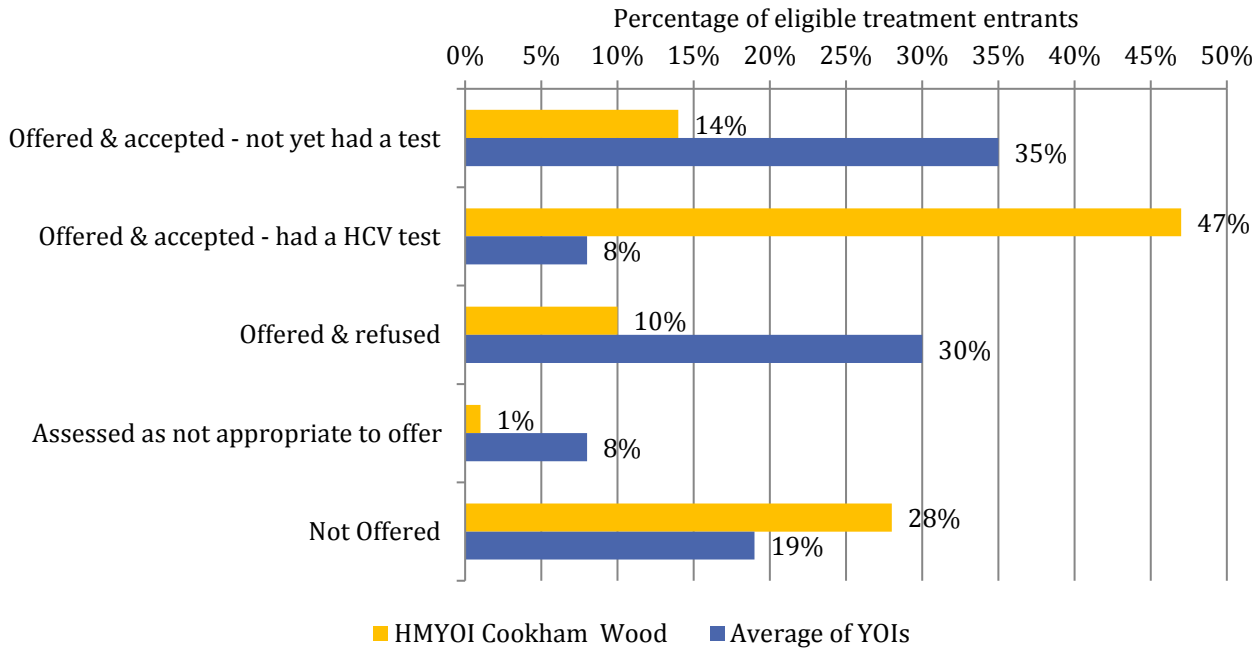
Three different sources are used for the data in this chapter: NDTMS, CYPIPs and SystmOne. In some cases, these can produce very different data for the same phenomenon. NDTMS is normally the most accurate when applied to substance misuse but is less relevant when applied to young people as the issues concerned are largely around injecting, and few juvenile offenders have ever injected. SystmOne data may cover a wider population than those normally considered at risk of BBVs, but as injecting is so rare this is less of an issue than it is in the adult estate. CYPIPs are more likely to be accurate, but cover a narrow, defined area and are a relatively recent tool. In most cases, we have taken whichever has the highest figures, on the basis that none are likely to over-count, with provisos outlined in the text.

NDTMS data describes the proportion of residents starting substance misuse treatment who have previously injected and who are currently injecting. This is important as it is an indicator of likely need in relation to BBV prevention or treatment. The data for both HMYOI Cookham Wood and the national average is very low, i.e. less than five people having ever injected, as would be expected from the national average.

NDTMS data shows an above-average proportion of substance misuse treatment entrants who are eligible for hep C testing accepting and receiving such interventions. The definition of 'eligible' below is not accurate where HMYOI Cookham Wood is concerned, as the NDMTS guidance[32] is clear (Appendix H) that the young person should first be assessed to see whether the test or vaccination is appropriate. Most of the BBV testing is part of the process of opt-out dry blood spot testing (DBST) that all receptions undergo, rather than a specific assessment around risky injecting histories. Considering the low injecting rates, many of the BBVS are not currently relevant to most of the young people, particularly testing for hepatitis C. However, this is a part of the DBST process at assessment, and whilst not necessary, does no harm.

[32] National Drug Treatment Monitoring System (NDTMS) Young people's treatment business definitions Core dataset N

Figure 63 – NDTMS Hep C Testing Data (2018/19)



Whilst the figures involved above are not relevant to any actual risk (that would only relate to the small number of injectors), it is interesting to note that there is normally a much larger number agreeing to the HCV test than those actually having it (as in the national figures), whereas it is the other way round at HMYOI Cookham Wood, which suggests that staff are good at persuading receptions to undergo DBST, and that these agreements are not being formally noted as an agreement to have an HCV test.

In this respect, one of the young people we spoke to described being 'made' to do DBST. Whilst it was clear at the time that they did not mean this literally, it did show primary care's proactive approach, and that this was working. Most of the young people said that they didn't mind being tested, although some appeared to have forgotten any explanation involved.

A further challenge in interpreting the data is some confusion between 'screening' and 'test' as part of the SystmOne read code. It is clear that, in some cases, the number in the data refers to 'screens', in the sense of a question that may lead to an intervention, and in other cases, a 'screen' means an actual intervention, such as a blood test. These differences are discussed, and judgements made as to what are the most likely figures and what the implications of these might be. In that respect, some of the codes in the tables below have been renamed to better represent what is meant, e.g. 'test' renamed as 'screen' when the latter is what is taking place.

The numbers recorded on SystmOne as receiving BBV interventions during 2018/19 are shown below. The numbers of patients reported as having been offered testing and the numbers tested are inconsistent and quite possibly inaccurate, i.e. the numbers tested are all larger than the numbers asked. This is almost certainly down to confusion in coding of screening and tests. Perhaps the most important aspects of this information (and more likely to be accurate) are the numbers identified as positive – the percentages shown are of the total number tested for each BBV. None are recorded with a positive result for hepatitis B or C, and fewer than five were recorded as positive for HIV.

Figure 64 – Screening Activity (SystmOne data)

HMYOI Cookham Wood	2018/19
HIV test offered	30
HIV screening declined	0
HIV test	160
HIV positive	<5 (<3%)
HIV negative	0
Hepatitis C test offered	61
Hepatitis C test declined	19
Hepatitis C test	155
Hepatitis C test positive	0
Hepatitis B test offered	31
Hepatitis B test declined	<5
Hepatitis B test	161
Hepatitis B screening positive	0

CYPIPS reports do not include information on BBV testing, however, the reporting indicated that on average, 62% of new receptions to HMYOI Cookham Wood between July 2018 and June 2019 were given advice regarding BBVs.

SystmOne data showed that at an August 2019 snapshot, no patients in HMYOI Cookham Wood had a record of a positive BBV test result (presumably the HIV positive patients had left).

The Office for National Statistics (ONS)[33] states that 2% of the adult population describe themselves as gay or bisexual. The rate of HIV infection amongst gay men is around 26 times greater than in the general population.[34] The equalities team reported no gay or bisexual residents at this time, although it is likely that many young men would not disclose.

The numbers with any of the above BBVs would be expected to be very low or zero most of the time at HMYOI Cookham Wood. The rigorous assessments and the opt-out DBST suggest that most actual need would be identified. In practice, education and advice to promote avoidance of BBVs in the future is probably more directly relevant to the HMYOI Cookham Wood population.

The challenges with the data discussed throughout this chapter are common across the secure estate. It might be assumed that these would be easy to overcome if there was consistent recording by all involved – and this would clearly help – but it is likely that careful analysis will remain necessary. Despite the data issues we are confident that the BBV work is appropriate and most needs are being met.

[33] ONS (accessed 10.1.2019).
[34] Terence Higgins Trust 53% of HIV cases diagnosed in 2017 were gay or bisexual men. ONS 2% of adults are gay or bi-sexual (accessed 10.1.2019).

7.1.1 Blood-Borne Viruses – Pathway

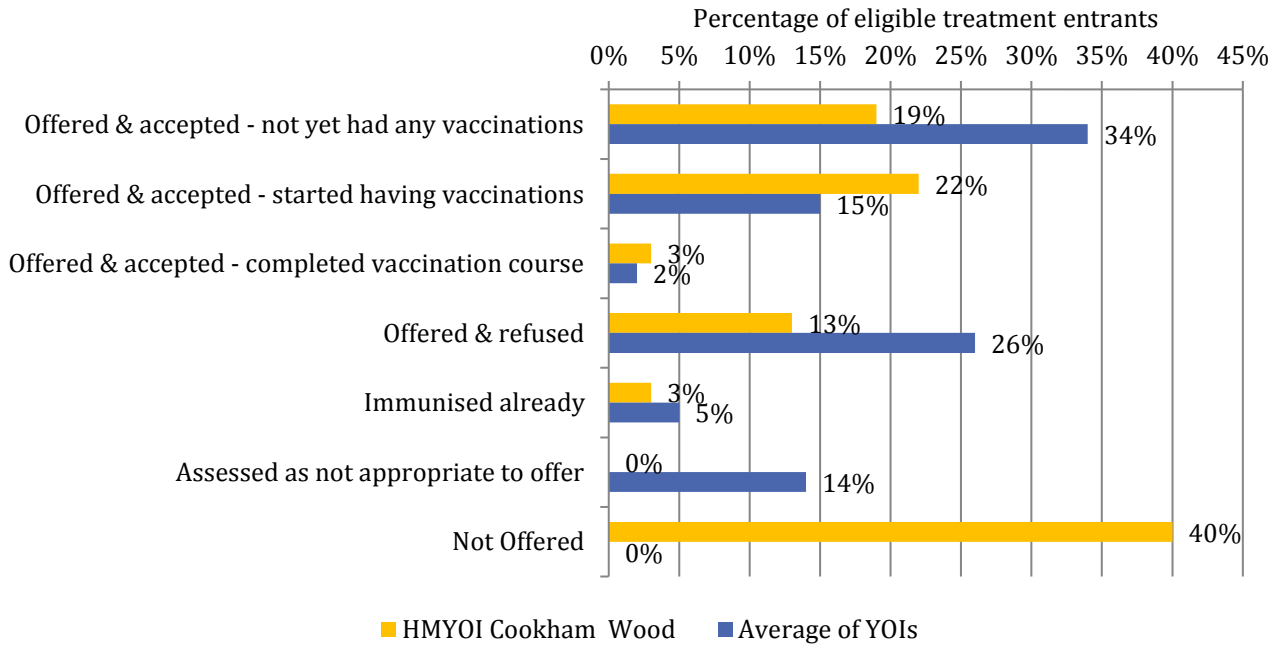
Specialist treatment for BBVs would very rarely be needed. If needed, this would be accessed via an escort to community services or possibly by those community services coming into the establishment (e.g. the Hep C Trust).

7.2 Vaccinations

7.2.1 BBV Vaccinations

NDTMS data shows an above-average proportion of substance misuse treatment entrants who are eligible for hep B vaccination accepting and starting (or completing) a course of vaccination. With regard to the point in 7.1 about 'eligibility', note that HBV is also sexually transmissible, so for this and other reasons, the eligibility criteria should be broader. Again, it is worth noting the contrast between 'offered' and 'started' for HMYOI Cookham Wood compared to the national picture, although in both cases completions of the course are rare.

Figure 65 – NDTMS Hep C Testing Data (2018/19)



The CYPIPS reports cover the numbers of patients eligible for, and receiving, hepatitis B immunisations. Data was only available for the three months April to June 2019, during which time an average of 23 patients were reported as eligible each month (note previous points about 'eligibility'). The report indicated eight patients receiving at least one dose of the vaccine during the three months.

SystmOne data described greater numbers vaccinated during 2018/19, with 46 patients recorded as receiving a third vaccine dose (although none were recorded as receiving a booster dose).

Completing a course of HBV vaccinations is always difficult in a prison with a quick turnover. The SystmOne data suggests some success at managing the full course, although it is impossible to know how many were potentially at risk or had been assessed as such, or the status of their HBV vaccinations, as the eligibility criteria may differ between the NDTMS data and primary care practice at HMYOI Cookham Wood. Even allowing for the range of risk factors for HBV, the numbers suggest that primary care is likely meeting at least some of the needs for HBV vaccination, although the data suggests that completing the course remains a challenge. Note that a single dose does offer some protection.

7.3 National Immunisation Schedule

The CYPIPS reports cover the monthly numbers of patients eligible for, and receiving, certain immunisations. These are presented in the following table.

Figure 66 – Immunisations and Vaccinations (CYPIPS data)

HMYOI Cookham Wood	Average per month Jul-18 to Jun-19			Total number vaccinated Jul-18 to Jun-19
	Number eligible	Number vaccinated	Percentage of eligible vaccinated	
Flu Vaccinations	13	1	4%	6
MMR	27	7	25%	79
Men C	33	0	0%	0
Men ACWY	34	4	13%	52

Primary care report that the low levels of flu vaccination are because most young people refuse them. One of the young people spoken to for the HNA had been refusing vaccinations over concern about what might be in them, i.e. he did not trust that there wasn't some sinister motive for vaccinations. This view was not shared by other young people. Whilst such views are irrational and uncommon, they are unlikely to be unique, and primary care may need to give some thought to how to address these, perhaps with help from the psychologists and in the context of the formulation plan. Consulting the young people themselves on what strategies might promote take up and reduce resistance may be a way of helping to ensure flu vaccinations.

Recommendation 17 – Improve the rate of flu vaccinations, in consultation with the young people.

Primary care reported that there were normally respectable rates of MMR, but that the lack of a fridge to store the vaccines for several weeks had contributed to a dip in uptake.

Recommendation 18 - Every effort should be made to ensure that all young people receive the full MMR vaccine.

CYPIPS commentary (added by healthcare) indicates that the men C vaccination is not used at HMYOI Cookham Wood, with the men ACWY vaccine used instead. This protects against four different strains of the meningococcal bacteria that cause meningitis and septicaemia. CYPIPS data indicates a total of 52 residents given the men ACWY vaccination during the most recent twelve months available. What is not clear is how many may have already had the vaccination. It should be established (and recorded in SystmOne) if the young person has had a meningitis vaccine and if there is any doubt then they should be offered one.

Recommendation 19 – All young people should have had the Men ACWY vaccine.

The vaccination rates listed above are not high and it is not clear on SystmOne who may have already been vaccinated previously. It should be noted that while the reporting only considers a patient to be vaccinated once all doses are received (for example the MMR vaccination requires two doses and hepatitis B requires three), those receiving a single dose before being released or transferred will still benefit from partial protection.
Those leaving the establishment having received one dose will be able to complete the immunisation elsewhere, provided the initial dose is properly recorded.

The CYPIPS data only reports on some of the national immunisation schedule (NIS) vaccinations which should be provided for residents who have missed them in childhood. The NIS also includes immunisations for diphtheria, tetanus, pertussis, and polio which are relevant to a young offender population. Some data regarding NIS vaccinations given was available from SystmOne for 2018/19.

Figure 67 – National Immunisation Schedule Vaccinations (SystmOne data)

Vaccination Type	2018/19
Diphtheria, Tetanus and Poliomyelitis 1	18
Diphtheria, Tetanus and Poliomyelitis Booster	10
Influenza 1	6
Meningococcal group 1	66
MMR 1	52
MMR Booster	41

These figures appear slightly higher than the CYPIPS data, although the same recommendations apply.

Note that the issue of consent for injections for some young people can delay them and even lead to them not happening at all, particularly if it is hard to establish where permission may need to be sought from, or where the responsible person (parent) has already made it clear that they do not agree, but the young person wants the vaccination. In the latter case, primary care will usually go with the young person's wishes, as is national policy and good practice.

7.4 Sexual Health

Sexual health interventions, health promotion and advice at HMYOI Cookham Wood are nearly always in-house from primary care, although education also cover sexual health in a number of their classes. SystmOne reported a DNA rate of 0% for the sexual health clinic between February and July 2019 (compared to an average of 10% across all primary care clinics). The waiting time for the sexual health clinic, based on SystmOne data as of August 2019, was one working day. There are no visiting GUM services. When young people need to access secondary care services this is arranged via an escort. Condoms were reported to be available from health staff.

CYPIPS reports an average of 30% of new receptions to HMYOI Cookham Wood per month referred for sexual health screening during the twelve months from July 2018 to June 2019, a total of 105 patients during the year. In total (including patients from the existing population), 476 patients during the year were reported to have been referred for STI screening, and 94% of these (n=461) screened. These figures suggest most need is likely identified.

Data regarding test results was only available for the three months April-June 2019, during which time eight patients were reported to have tested positive, and all of these had received appropriate treatment.

The current national vaccination programme for the human papillomavirus (HPV) protects against both cervical cancer and genital warts and is largely aimed at younger women (under 25), although the role of men in transmission is increasingly recognised as necessitating that they too are vaccinated. Between April and June 2019, an average of 22 patients per month were reported as being eligible for vaccination against human papillomavirus (HPV) at HMYOI Cookham Wood. None of these were reported to have been vaccinated. Oxleas are currently piloting HPV vaccinations at HMP/YOI Rochester. Oxleas should consider whether as part of the secondary screen at HMYOI Cookham Wood they check for HPV vaccinations and attempt to provide these where they may be missing, and who this may be appropriate for. Note that the course involves multiple injections over several months and thus may be difficult to complete.

Recommendation 20 - Oxleas to consider the need and possible pathways etc. for HPV vaccination.

SystmOne reporting on chlamydia screening contained some inconsistencies (for example, a higher number of test results recorded than numbers having received a test) though indicates 41 patients having tested positive during the year. Primary care report that this reflects the high rate of chlamydia in the local community.

Figure 68 – Sexual Health Screenings (SystmOne data)

HMYOI Cookham Wood	2018/19
Chlamydia test positive	41
Chlamydia test negative	229
Syphilis serology	18
Syphilis infectious titre test	0
Gonorrhoea test positive	<5
Gonorrhoea test negative	34

Primary care reported that they used to test for chlamydia and gonorrhoea separately, but that this was contributing to missing gonorrhoea, as this was only tested for when there was a positive chlamydia result, i.e. those who were negative for chlamydia but positive for gonorrhoea weren't being tested. The current approach is to test jointly, and this should help ensure all gonorrhoea is identified and treated.

Primary care also reported that it was a challenge to get the young people to complete the current treatment for chlamydia. The usual treatment for chlamydia is the antibiotic Azithromycin as a single, large oral dose. Primary care are currently using alternative

antibiotics that need to be taken twice a day for a full week, and it is proving difficult to ensure the young people complete the full course. Whilst there may be some slight health benefits of one antibiotic over another, this is likely outweighed by the needs of this patient group, i.e. they may be more at risk of chlamydia and less likely to complete treatment. Consideration should be given by Oxleas and pharmacy to using Azithromycin instead, perhaps after an audit of current completion rates within the present regimen.

Recommendation 21 - Consideration should be given to using Azithromycin to treat chlamydia in order to improve treatment outcomes.

7.5 Chapter Summary

- Opt-out DBST and sexual health screening are a part of the initial assessments.
- Injecting rates are expectedly low. HCV testing more than covers this number.
- Positive BBVs are expectedly rare.
- Courses of HBV vaccinations are rarely completed, although numbers suggest need is being identified well.
- Only 3% of the drug treatment patients are described as previous injectors, which is less than a quarter of the YOI average (16%). This would suggest a lower level of BBVs.
- Rates of flu vaccination need improving, perhaps with input from the young people. See Recommendation 17.
- Rates of MMR vaccination need improving. See Recommendation 18.
- Rates of men ACWY vaccination need improving. See Recommendation 19.
- Sexual health provision is good and most need is probably identified and met, apart from HPV vaccinations. See Recommendation 20.
- Some young people are finding it difficult to comply with the new chlamydia treatment. See Recommendation 21.

Chapter Eight – Safeguarding

This chapter explores care for the vulnerable and responses to self-harm and violence. The latter two are important for primary care as these describe the cause of much of the unplanned work responding to alarms, codes, injuries etc. The escort data illustrates that a sizeable proportion of all patients accessing secondary healthcare services are 'unplanned', this is largely in response to incidents.

8.1 Safeguarding Systems

There are established links around safeguarding with Medway Council and a single point of contact for all concerns. The governor felt that most of the staff understood safeguarding and took it seriously. A governor is head of safety, which covers both security and safeguarding.

In order to manage allegations against child care professionals (e.g. any of the staff at HMYOI Cookham Wood), every local authority appoints a local authority designated officer (LADO) who should be alerted to all cases where it is alleged that a person who works with children has behaved in a way that has harmed or might harm a child. HMIP reported in late 2019 that this process at HMYOI Cookham Wood could be slow and was inconsistently applied.[35]

Medway Council report that staff at HMYOI Cookham Wood have been trained as to how the LADO process should work and this generally works well now, although health staff have not made a LADO referral in the last 2.5 years, in contrast to other departments in the establishment. This may be appropriate (e.g. there were no concerns) but should be explored.

Recommendation 22 – Health managers to ensure their staff are clear on LADO and safeguarding processes.

The SBAR assessment carried out by the designated social workers aims to screen for child trafficking, criminal and sexual exploitation.

Some of Chapter Ten is also relevant to safeguarding in the overview of the safeguarding team and other work to ensure the child's safety, health and wellbeing.

8.2 Self-Harm and ACCT

Globally, suicide is the second leading cause of death among 15–29 year olds, and self-harm is one of the strongest known predictors of death by suicide.[36]

8.2.1 Prevalence

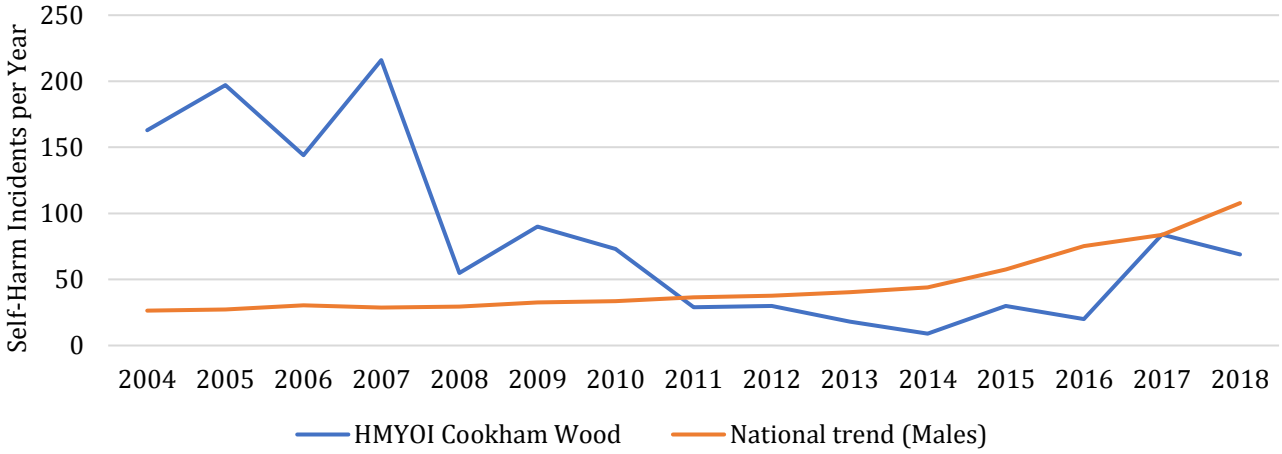
In relation to HMYOI Cookham Wood, HMIP recently noted:

[35] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/
[36] Suicide and Self Harm: advancing from science to preventing deaths. Journal of Child Psychology and Psychiatry 60:10 (2019), pp 1043–1045

Levels of self-harm were low and there was good care for children in crisis. Levels of violence remained too high.[37]

The chart below considers the number of self-harm incidents in HMYOI Cookham Wood over time. The chart also reports the national trend, showing incidents of self-harm per annum for a male prison population (including both adults and young offenders) the size of the current op cap. Self-harm incidents at HMYOI Cookham Wood have, like the national trend, increased over the last several years, although remain lower than they were 10-15 years ago. The rate is currently still below the national average. As described in Part B, self-harm among young offenders is typically more common than among the adult male prison population.

Figure 69 – Self-Harm in HMYOI Cookham Wood (comparison) [38]



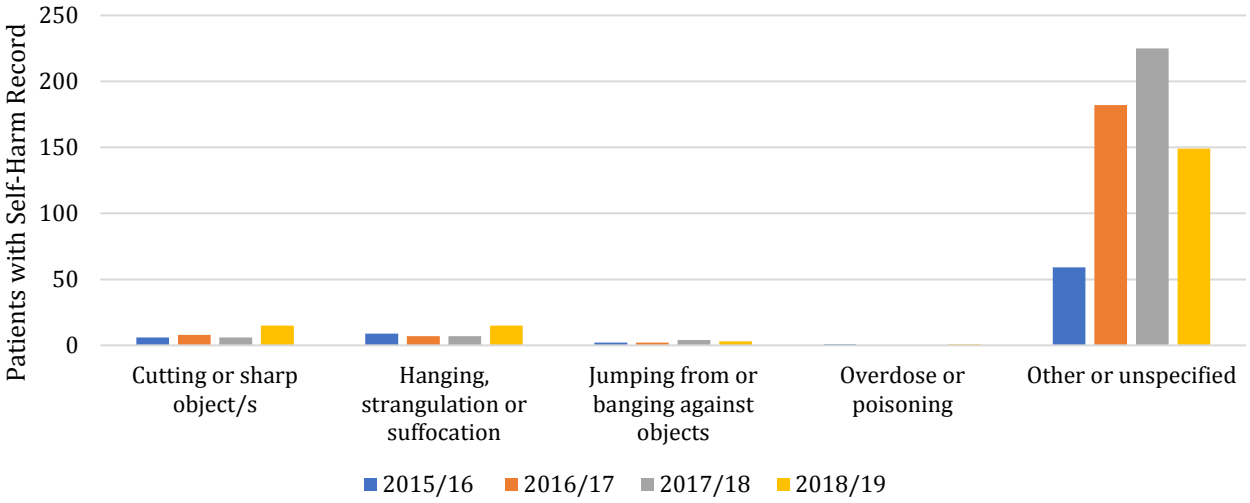
In some cases, high numbers of self-harm incidents may indicate a range of individuals engaging in these behaviours; in other circumstances a small number of prolific self-harmers may account for a large proportion of the incidents reported. MOJ data no longer includes the number of prisoners recorded as having self-harmed in each prison. SystmOne data indicates that during the full year 2018/19, 115 patients had at least one self-harm incident recorded on the system (a decrease from 187 in 2017/18). Recording of F213SH (self-harm injury) forms on SystmOne appears inconsistent, with only 18 patients in 2018/19 having a form opened on the system.

SystmOne data indicated that most incidents of self-harm over the past few years did not have the type of self-harm recorded, however, the data does illustrate an increase up to 2017/18 followed by a reduction in 2018/19. Where specified, the most common type of self-harm incident recorded was cutting, harm caused by a sharp object, or self-strangulation. However, this is far from conclusive as the numbers of specified incidents are so low. Primary care reported that injuries from punching walls were common.

[37] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

[38] MOJ (2019) Safety in custody Statistics. Table 2.13 National trend refers to male prisoners only and is standardised based on the op cap, so shows the number of incidents per that number of prisoners.

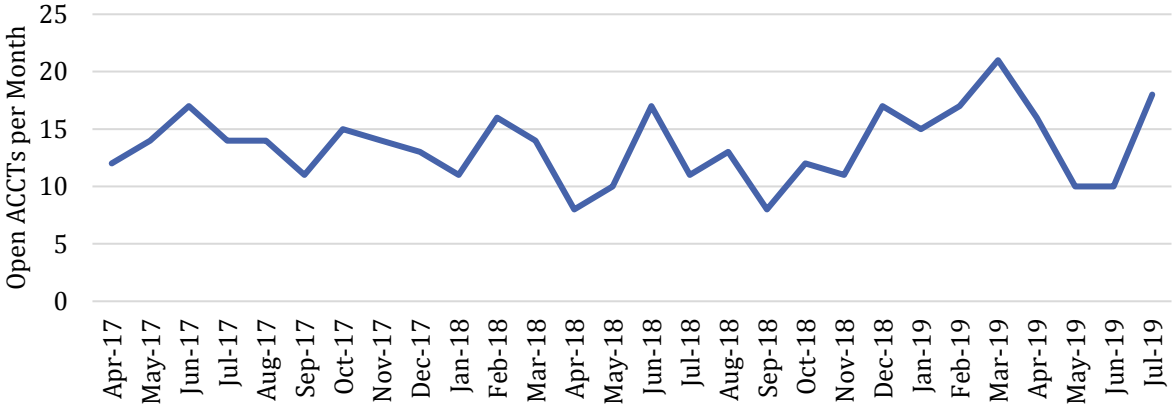
Figure 70 – Recorded Types of Self-Harm (SystmOne data)



8.2.2 ACCTs

The 2015 HNA did not report on numbers of ACCTs opened. Using data supplied by the establishment's safer custody team for the past three years, numbers of ACCTs opened each month have fluctuated but there has been little overall change in the numbers opened per month. The governor felt that this had risen recently, attributed to taking in young people who normally would have gone to HMYOI Feltham.

Figure 71 – Opened ACCTs (safer custody data)



Mental health mostly attend ACCT reviews, though sometimes primary care do, particularly at weekends. The establishment felt that this worked well and were content with the support for ACCTs. This is an improvement on the HMIP inspection's findings that there was insufficient health support to the ACCT process.[39] The designated social workers also sometimes attend ACCT reviews and may quality assure the ACCT plans in safeguarding terms to see that the plans and responses are necessary and appropriate, e.g. with respect to anti-ligature clothing or constant watch. On occasions the outside social worker may also attend an ACCT review.

[39] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

8.3 Self-Inflicted Deaths

There has been only one self-inflicted death in HMYOI Cookham Wood in the past 25 years, in 2012.

As noted in Part B, there are a number of reports which specifically focus on self-inflicted deaths in custody amongst the 18-24 year old age group and contain a range of good practice recommendations.

The Prison and Probation Ombudsman (PPO) reports no self-inflicted deaths in HMYOI Cookham Wood in more recent years. Healthcare and the establishment also reported no recent self-inflicted deaths waiting investigation.

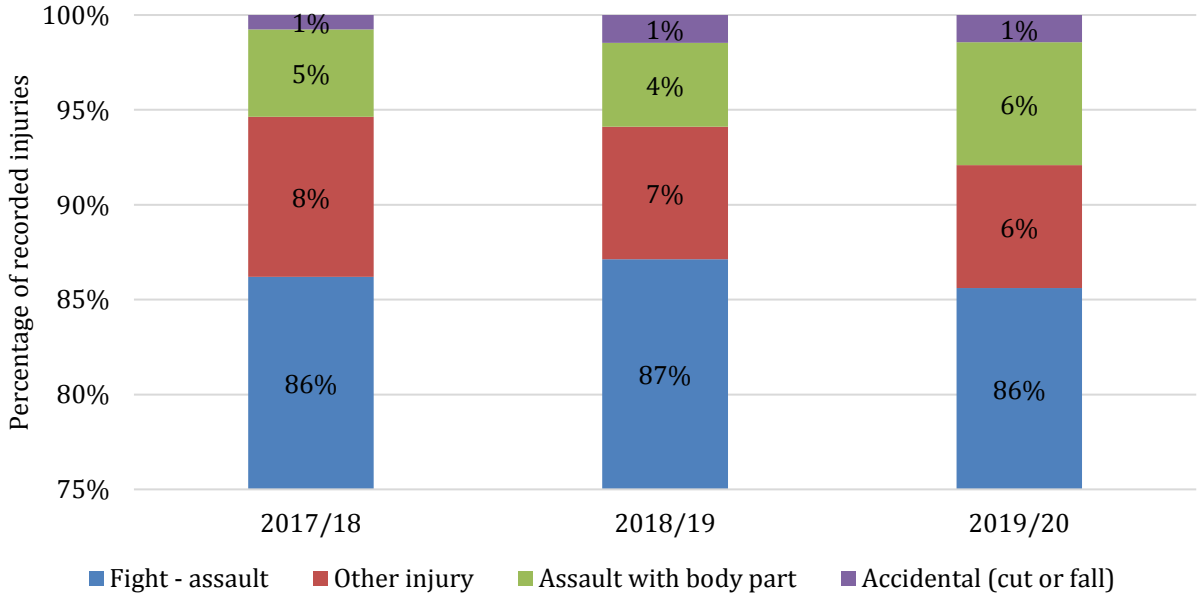
There is no established data set to refer to, but staff report anecdotally that there have been deaths of young people soon after release, although the causes are unknown.

8.4 Accidents and Injuries

Injuries are not unusual. Most result from violence, some from accidents (including sports injuries), and some are self-inflicted. Healthcare manage most injuries, referring to A&E and secondary care where necessary.

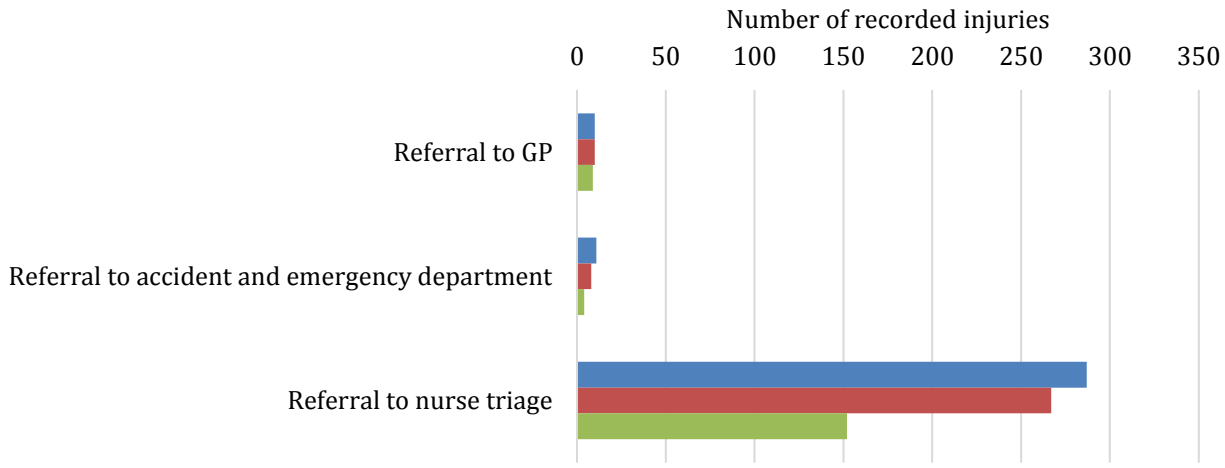
As noted above, it is not clear how rigorous or consistent the inputting of injury recording forms on SystmOne may be at HMYOI Cookham Wood. However, some data was available from inputted F213 (general injury record) forms for the past three years. This is shown below, with by far the greatest proportion of recorded injuries being reported as due to assault.

Figure 72 – Cause of Injury (F213 form data from SystmOne)



The same forms include a record of the action taken by health in response; this is shown below. Note it is possible that the same read codes are also present on other SystmOne templates, thus the below may include additional instances of treatment or referral (not only those made following an injury). As can be seen, the great majority are managed in the establishment without a referral to A&E.

Figure 73 – Injury Outcomes/Action (F213 form data from SystmOne)



Data provided by healthcare at HMYOI Cookham Wood (in section 3.4), covering external secondary care appointments for the full year 2018/19, showed that 29% of escorts were for patients attending A&E, and 9% were for x-rays; it is likely that most of these appointments are due to injuries, most resulting from violence.

As discussed in 3.4, Medway Council raised a concern about safeguarding where injuries are concerned, i.e. that in the community injuries would lead to an examination within a safeguarding context by a paediatric consultant, and that this was not always happening. This could be discussed and reviewed as part of the overall review of social care and safeguarding recommended in Chapter Ten.

8.5 Violence

HMIP expressed concerns about the levels of violence in their 2019 report, noting increases in many areas of violence since their last inspection.[40]

HMYOI Cookham Wood has a strategic approach to reducing and managing violence and a range of approaches involved, although everyone involved (including the young people) recognised the limitations of these and that it would likely never be possible to eliminate violence altogether. Gang affiliations and the associated violence are significant factors, though some of the staff spoken to had hopes that the SECURE STAIRS approach may help reduce violence through a range of direct and indirect impacts.

[40] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

Primary care and other health services reported that they were rarely on the receiving end of violence beyond the occasional incident of verbal abuse. Staff were kept informed by the prison of possible risk. The young people generally expressed a positive regard for the health professionals, some pointing out that even when they were difficult or abusive this wasn't necessarily personal.

As described in Chapter Three, the need to keep some young people apart from others is a significant drain on resources, makes life more difficult for all the young people and can undermine effective use of health resources, e.g. by increasing DNAs.

8.6 Emergency Calls/Codes

A 'code'/emergency call to healthcare automatically triggers a call for an ambulance which healthcare may stand down.

SystmOne did not show any records of the usual 'healthcare emergency response' read code used to report emergency calls; nor were any instances of 'Code Reds' or 'Code Blues' (often used to denote emergency healthcare attendances) recorded, over the past three years. Several other read codes[41] denoting an emergency scenario were queried to give an indication of typical numbers of emergency responses. Overall there was no consistently recorded data on emergency responses, so these are not shown.

Primary care report that there are few emergency codes called and that these are nearly always appropriate. They also respond to every alarm bell on the assumption that there may well be injuries to attend to and/or restraints to be checked. This is good practice. Need is being appropriately met.

[41] Read codes included were: Emergency treatment (8B1); Emergency appointment (9N58); Referral to accident and emergency service (XaAcH); Seen by accident and emergency - service (XaBTN); Prisoner health - healthcare emergency response (Y0d05).

8.7 Chapter Summary

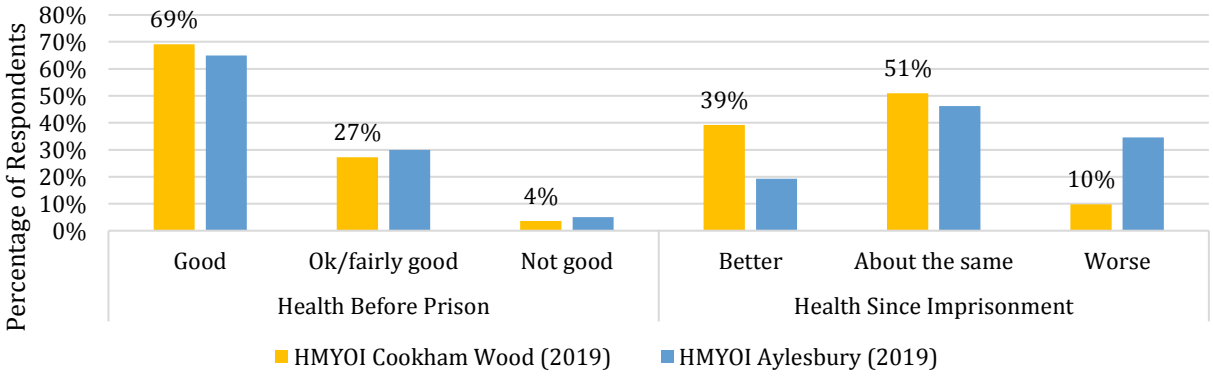
- There is a strong emphasis on safeguarding at HMYOI Cookham Wood and good links with Medway Council. The process for managing safeguarding allegations has improved, although health have yet to refer. See Recommendation 22.
- The rate of self-harm is lower than the national prison average.
- The number of ACCTs fluctuates considerably, with roughly 10-15 opened per month. The ACCT process is well supported by health services.
- There has been one self-inflicted death in the last 25 years.
- Violence is a big problem at HMYOI Cookham Wood. Several initiatives attempt to address this.
- There are a lot of injuries from violence; most of these are managed in the establishment by healthcare.
- Escorts to A&E constitute 29% of all escorts.
- Emergency codes are rare. Primary care attends all incidents and alarms.

Chapter Nine – Wellbeing and Health Promotion

Health promotion is a key part of healthcare for young people as they will not have had a chance to develop most physical conditions yet, and health promotion can help reduce the risk that they will. Primary care at HMYOI Cookham Wood are clear on the centrality of health promotion in their provision and this was recognised by the young people. Any health promotion concerns and needs should be reflected in the SECURE STAIRS formulation plan.

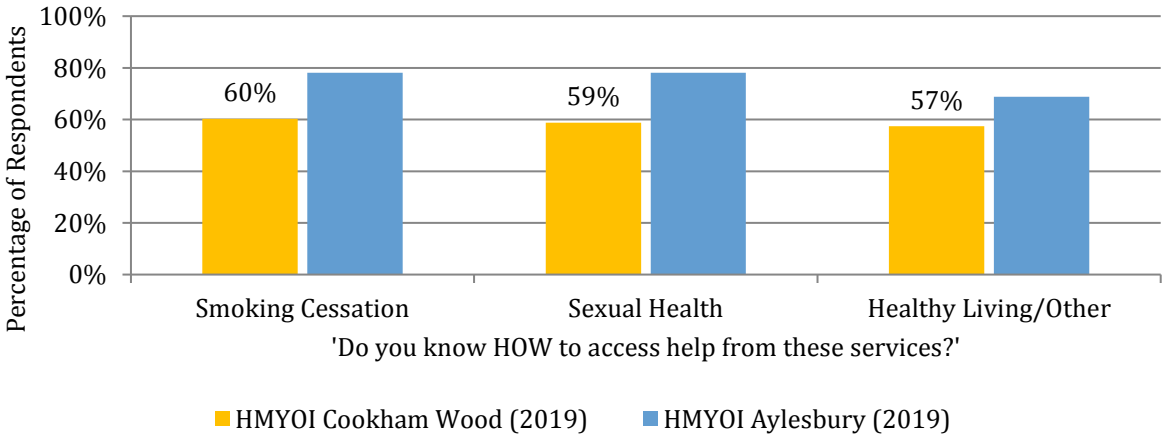
In our patient survey, respondents were asked about their health in general, before and since imprisonment. In relation to HMYOI Aylesbury (a similar prison we have surveyed recently), patients at HMYOI Cookham Wood were slightly more likely to report their health had been good prior to imprisonment, and also more likely to say it had improved while in the establishment.

Figure 74 – Health Before Imprisonment and Now (survey data)



Patients were asked if they knew how to access health promotion services. As with other healthcare services, patients were a little less likely than those at HMYOI Aylesbury to report confidence in accessing the services. Young people spoken to for this report said that if they or anyone else wanted to access a service it wouldn't be difficult to find out how, as almost anyone working in the establishment could probably tell them, although they would probably start with primary care.

Figure 75 – Accessibility of Health Promotion Services (survey data)



9.1 Generic Health Promotion

Primary care has a Band 4 HCA leading on health promotion. She puts a lot of effort into sourcing appropriate material and to how the relevant messages can best be delivered, with a combination of methods being used, i.e. static materials (e.g. posters) and face-to-face conversations. In terms of generic health promotion, the core of this is the PHE health promotion calendar, e.g. August 2019 was about protection from the sun, September 2019 was 'healthy hearts'. Material is displayed on the main landings/units and promptly changed every month. There are six health promotion noticeboards in the establishment as well as other noticeboards advising on health provision.

Residents consulted for this report were aware of the health promotion material and clarified that this was often backed up verbally by health and other staff. HMIP were also positive about the health promotion work at HMYOI Cookham Wood.[42] It is hoped that SECURE STAIRS will further the health promotion agenda, particularly where specific individuals have health promotion needs (e.g. often forget to brush their teeth) and the messages can be reinforced by all the staff who work with them.

Links with the gym and education were reported as good, and a lot of the work of both could be considered as promoting both physical and mental health. In this context it is also worth noting that the food from the kitchen was considered by staff and the young people to generally be good and with healthy options.

As noted in 3.5, the dentist reported a sustained emphasis on dental self-care and hygiene.

9.2 Smoking

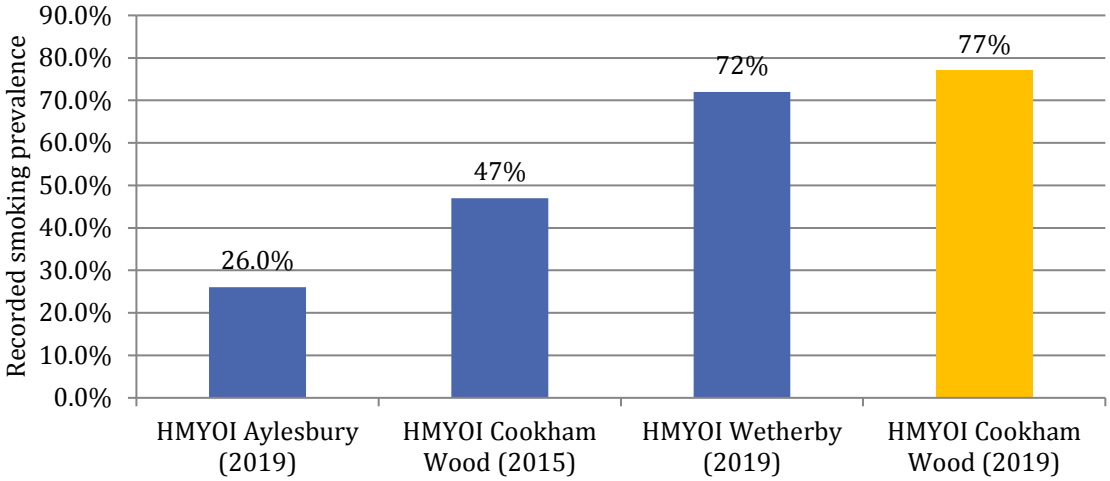
Figures from CYPIPS reporting (CYP national report Q1 2019/20) show that an average of 74% of new receptions identified as current smokers were offered smoking cessation advice, support or treatment. The YOI average for that quarter is 86%. The higher figure will be due to the presence of over 18s across other YOIs.

SystmOne data indicated that 77% of the establishment population at an August 2019 snapshot were recorded as being smokers, though this may include long-term patients who were recorded as smoking on entry and have since quit. This percentage is higher than for comparators, although the marked contrast with HMYOI Aylesbury is likely to be down to differing crieria for recording, i.e. that HMYOI Cookham Wood has much broader criteria as to what counts as a smoker. This probably also accounts for the apparent marked increase in smoking since the previous HNA.

In our patient survey, 56% of respondents reported that they had smoked before entering the establishment, similar to the 58% at HMYOI Aylesbury. Note that in terms of interventions, there is a difference between having smoked and being a dependent smoker, specifically that the former will not need nicotine replacement therapy (the latter may not either).

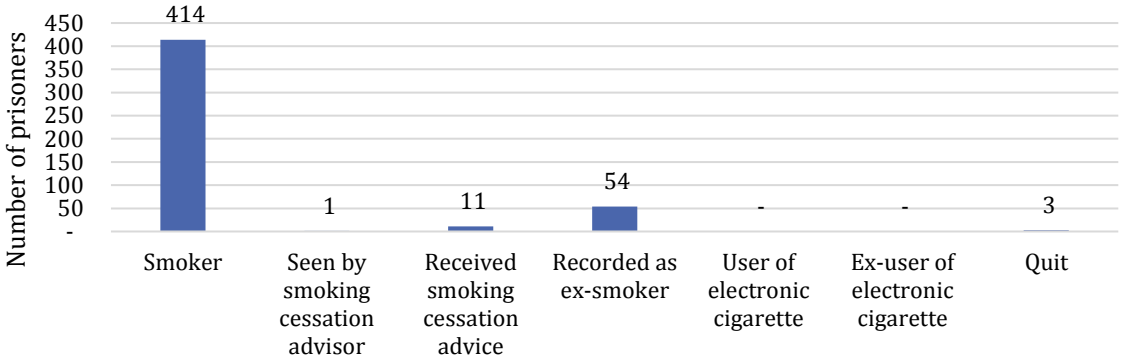
[42] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-cookham-wood-5/

Figure 76 – Smoking Comparison (SystmOne snapshot data)



The chart below shows information on smoking cessation interventions in 2018/19. Interestingly, very few reported vaping.

Figure 77 – Smoking Cessation Interventions (SystmOne data 2018/19)



We were not able to report on the waiting time or DNA rate for smoking cessation clinics from SystmOne, although the lack of dependency and the low levels of interest in formal smoking cessation interventions suggest that any 'treatment' need is more than adequately met.

Primary care reported that whilst a lot of the young people smoked prior to custody, few appeared to have an entrenched dependency. Many weren't interested in nicotine replacement therapy (NRT) or would only stick with it for a couple of weeks. There was also little interest in education/advice approaches. The whole issue was further complicated by the role of tobacco in cannabis consumption, which was largely seen as irrelevant in health terms by the young people, as were any adverse physical effects from the smoking of cannabis itself.

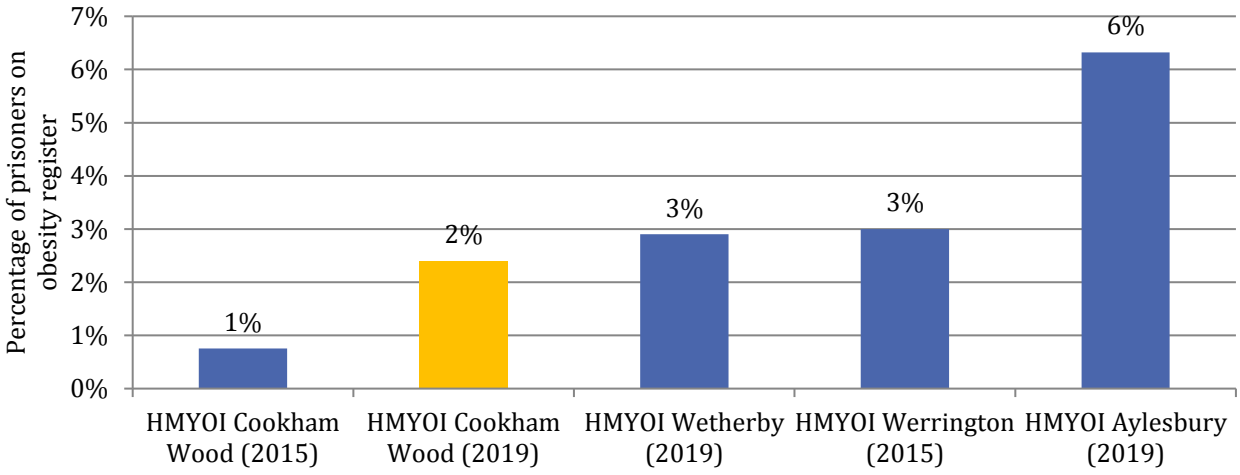
The assessment process appears to identify possible need and risk, and all the appropriate pathways and provisions are in place. Efforts are made to engage and educate the young people around smoking, although the levels of interest and engagement in this were reported as low by both staff and residents.

9.3 Weight Management

There are two systems where weight is recorded. SystmOne should report weight as taken at reception or subsequently updated, and QOF should record any patients where obesity is considered an issue. In theory, these two measures should show a similar prevalence of obesity.

QOF data at the time of the previous HSCNA indicated that 1% of residents were on the QOF register for obesity. At an August 2019 snapshot, this had increased to 2.4% (n<5). This is low compared to similar establishments for which this data was available.

Figure 78 – Percentage of Residents on QOF Obesity Register



At August 2019, SystmOne data showed that 7% of residents had a BMI over 30, indicating obesity (though not all of these were on the QOF register). A further 10% of residents had a BMI indicating they were overweight, and 11% were underweight. A total of 17% overweight shows a need for sustained health promotion aimed at healthy weight (as does the 11% underweight).

All the relevant departments are largely alert to this issue and the population is healthier and fitter than many comparators. The young people did not seem resistant to support and encouragement around weight. Weight concerns should be in the SECURE STAIRS formulation plan and this will hopefully reinforce health promotion messages and actions. Potential need is being identified and responded to.

Several of the young people described how the gym had graded canteen products for healthiness, and that they found this useful and easy to understand. This grading was not available at the canteen itself. It should be widely available, and prominently so at the canteen.

Recommendation 23 – 'Healthiness' grading of canteen products should be widely publicised.

It is worth noting that in contrast to most prisons, the food the kitchen produces is viewed positively by both staff and the young people, and there are usually healthy options available.

9.4 Gym/Exercise

The gyms are well-equipped, and provision is good. There is equipment and provision for the less fit and a remedial programme. Problems with keeping children apart and with staff shortages undermine use of the gyms and the therapeutic potential of group activities. The young people mostly enjoyed access to the gym and wanted more of it. Access to the gym and exercise in general was more difficult for those on Phoenix and the Bridge, not least as keep-apart issues were often involved.

Exercise and sport have considerable therapeutic potential and will hopefully be integral to SECURE STAIRS.

9.5 Transgender

It was reported that there are currently no transgender residents. The establishment and health services believe that the needs of any transgender young people can be met, although they recognise the potential challenge of the attitudes of some of the other young people. Part B of this report describes the health needs of transgender patients, the likely health inequalities, and includes further references to guidance documents.

9.6 Family

The young people as parents is covered in 2.3.9.

HMIP summarises a broad body of research which concludes that maintaining family contact is one of the core components of effective rehabilitation.[43] Maintaining family connections is also one of the greatest determinants of re-offending rates.[44] HMYOI Cookham Wood recognises this and considerable effort is put into maintaining and strengthening family links, where appropriate.

Family are encouraged to visit, including into residential areas of the establishment such as the Cedar Unit. All the young people's rooms have phones (except on Phoenix), primarily to support contact with the family. The designated social worker and the safeguarding team are particularly focused on family relationships, both in child protection terms and in the context of promoting resilience factors and support for the young person. Mental health deliver some interventions that directly involve the family, and the forensic psychology team have a family worker. Substance misuse also consider the family context. This approach is expected to develop under SECURE STAIRS, where ideally the parents would be part of the formulation plan.

Some of the professionals interviewed for this report felt that there should be more parenting orders imposed as these would help to both keep the parents engaged with their child and to increase the chance of their interactions being positive, particularly if the YOTs or the local authority worked with them on their parenting whilst their child was in custody.

[43] HMIP (2016) Life in Prison: contact with families and friends.
[44] Lord Farmer (2017) The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime.

Where the family is not involved, this is clearly more complicated. Sometimes there may be a parental figure (such as a previous foster carer or residential care worker) that staff can involve, but often there is no specific individual, only the home authority. As discussed in the following chapter, engagement with the home authority can be a challenge, particularly when there is no clear release date (as in remands) or no identified placement until very late in the sentence.

Whilst the home social worker is not family, they can be an important figure in the young person's life and sometimes the one who knows them best. HMYOI Cookham Wood has established several procedures to help support the young person's contact with their social worker, e.g. they can visit much quicker after reception than most professionals and even the same day if they are needed to attend an ACCT.

9.7 Patient Engagement

There is an establishment-wide youth council, and this appears effective, as noted by HMIP.[45] There are peer mentors on the induction landing to help support receptions to settle in.

The health and wellbeing team currently have three young people working with them to promote inclusion, destigmatise mental health issues, advise on the work and profile of the team, help develop research ideas, co-facilitate therapeutic groups and assist with recruitment. Their service user involvement programme has won awards, etc. Open Road have peer supporters also.

Healthcare don't have any red bands, health champions, peer workers or other similar posts. There is potential in developing such roles.

Recommendation 24 – Primary care to develop patient engagement and peer support.

It is likely that the establishment of SECURE STAIRS will help support further development of resident and patient engagement.

[45] https://www.justiceinspectorates.gov.uk/hmiprisons/i nspections/hmyoi-cookham-wood-5/

9.8 Chapter Summary

- There is a developed emphasis on wellbeing and health promotion at HMYOI Cookham Wood, and this is likely to develop further under SECURE STAIRS. Most of the relevant needs are met.
- Generic health promotion is well established across the establishment, recognised by the young people, and involving a range of departments.
- Data on smoking varies, and it is likely that a lot of the young people who identified as smokers on reception were not dependent on nicotine.
- The appropriate smoking cessation interventions are available, although the young people largely don't see the need.
- Services recognise the role of cannabis in both tobacco consumption and potential health damage, though struggle to get the young people to take this seriously.
- In terms of weight, the population is fitter and healthier than most comparators and there is an appropriate range of support and interventions. See Recommendation 23.
- Gym provision is good, though most of the young people would like more of it.
- There are no transgender young people in HMYOI Cookham Wood at present.
- There is a strong emphasis on supporting family ties and prison departments do what they can in this regard. For those young people where there isn't family involvement, it can be much more complicated to involve the home authority as needed.
- Patient engagement is relatively well-developed across the establishment, though there are no such roles in primary care. See Recommendation 24 directly above.

Chapter Ten – Social Care

10.1 Overview

Social care at HMYOI Cookham Wood touches on child safeguarding, social work, social care, 'looked after children' and some of the legal responsibilities involved with all of these and educational and custodial settings. This range of concerns is reflected in the range of frameworks, roles and pathways involved. Much of this is outside the scope of a health and social care needs analysis, so the following outline is illustrative rather than comprehensive.

Medway Council are central to this in legal, strategic and safeguarding terms as HMYOI Cookham Wood is in Medway. Medway attend the main strategic and partnership meetings and oversee the designated social workers (DSWs) and the safeguarding framework. Additional to all this is the prison-employed safeguarding team who are advised by the designates social workers and work directly with the young people, supporting them in custody.

There is a team of three full-time designated social workers (a senior and two social workers) who fulfil the independent statutory role (similar to that with respect to looked after children). They provide support and guidance to other prison staff, including the governors and the safeguarding team. The DSWs screen all the information received from the home local authorities to help identify risk and assess all the young people themselves, including screening for safeguarding risks such as trafficking, criminal and sexual exploitation. The DSWs also get involved when there are concerns involving the home authorities (e.g. not complying with child protection guidelines or the National Referral Mechanism (trafficking)). These posts are funded by the YJB and employed by and overseen by Medway Council.

In terms of the young people's views on their safety at HMYOI Cookham Wood, there were largely positive views of staff and the young people felt safe with them. How safe they felt around other young people varied, as might be expected, but violence was a significant concern for most. Whilst they were not necessarily clear on how to formally raise concerns about any poor treatment from staff, some commented that they could work it out if it was bad enough for them to complain, e.g. by talking to a trusted member of staff. This possible route for raising safeguarding concerns by the young people underlines the importance of all staff understanding the process and being willing to follow it through.

In terms of their safeguarding post-release there was, to a certain extent, a generalised apprehension about the future, although not specifically about criminal or sexual exploitation (perhaps as the young people were not aware enough of their own vulnerabilities). They appeared willing to engage with professionals about their future and largely trusted those professionals to have their interests at heart. Not surprisingly, considering their maturity, their judgement as to their prospects were not always balanced and thought through.

The safeguarding team (15-20 full-time posts) are not necessarily qualified social workers (although some are), though work directly with the young people. The work is focused on supporting their time at HMYOI Cookham Wood, e.g. working closely with security and conflict resolution (a team of staff who aim to resolve conflicts and reduce violence).

There is a strong emphasis on working within the family context where applicable and possible. Issues around release and transition are discussed further in 10.6.

Social care in terms of support with daily living may be seen as primarily there for the elderly or physically disabled and not relevant to this age group, however, young people can have a range of (often hidden) social care needs. These support needs are discussed throughout the rest of the chapter.

10.2 Social Care Needs and Provision

As with some other aspects of SystmOne recording, the read codes for social care needs can be confused and over-lapping, making it difficult to gain a clear picture; this is being addressed as a national issue and is outside local control. This is further complicated by a lack of clear definitions and formal assessments/diagnoses, as well as a reliance on self-reporting. Ideally, all such diagnoses would be formally assessed, although in practice this is not a priority.

The SchoolScreener covers the more common disabilities as, to some extent, does the CHAT assessment, and in most cases it appears likely that need is being met.

As at August 2019, OMU data reported 18 young people (11%), and SystmOne data described 14 (8%), with a recorded disability. This is lower than the proportion found in HMYOI Aylesbury, the only similar prison for which comparable data was available (23% reported on SystmOne). HMIP reports state that, in its survey, 16% of residents across a range of YOIs self-report some form of disability.[46] It is worth noting that when we visited, no residents had a PEEP (personal emergency evacuation plan). This is relevant as PEEPs are often a good indicator of where a disability can be seriously impacting on daily living.

The table below shows the numbers of records on SystmOne of disability, mobility problems, or use of mobility aids (affecting five or more residents).

Figure 79 – Disability and Mobility Problems (SystmOne data)

HMYOI Cookham Wood	Snapshot Aug 2019
Difficulty writing	14 (8%)
Neurodisability	7 (4%)
Specific learning disability	7 (4%)

In our patient survey, less than 5% (fewer than five) of respondents self-reported having a physical disability or mobility problem. This was lower than the 5% of respondents at HMYOI Aylesbury. Primary care reported that mobility support needs were rare, and usually temporary and related to injuries, e.g. limping, or needing a crutch.

It appears that there had never been a request for social care equipment or the like until September 2019. Primary care reported that although the pathways were established and clear, until this point these had yet to be used. This was echoed by one of the senior staff involved at Medway Council who also reported that there had never been a request for social care support from HMYOI Cookham Wood.

[46] HMIP (2017) Report on unannounced inspection of HMYOI Cookham Wood by HM Chief Inspector of Prisons 4-5, 24-28 April 2017.

During the finalising of this report, a young person was admitted to HMYOI Cookham Wood with mobility problems potentially requiring a wheelchair. There was some uncertainty about who might be responsible for funding this (it should be Medway).

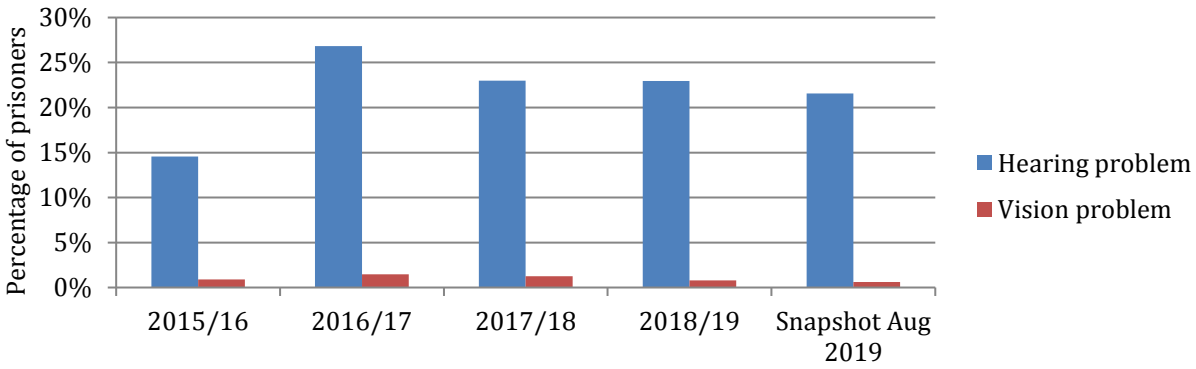
Despite this, it is clear that the need for social care advice and equipment to support daily living is very low. There are no cells specifically designed or adapted to accommodate a resident with mobility issues, although many of the ground floor cells would be adequate for most needs. It is likely that need is being identified and met, though the example of the wheelchair user illustrates that this may not always be a smooth process and could benefit from review, as recommended in the following section.

The chart below outlines the numbers of residents recorded on SystmOne with sensory impairments in recent years and at a recent snapshot. The data describes a gradual decrease since 2016/17 in recording of both vision and hearing problems, although numbers with vision problems are much lower. At snapshot, there were no patients with a recorded speech problem. Pathways are established for all these issues and the SchoolScreener should ensure these are picked up at assessment.

The current procedure for hearing concerns at HMYOI Cookham Wood is to test the young person's hearing on two separate occasions and then if there is still a problem, refer them on to the GP who will then decide if a further referral to outside services is needed.

As a benchmark, the 22% (n=36) at snapshot with a recorded hearing problem was almost double the 12% reported at HMYOI Aylesbury.

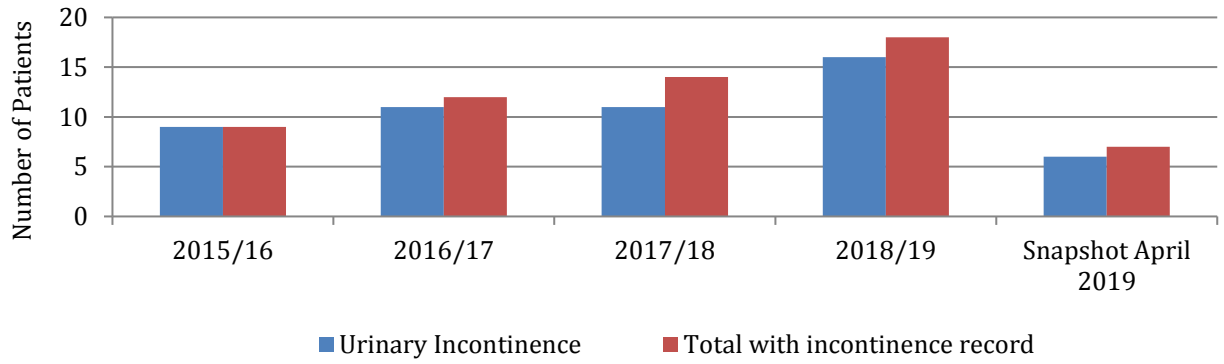
Figure 80 – Sensory Impairment



In our patient survey, 7% (n=85) of patients said they had a hearing or sight problem. It is likely that needs are being both identified and met.

The chart below summarises SystmOne data on recorded continence problems at HMYOI Cookham Wood. At August 2019, there were fewer than five residents (<5% of the population) with any continence problems recorded. This was not dissimilar to the other YOI for which data was available (2.8% at HMYOI Aylesbury). Primary care report that continence is very rarely an issue, although can be managed when it is.

Figure 81 – Continence Problems (SystmOne data)



The table below shows the numbers of records on SystmOne of self-care problems affecting five or more residents recorded on SystmOne at a snapshot in August 2019.

Figure 82 – Disability and Mobility Problems (SystmOne data)

HMYOI Cookham Wood	Snapshot Aug 2019
Unable to prepare meal	9 (5.4%)
Unable to summon help	6 (3.6%)
Unable to perform laundry activities	5 (3.0%)

Primary care report that it is very rare to have a resident who is unable to care for themselves, and in most cases this would lead to a transfer to somewhere with 24-hour care, e.g. HMYOI Feltham. This apparent mismatch with the above data recorded on SystmOne by primary care appears to be a matter of degree of difficulty and accuracy of associated recording, i.e. strictly speaking the young person may have difficulty preparing their meal rather than being unable to.

The young people reported that staff were generally helpful in this respect although did not give the impression that staff or other residents were acting in a way that might be described as providing social care. There is inevitably a fine line involved, and the degree of ability can fluctuate, so there do need to be processes and pathways for assessing and responding to various degrees of need. However, in practice, much of the support will inevitably be informal and ad hoc. This fluctuation in need requires some flexibility in the response, but the outline and main pathways needs to be clear, particularly to those working directly with the young people.

10.3 Social Care Arrangements

There is some uncertainty about the existence of a memorandum of understanding (MOU) at HMYOI Cookham Wood for social care and safeguarding arrangements between Medway Council, HMYOI Cookham Wood and primary care. Some staff believe this was initially established in 2014, but others are not sure there is one at all. There is certainly one for HMP/YOI Rochester next door. The detailed descriptions from some people at HMYOI Cookham Wood suggest that this does exist, although if it does not it should certainly be developed in line with the recommendations below.

In broad terms, the pathways and processes involved are meant to be the same as for the community, i.e. the establishment is in effect just a different address. Social care responsibilities and pathways should be outlined in the MOU. Medway have a lead role in this, as the local authority is best placed to clarify the range of issues around social care support and is potentially responsible for ensuring some of this. These issues could be revisited as part of the review recommended below.

Medway's main focus in HMYOI Cookham Wood has been on child safeguarding rather than the provision of social care. This has been appropriate considering where the risks and the needs are. Some of the Medway staff felt that it might be useful to formally review the 2014 agreement to ensure that it still effectively addresses potential need both in terms of social care and safeguarding. As discussed previously, Medway Council noted a lack of LADO referrals from health staff and a concern about the paediatric assessments within a safeguarding context at A&E. These issues should also be discussed as part of any review.

Recommendation 25 – Medway and HMYOI Cookham Wood to review the Memorandum of Understanding and social care arrangements to ensure that they are still fit for purpose.

10.4 Social Care Enablers/Buddies

There are no social care enablers or buddies at HMYOI Cookham Wood assisting with the basic activities of daily living, although there is inevitably some ad hoc and informal help and support, both from other young people and from staff. Primary care did not feel that there was a need for a formal framework of support, although the SystmOne data in Figure 82 above suggests that there may be. Currently, high social care need would likely trigger a transfer, and low or occasional need could be effectively managed through the formulation plan in most cases and may not require a formal arrangement of buddies, etc. However, if such a need did develop or it became clear that there was a need, this should be properly established to ensure safeguarding for all concerned; this should be reflected in the memorandum of understanding.

The designated social workers agree with primary care that the need is likely to remain low and would be infrequent. This would argue against a formal scheme as it would have no momentum and might raise expectations amongst the young people involved. If need remains infrequent, a better approach may be a more ad hoc one where 'training' and supervision for any young people in the buddy role is bespoke and ad hoc, as and when needed, ensured by primary care and the DSWs.

The designated social workers should work with primary care and the prison to establish whether there might be a need (ongoing or occasional) for such arrangements, and if so, to ensure the most appropriate arrangements. Note that the buddy scheme at neighbouring HMP/YOI Rochester is covered in the memorandum of understanding there with Medway Council and could helpfully inform any such developments at HMYOI Cookham Wood. Further information about such schemes are provided in Part B.

Recommendation 26 – Establish the need for a buddy scheme and, if appropriate, ensure this is developed and included in the memorandum of understanding.

10.5 Care Experienced

During 2018/19, there were 340 residents in HMYOI Cookham Wood (99% of the population) aged under 21. As described in Part B, it is estimated that 40% of residents under the age of 21 will have been in care. Taking these figures, we estimate that during 2018/19, approximately 136 young men will have been care experienced, many of whom would be eligible to leaving care support.

The safeguarding team are very aware of this issue and it is a core part of their work when trying to ensure post-custody plans and care, though note the difficulties involved for some young people discussed in the following section. The need is certainly identified, though meeting it can be difficult for some young people for the reasons discussed below.

Medway report five care leavers referred to them over the last year. This will be the small number returning to Medway. Most young people are reported as returning to London.

The memorandum of understanding apparently does not mention care leavers. Although these pathways are clear, for the sake of completeness these should be reflected in the MOU.

Recommendation 27 – Review the memorandum of understanding between Medway Council and HMYOI Cookham Wood to ensure it clarifies the pathways for all care leavers.

10.6 Transition and Release Planning

The transition involved in leaving the young person's estate was reported to be a challenge by most of the staff spoken to, and this was reinforced by some of the young people (this is a common issue across the estate). The main departments working with the young people already focus on supporting transition, and SECURE STAIRS will place an even greater emphasis on this. The increase in serious offences committed by young people (and therefore longer sentences) mean that the numbers transferring into the adult estate is slowly rising.

As said, a small but increasing number are being transferred to the adult estate, and every effort is made at HMYOI Cookham Wood to make this as smooth a transition as possible by preparing the young person as much as is feasible and by engaging with the new providers to encourage them to continue care and support the transition.

The transition into the community can be a lot more challenging. There is something of a postcode lottery amongst the many different authorities involved as to what resources are available and how much the receiving authority engages, but overall there is a considerable shortage across all areas of the community in what is needed to help sustain and enhance health and wellbeing. Several of the senior staff interviewed for this report also commented that the adherence to the duty of care and child protection procedures for some of the home authorities left something to be desired.

One of the most challenging areas is accommodation/housing/placements. Legislation requires the home authority to ensure accommodation at least ten days before release. When it gets to five days before release, the DSWs at HMYOI Cookham Wood are able to escalate non-compliance with the home authority, but often this isn't established until two or three

days before release, or at times still hasn't been established at the point of release, in which case HMYOI Cookham Wood 'keep' the young person (never for long) rather than deliberately make them homeless.

There is a real risk that the eventual accommodation is not in the same area, and this uncertainty makes it impossible to engage with community services to ensure throughcare and continuity before the new address is established. There are clear implications for undermining positive gains and increasing risk across the board, but these matters are outside the control of any of the prison staff.

Suitable accommodation is in short supply, and the young people may be placed in accommodation that fulfils the council's obligation but is very likely to put them at risk. It can also be particularly hard to place or house young people with certain criminal histories or risk profiles. Additionally, England does not have the kind of 'step-down' accommodation available in some other countries, so even when it is possible to place or house the young person, the scale of the transition involved can significantly jeopardise outcomes. Accommodation and placements can be further complicated by the issue of violence and gang/area affiliations. The DSWs felt that the local authorities often did not try hard enough to find less risky accommodation, e.g. within the extended family.

The other most challenging issue is that of specialist interventions and support, and this contrast will become more acute with SECURE STAIRS, i.e. the young person will be unlikely to get anything like the same level of support and interventions on release or within the adult estate. There was a consistent view across the staff spoken to for this report that many of the young people lacked the necessary social skills, practical skills, emotional stability and maturity to manage in the outside world without intensive support and supervision. This was echoed by some of the young people themselves.

The social workers and safeguarding team (and all other staff) are very aware of the challenges and risk of transition, and as well as doing what they can to smooth this process they also do what they can to prepare the young person for what is to come. Within the current national context, it is difficult to know what else staff can do, as much around transition depends on strategic decisions taken at local levels elsewhere and on national policy and priorities. In other words, whilst the need for safe accommodation and intensive post-custody support is consistently identified, it is all too often not met.

Even though there is considerable focus and effort already on transition and release, the need to support this has been made a recommendation in order to highlight the risks involved and the importance of doing everything possible. This area may also benefit from formal and structured approaches such as audits and task-finish groups.

Recommendation 28 – All stakeholders to work together to support the transition to the adult estate and into the community.

10.7 Chapter Summary

- Social care and safeguarding at HMYOI Cookham Wood shows a comprehensive, multi-faceted and well-resourced partnership between the establishment and Medway Council.
- The designated social workers and the safeguarding team fulfil the social work function in relation to time in custody and preparing for release.
- Levels of social care need are relatively low. Most need is identified and met whilst in custody.
- The existing memorandum of understanding is due for review, and this should include safeguarding and LADO arrangements, social care arrangements, care leaver pathways and buddy schemes. See Recommendation 25.
- There is little need reported for a formal buddy scheme, although this may change. See Recommendation 26.
- Care leavers are identified, and every effort made to ensure their needs are met post-release. See Recommendation 27.
- The transition to the adult estate and post-release support and care can be particularly difficult to ensure. See Recommendation 28.

Chapter Eleven – Overview of Findings and Recommendations

11.1 Summary

This HSCNA has systematically explored the predicted needs, the actual identified needs, and the service provision of health and social care within HMYOI Cookham Wood. This has been through the lens of prevalence, incidence and, where possible, the likely demand for services. Current local data is compared to the previous HNA, to academic studies, and to data sourced from a range of similar establishments. This is supplemented with qualitative work exploring stakeholder perspectives among patients, operational staff, managers and commissioners around actual service usage.

HMYOI Cookham Wood is a relatively small YOI holding young male remand and sentenced offenders aged 15-18. Health services are child-focused and appropriate for this often complex and challenging population, and it is likely that most needs are identified and met to the extent to which they can be during what is often a short stay in the establishment.

Despite every effort by the staff involved, ensuring a smooth transition into the community is particularly challenging however, and can significantly undermine outcomes in general and any gains made in HMYOI Cookham Wood in particular. This is largely due to the lack of availability of relevant resources in the community, although other factors are involved. These are all largely outside the control of the establishment and the staff there, and are dependent on national and local authority policy and resourcing. Ensuring throughcare on release is even more challenging where mental health is concerned. Many of these challenges also apply in transfer to the adult estate.

The establishment is in the process of implementing SECURE STAIRS. This is a significant increase in resources for both direct work with the young people and in supporting other staff in their work. It will take at least two years for SECURE STAIRS to become embedded in the core context within which the establishment operates. If all goes well, its implementation should make a significant difference to health, wellbeing and offending outcomes for the young people in and after custody, as well as supporting the health and wellbeing of the staff involved.

11.2 The Report

This report is presented in two parts. Part A describes needs and provision in HMYOI Cookham Wood. Part B is a reference document detailing background information about a wide range of health and social care needs amongst residents. The following chapter summaries outline the key findings in each area; specific recommendations are further below.

Chapter One sets the context for prison healthcare and the rationale for the HSCNA. It also details the methodology used to combine qualitative and quantitative methods to achieve a balanced analysis of need.

Chapter Two outlines the demographic information from the establishment, with a focus on those demographics that are known to affect the demand for aspects of healthcare. The turnover rate and lengths of sentence and stay are such that there is time to identify most need, although the length of stay is such that it may not always be possible to meet that need at HMYOI Cookham Wood. A quarter of residents are not there for long. A significant percentage of the population is from a BME background.

Chapter Three describes a child-focused primary care service appropriately addressing the needs of the population. Staffing and facilities are broadly adequate, although the need to keep some of the young people apart from each other wastes resources. Assessments are thorough, and most need appears to be being identified and met. The health provision is well regarded by the rest of the establishment and by the young people and waits are minimal. Dental facilities and provision are good, as is pharmacy and meds management.

Chapter Four describes physical health, providing data on the predicted and identified health needs for key physical conditions, including long-term chronic conditions (LTCs). Many of the common LTCs are rare at HMYOI Cookham Wood. The most prevalent are asthma and skin conditions. Services are well regarded and most need is being identified and met.

Chapter Five explores mental health need and provision. HMYOI Cookham Wood has an integrated health and wellbeing team with a child-centred approach focused on the young person's needs. SECURE STAIRS is slowly being rolled out, moving the establishment towards a psychologically and trauma informed environment. Transitions can be very difficult to ensure, whether into the adult estate or the community. Services are well regarded and it is likely that most mental health need is being identified and responded to.

Chapter Six looks at prevalence, incidence and likely demand for substance misuse services and compares these against actual recorded demand from NDTMS and local data. The service is provided by Open Road and is largely psychosocial. It is appropriately child-centred and well regarded by all. The range of assessments, support and interventions available suggest most need and risk is likely identified and responded to. Dependency is very rare; cannabis and alcohol are the main substances used. Most of the young people do not see themselves as having a problem. Illicit use in the establishment is low.

Chapter Seven describes screening and vaccinations for communicable diseases. Opt-out DBST and sexual health screening are part of the initial assessments. Injecting rates are expectedly low. Positive BBVs are expectedly rare. Rates of flu, MMR and men ACWY vaccination need improving. Sexual health provision is good and most need is probably identified and met.

Chapter Eight covers safeguarding, particularly physical harm to the young person from violence and self-harm. There is a strong emphasis on safeguarding at HMYOI Cookham Wood and good links with Medway Council. Self-harm is lower than the national prison average and ACCTs are well supported by health services. Violence is a big problem and there are a lot of associated injuries, most managed in the prison by healthcare. Emergency codes are rare, though primary care attend all incidents.

Chapter Nine discusses wellbeing and health promotion. There is a strong emphasis across the establishment on wellbeing and health promotion and most of the relevant needs are met.

Generic health promotion is well established, and the population is relatively healthy. Smoking pathways are appropriate, although it is hard to engage the young people. Gym provision is good and popular. There is a lot done on involving the family. Patient engagement is relatively well-developed.

Chapter Ten explores social care. There is a memorandum of understanding covering social care and safeguarding, although this needs review. Social care and safeguarding at HMYOI Cookham Wood shows a comprehensive, multi-faceted and well-resourced partnership between the establishment and Medway Council. Levels of social care need are relatively low, and most need is identified and met whilst in custody. There is no formal buddy scheme. Post-release support and care can be particularly difficult to ensure.

11.3 Findings and Recommendations

Figure 83 – Findings and Recommendations for HMYOI Cookham Wood

Section	Finding	Recommendation
Healthcare Provision	Young parents would benefit from targeted support.	**Recommendation 1 -** Support young parents in healthy parenting and relationships.
	Health provision is child-centred and viewed positively. Waits are minimal and 90% of appointments are attended. Resources are adequate, apart from the optometry contract.	**Recommendation 2 -** Review the optometry budget.
	Most cells have phones, though these cannot be used to communicate with health.	**Recommendation 3 -** Pilot access to healthcare through in-cell phones.
	The young people are comprehensively assessed and it is likely most need is identified and met. There is no health promotion or other relevant material in reception.	**Recommendation 4 -** Display health promotion and other relevant media in reception.
	The rollout of SECURE STAIRS may provide a revised context and reason for reviewing what health information is passed on to community services.	**Recommendation 5** – Review what health information is passed on to community services on release.
	The need for escorts for external appointments could perhaps be reduced.	**Recommendation 6** – Review the use of escorts for secondary care.
	The dental suite is adequately equipped though lacks a phone.	**Recommendation 7 -** Install a phone in the dental suite.
	Dental provision is good, and waits are low. DNAs might be improved if there was dedicated escort profiled.	**Recommendation 8 -** Ensure dedicated escort of dental patients.

Section	Finding	Recommendation
Physical Health and Long-Term Conditions	Most LTCs are rare amongst young people. The management of LTCs appears to be effective, with most need identified and met apart from hypertension.	**Recommendation 9 -** Primary care to review hypertension screening to ensure best practice.
	Asthma and skin conditions are relatively common. Some of the LTC reviews may be being missed.	**Recommendation 10 -** Ensure QOF reviews for LTCs.
Mental Health	The integrated health and wellbeing team has a child-centred approach. SECURE STAIRS is helping the establishment move towards a psychologically and trauma informed environment. Staffing levels are good and increasing. Waiting times are minimal. Provision is only six days a week.	**Recommendation 11 -** The mental health service should meet the requirements of the current NHS England specification for an integrated service operating seven days per week cover.
	There are no dedicated staff to escort for mental health in the same way as for primary care.	**Recommendation 12 –** Review the use of escorts for secondary care.
	It is likely that most mental health need is being identified and responded to, although the recorded prevalence of most conditions is below what would be expected. Eating disorders and food issues may be being overlooked.	**Recommendation 13 –** Consider eating disorders and other food issues when assessing/reviewing young people's needs.
	Transitions can be very difficult to ensure, whether into the adult estate or the community. Learning difficulties are being identified and needs met, though it would be useful if learning disabilities were diagnosed where appropriate.	**Recommendation 14 –** Establish diagnoses of learning disability where appropriate.
	Speech and language needs are identified and met although this is not reflected in the data.	**Recommendation 15 –** Ensure consistent coding of speech and language difficulties and interventions.
Substance Misuse	The service is appropriately child-centred, well regarded and largely psychosocial. Most need and risk are likely identified and responded to, although more harm and risk-reduction may be needed. Dependency is very rare; cannabis and alcohol are the main substances used. Illicit use is low.	**Recommendation 16 -** Ensure harm-reduction advice on the main risks involved in substance use is provided to all young people, not just those engaged with substance misuse services.
Screening, Immunisations and Vaccinations	Opt-out DBST and sexual health screening are part of the initial assessments. Injecting rates are low. Positive BBVs are rare. Flu vaccination rates are low.	**Recommendation 17 -** Improve the rate of flu vaccinations in consultation with the young people.

Section	Finding	Recommendation
	MMR vaccinations were not complete.	**Recommendation 18 -** Every effort should be made to ensure that all young people receive the full MMR vaccine.
	Rates of men ACWY vaccination are low.	**Recommendation 19 -** All young people should have had the men ACWY vaccine.
Safeguarding	Sexual health provision is good and most need is probably identified and met, apart from HPV vaccination.	**Recommendation 20 -** Oxleas to consider the need and possible pathways etc. for HPV vaccination.
	Some young people are finding it difficult to comply with the new chlamydia treatment.	**Recommendation 21 -** Consideration should be given to using Azithromycin to treat chlamydia in order to improve treatment outcomes.
	There is a strong emphasis on safeguarding and good links with Medway Council, although health are yet to refer. ACCTs are well supported by health services. Violence remains a problem. Most injuries are managed in the establishment by healthcare.	**Recommendation 22 -** Health managers to ensure their staff are clear on LADO and safeguarding processes.
Health Promotion	Several of the young people described how the gym had graded canteen products for healthiness, and that they found this useful and easy to understand. This grading was not available at the canteen itself.	**Recommendation 23 -** 'Healthiness' grading of canteen products should be widely publicised.
	There is a strong emphasis across the establishment on wellbeing and health promotion and most of the relevant needs are met. Generic health promotion is well established, and the population is relatively healthy. Smoking pathways are appropriate. Gym provision is good. There is a lot done on involving the family. Patient engagement is relatively well-developed apart from in primary care.	**Recommendation 24 -** Primary care to develop patient engagement and peer support.
Social Care	Social care and safeguarding at HMYOI Cookham Wood are comprehensive, multi-faceted and well-resourced. Levels of social care need are relatively low, and most need is identified and met whilst in custody. Post-release support and care can be particularly difficult to ensure. There is a memorandum of understanding covering social care and safeguarding, although this needs review.	**Recommendation 25 -** Medway and HMYOI Cookham Wood to review the Memorandum of Understanding and social care arrangements to ensure that they are still fit for purpose.
	There is no formal buddy scheme.	**Recommendation 26 -** Establish the need for a buddy scheme and, if appropriate,

Section	Finding	Recommendation
		ensure this is established and included in the memorandum of understanding.
	Care leavers are identified, and every effort made to support their release, although they are not covered in the memorandum of understanding.	**Recommendation 27 -** Review the memorandum of understanding between Medway Council and HMYOI Cookham Wood to ensure it clarifies the pathways for all care leavers.
	The transition to the adult estate and post-release support and care can be particularly difficult to ensure.	**Recommendation 28 –** All stakeholders to work together to support the transition to the adult estate and into the community.

APPENDIX A – List of Interviewees

Name	Job Title	Organisation
Peter Gates	Children and Young Peoples Lead	Health and Justice NHS England and NHS Improvement South East
Paul Durham	Governor	HMYOI Cookham Wood
Ian Bicker	Healthcare Operational Manager, HMYOI Cookham Wood & HMP/YOI Rochester	Oxleas NHS Foundation Trust
Tony Fuller	Business Change Manager, Performance & Change Team	HMYOI Cookham Wood
Sally Morris	Service Manager Mental Health, HMYOI Cookham Wood	CNWL
Laura Hammond	Team Manager, HMYOI Cookham Wood	Open Road
Dr Celia Sadie	Consultant Clinical Psychologist and Lead for Children and Young People, Offender Care, CNWL; Clinical Lead - Secure Stairs	Health and Wellbeing Team/Sexual Behaviour Service HMYOI Cookham Wood/Medway STC
Julie Amos	Support Time & Recovery Worker (Health Promotion)	Oxleas NHS Foundation Trust
Ayub Pangarker	Dental Officer, HMYOI Cookham Wood	Independent
John Rose	Optician	Independent
Jackie Dalton	Operational Manager, Hospital Integration Team and OT Team	Medway Council
Mark Powell	Strategic Development Manager (Youth Justice), Early Help & Preventative Services, Children, Young People & Education	Kent County Council
Paul Mitchell	Independent Consultant (SECURE STAIRS)	NHS England
Andrew Willets	Head of Partnership Commissioning, Resources and Youth Justice	Medway Council
Stephanie Ponter	LADO and Education Safeguarding Manager, Children's Services	Medway Council
Teresa Uings	Senior Designated Social Worker (Safeguarding) HMYOI Cookham Wood	Medway Council

In addition, 68 residents completed our survey and a focus group was held with eight young people on the Cedar Unit. Three officers and one member of the gym staff were also present and occasionally contributed to the discussion. There was also a presentation of initial findings and discussion involving the main governor and the heads of primary care, mental health and substance misuse.

APPENDIX B – Long-Term Condition Management

Figure 84 – Full Data for Selected QOF Indicators

Condition	Indicator	Percentage of Eligible Complete	Complete	Eligible
Asthma	Measures of variability or reversibility	60%	<5	5
	Review in previous 12 months	17%	<5	6
COPD	Review last 12 months		0	0
	Oxygen saturation record in last 12 months		0	0
	Influenza immunisation in last winter		0	0
Cancer	Review within 6m of diagnosis		0	0
Diabetes	BP effectively controlled (<150/90)	100%	<5	<5
	Foot examination in last 12 months	0%	0	<5
	Influenza immunisation in last winter	0%	0	<5
Hypertension	BP effectively controlled (<150/90)		0	0
CHD	BP effectively controlled (<150/90)		0	0
	CHD medication record in last 12 months		0	0
	Influenza immunisation in last winter		0	0

Figure 85 – Definitions of QOF Indicator Values from 'How Am I Driving', used in Chapter Four

Indicator	Explanation
Asthma - with measures of variability or reversibility	The percentage of patients aged eight or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between three months before and any time after diagnosis.
Asthma - review in previous 12 months	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the three RCP questions.
COPD - review + MRC	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months.
COPD - oxygen saturation in last 12 months	The percentage of patients with COPD and Medical Research Council dyspnoea grade >= 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months.
Cancer - review within six months of diagnosis	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within six months of the date of diagnosis.
Diabetes - last BP is 150/90 or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
Diabetes - foot examination in last 12 months	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer), or 4) ulcerated foot within the preceding 12 months.
Hypertension – BP < 150/90	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.

Indicator	Explanation
CHD - BP <150/90 in last 12 months	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
CHD - CHD therapy in last 12 months	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.
No indicators for epilepsy	

APPENDIX C – Predicted Substance Use Incidence Calculations

Figure 86 – Calculation of Predicted Need

Drug Treatment	HMYOI Cookham Wood
Population in a year (op cap + turnover)	494
Prevalence estimate (low)	28%
Prevalence estimate (high)	51%
Expected incidence (low)	138
Expected incidence (high)	252
Expected incidence (mid-point)	195
Alcohol Treatment	HMYOI Cookham Wood
Population in a year (op cap + turnover)	494
Prevalence estimate (low)	16%
Prevalence estimate (high)	43%
Expected incidence (low)	79
Expected incidence (high)	212
Expected incidence (mid-point)	146

Figure 91 – Calculation of Estimated Demand[47]

NDTMS-Based full year estimate of actual demand for HMYOI Cookham Wood, based on 2018/19	New Treatment Entrants (NDTMS)	All in Treatment (NDTMS)
Drug Users (all patients in treatment)	0	108
Alcohol Users (patients recorded as using alcohol)	0	65

[47] Please note this will double count those who are in treatment for both drug and alcohol use ('Non-opiates and alcohol'); for the purposes of comparing likely substance misuse with treatment penetration this is accepted.

Part B

Background Research

Introduction

Aims and Objectives

This health and social care needs assessment (HSCNA) was commissioned to better understand the health needs of the young offender (YO) population and to assess the extent to which the current need and demand for health establishment(s) were being met.

The methodology used for this is the PHE '*toolkit*'[48] and NICE:

> *A health needs assessment is a systematic method for reviewing the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.*[49]

It should be noted that health needs may be *met* or *unmet* and that there is a difference between a *need* and a *demand* for a service. These concepts are addressed later in this report.

Purpose

NHS England commissioned this health and social care needs assessment primarily in order to inform its commissioning of healthcare services in the establishment.

There is also a clear legislative expectation that regular and thorough health needs assessments are carried out for all YOIs to ensure that the provision of services within a given establishment meets the needs of the inmate population, and that services are adapted to meet any changes in the population.

Her Majesty's Inspectorate of Prisons (HMIP) stipulates that the following governance arrangement must be in place:

> *Prisoners are cared for by a health service that accurately assesses and meets their health needs while in prison and which promotes continuity of health and social care on release.*[50]

An important indicator of this expectation is that:

> *Health services are informed by the assessed needs of the prison population and are planned, provided and quality assured through integrated working between the prison and its local health economy.*[51]

This HSCNA ensures compliance with this indicator for this establishment.

The document is also intended to assist commissioners of prison healthcare services (NHS England) and the providers of these services.

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[48] PHE (2014) Health Needs Assessment toolkit for prescribed places of detention (parts 1 and 2).
[49] Cavanagh, S. and Chadwick, K. (2005) *Health Needs Assessment: A Practical Guide*. NICE.
[50] HMIP (2012) *Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons*, version 4. Expectation 32.
[51] *Ibid.*

Scope

As is always the case, there is a fine line between undertaking a health needs assessment and a service audit/review. This report focuses on describing the likely and actual health needs of young offenders and the extent to which they appear to be being met, rather than assessing service efficacy.

Policy Context

Policy documents acknowledge the strong evidence base that YOs have significant health needs.

> *Children, young people and adults in contact with the criminal justice system, or in detained settings, are more likely to smoke, misuse drugs or alcohol, have mental and physical health problems, report having a disability, self-harm or attempt suicide. Their lives are often further complicated by complex social and personal issues such as unemployment, low educational attainment or even homelessness. They are marginalised by society. As a consequence of all these influences, their lives are often cut short in a brutal manifestation of social and health inequality.*[52]

The House of Commons Justice Committee notes:

> *Research strongly supports the view that young adults, particularly young men, are a distinct group with needs that are different both from children under 18 and adults older than 25, and there is a strong case for a distinct approach to, and additional investment in, this cohort.*[53]

The picture with mental health follows a similar pattern, with around 80% of prisoners in the UK estimated to be suffering with some form of mental health problem, including substance misuse.[54] Lader described rates of mental health problems to be 95% amongst the population in young offenders' institutes in England and Wales.[55] Following publication of the Bradley Report, there has been a significant focus on vulnerable adults caught up in the criminal justice system.[56] More recently, a national operating model has been developed for the roll-out of all age Liaison and Diversion (L&D) services, which now have a remit reaching beyond just mental health and covering a whole spectrum of vulnerabilities.[57] In 2016, this was supported with targeted government funding to continue the national roll-out.[58]

A consistent key aim of current government focus and policy is to reduce health inequalities.[59]

The NHS Long Term Plan[60] and NHS England Strategic Direction[61] are crucial policy documents which set a useful framework for a healthcare needs assessment. Both of these have a focus on patient engagement, timely access to services, and better access to secondary care, to name but a few.

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[52] NHS England (2016) *Strategic Direction for Health Services in the Justice System: 2016-2020* Introductory paragraph.
[53] House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system.
[54] HM Government (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*.
[55] Singleton, N. *et al.* (2000). Psychiatric Morbidity Among Young Offenders in England and Wales.
[56] *Ibid*.
[57] NHS England (2013) *Liaison and Diversion Operating Model 2013/2014*. Offender Health Collaborative.
[58] PRT comment on government announcement (July 2016).
[59] Marmot Review (2010) *Fair Society, Healthy Lives*. Strategic Review of Health Inequalities in England post 2010.
[60] NHS (2019) The NHS Long Term Plan
[61] NHS England (2016) Strategic Direction for Health Services in The Justice System: 2016-2020

NHS England (2016) sets out three aims:

- *narrow the gap between those in criminal justice and detained settings and the rest of the population in terms of health and care outcomes, through improved support from all health and social care;*
- *reduce the number of people who are detained as a result of untreated health problems, and so support reductions in offending; and*
- *ensure continuity of care post release, and so support reductions in re-offending.*[62]

This sits within a wider duty to address health inequalities that is detailed in NHS England guidance.[63] The delivery of effective healthcare interventions in prison settings is an important component of this work that should not only improve the health of the prison population, but also the wider community.

The aim of 'equivalence' between community and prison healthcare was established in 2001.

> *[P]risoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS.*[64]

In 2008, prison health performance indicators were developed to measure the quality of prison health services and to help meet the objective of giving YOs *'the same range and quality of healthcare as the public receives from the NHS'*.[65]

From April 2013, the responsibility for commissioning health services in prisons came within the remit of NHS England. NHS England's responsibility also involves the commissioning of prison substance misuse services, which was previously the responsibility of local drug action teams.

NICE has produced 'Physical health of people in prison';[66] and a complementary 'Further mental health assessment and care planning for people in prisons and young offender institutions'.[67]

NHS England sets out seven 'priority areas' for 2016-2020:

- *A drive to improve the health of the most vulnerable and reduce health inequalities*
- *A radical upgrade on early intervention*
- *A decisive shift towards person-centred care that provides the right treatment and support*
- *Strengthening the voice and involvement of those with lived experience*
- *Supporting rehabilitation and the move to a pathway of recovery*
- *Ensuring continuity of care, on perception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings*
- *Greater integration of services driven by better partnerships, collaboration and delivery.*[68]

Furthermore, the NHS England National Commissioning Intentions for health and justice (2017-2018)[69] sets out priorities for people detained in secure settings as outlined below:

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[62] NHS England (2016) Strategic Direction for Health Services in the Justice System: 2016-2020.
[63] NHS England (2015) Guidance for NHS commissioners on equality and health inequalities legal duties.
[64] DH and HMPS (2001) *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*.
[65] NOMS, DH and HMPS (2007) *Prison Health Performance Indicators*. Gateway Reference 8921.
[66] NICE (2016) Physical health of people in prison.
[67] NICE (2017) Further mental health assessment and care planning for people in prisons and young offender institutions.
[68] NHS England (2016) Strategic Direction for Health Services in the Justice System: 2016-2020.
[69] NHS England (2016) Health and Justice Commissioning Intentions 2017/18

- *Commission services in all programme areas which meet the national **patient and quality safety standards.***
- *Commission services to meet the **Intercollegiate Healthcare Standards for Children and Young People in Secure Settings** (CYPSS) across the Children and Young People's Secure Estate (CYPSE) and support the work of the **children and young people mental health transformation programme**.*
- *Continue to support NHS England's ambition to **reduce the incidence of suicide** as set out in the Mental Health Five Year Forward View, through the ongoing implementation of the agreed recommendations for healthcare from the Harris Review and Prison and Probation Ombudsmen investigations into **deaths in custody.***
- *To improve the **quality assurance** of healthcare services commissioned across the secure and detained estate.*
- ***Engage and involve patients,** families and the public in the planning, commissioning and delivery of healthcare services within the secure and detained estate.*
- *Delivering specific pathways within prisons and detained settings to **support stepped care approaches in meeting mental health needs.** We will develop mental health treatment pathways between establishments and into the community and ensure mental health hospital transfers are timely and appropriately managed.*
- *We will seek to implement **specialist dementia care services** across appropriate prison settings.*
- *Reduce health inequalities by improving delivery and uptake of **national screening and immunisation** programmes.*
- *Further develop NHS England's public health section 7a commissioning responsibilities by ensuring the delivery of the phased roll-out of **smoke-free** prisons in England by improving and enhancing the delivery, uptake and effectiveness of smoking cessation programmes.*
- *Implementation of our new service specification for **adult substance misuse services** to support and drive improvement and continue to make effective links and care pathways with community provision with a focus on recovery (including new psychoactive substances, alcohol and dual-diagnosis and incorporating stop smoking services).*
- *Commission **sexual assault services** in-line with specification 30 of the delegated public health responsibilities ensuring appropriate and qualitative adult and paediatric services and supporting pathways into community based support services.*
- ***Liaison and Diversion** services will be further rolled out on an incremental basis across England providing enhanced coverage across courts and police custody suites for individuals in the criminal justice system and supporting their engagement with services for their treatment and contribute to their rehabilitation.*
- *Further establish **pathways for those moving through the custodial or detained estate** to better support and manage integrated care, the national "through the gate" programme and CYP transitions agenda. Continue to establish these pathways during the ongoing reconfiguration of the male and female estate.*
- *Embed phase 1 of the **Health and Justice Information System** and complete the phased roll-out during 2017/18.*
- *Continue to improve the quality of data and reporting of the **Health and Justice Indicators of Performance,** further extend the dataset to support key strategic programmes. Embed the new performance dashboard for individual establishments to improve transparency and commissioning.*
- *Support for the **justice reform agenda** which constitutes reforms to the adult prison estate, children and young people's secure settings, the courts and sentencing guidelines. We will support the development of **local co-production and commissioning arrangements** with prison governors and ensure a focus on reducing health inequalities, strengthening rehabilitation and supporting the contribution healthcare services can make to the reduction of reoffending.*

Young offenders present with a range of needs, the Care Act (2014) clarified the responsibilities of each local authority in respect of the social care needs of those resident in prisons within the authority area.

The RCPCH Healthcare standards for children and young people in secure settings[70] have been updated in 2019 and determine the approach for children up to the age of 18 years.

SECURE STAIRS[71]

Children and young people in, or at risk of being within, the Children and Young People's Secure Estate (CYPSE), by default, have complex needs, including psychological needs.

In order to most effectively support these young people to facilitate positive long-term outcomes, service provision must be consistent and integrated both within the CYPSE, and between the CYPSE and the community.

At any one location in the CYPSE, these young people are often involved with multiple agencies/professionals (many from in-reach services), some of which may have conflicting agendas or be attempting to address different difficulties, not always in an integrated or joined up manner.

Across locations in the CYPSE nationally, the level of integration and coordination of care delivery between services varies and a framework is needed to address this lack of consistency.

Staff skills need to be developed accordingly, to enable appropriate integrated joint working, and to underpin a whole system approach to addressing the complex needs of the young people in the CYPSE.

In order to deliver these elements, NHS England have supported the development of a Framework for Integrated Care for children and young people in these settings. This approach has been termed 'SECURE STAIRS', which is an acronym linking the framework's components to its intended outcomes.

The group of children within the CYPSE require significant support and intervention. These children and young people are within a cohort that may be described as 'high risk, high harm, high vulnerability'. Typically, they have unmet and complex needs that may only be picked up once they are within a secure setting. They may exhibit a range of needs, and any successful solution to addressing these must take a holistic, integrated approach to their care, not only in CYPSE, but also whilst transitioning to, from, or within it and also once they are back in a community setting.

SECURE STAIRS is looking to help these children and young people who may:

- Have needs which are multiple (i.e. not just in one domain, such as mental health), persistent (i.e. long-term rather than transient), and severe (i.e. not responding to standard interventions).
- Exhibit high-risk behaviours (to self, to others and from others) and present with complex management difficulties.

[70] RCPCH (2019) *Healthcare standards for children and young people in secure settings*

[71] Excerpt from a document produced by DH in 2017 for members of the Health and Justice and Specialised Commissioning Workstream (of which the author of this report was a member) to help them communicate some of the details regarding their work to people from outside the workstream.

- Struggle to respond to, or maintain progress with, traditional regime and interventions.
- Have common histories of early onset anti-social and/or high-risk behaviours, often supplemented with complex mental health needs and experiences of trauma and attachment disruption.
- Be at increased risk of being diagnosed with personality disorder in adulthood.
- Be at risk of being diagnosed with personality disorder in the present, frequently resulting in managed moves.

These children and young people's complex needs require coordination of service provision across multiple providers, often over large geographical distances, in a consistent manner. Currently, service provision varies widely across England, and a Framework of Integrated Care could support and enhance the consistent integration of services and promote effective service delivery. Furthermore, there is a need to ensure that staff have the required skills to deploy this integrated approach.

The setting within the CYPSE for these children and young people may vary – it could be a Secure Children's Home, a Secure Training Centre, or a Young Offender Institution. Furthermore, the individual may be held within the CYPSE for youth justice reasons or on welfare grounds. However, irrespective of the setting or the reason, the objectives of the workstream project for these children and young people is the same – it is about providing a coordinated, holistic package of care that addresses their needs across multiple domains.

Failure to provide this support in a timely or consistent manner may lead to problems emerging subsequently in other settings (at high cost, but, more importantly, accessing support in this way is also unlikely to be helpful long-term), rather than addressing needs in a more appropriate way. In turn, this makes these children and young people much less likely to be able to fully reach their potential and gain a more positive future.

These children and young people would benefit from an integrated care framework that addresses their needs holistically, coordinating the services of several providers (both health and non-health) into a coherent package. This means a joined up approach to assessment, sentence/intervention planning and care, including input from mental health staff regardless of previous diagnosis, as well as from social care professionals, education professionals and the operational staff working on a day-to-day basis at the setting. Such an approach is intended to ensure that all of these groups of professionals have the same understanding of the needs of the child or young person.

Such a whole system approach can shape a shared multidisciplinary formulation which is not based on (but may still incorporate) a specific diagnosis or category and will focus on achieving the following:

- Summarise the core needs/problems
- Suggest how the difficulties may relate to one another by drawing on multiple psychological theories and principles
- Aim to explain, on the basis of psychological theory, the development and maintenance of the client's difficulties at this time and in these situations
- Indicate a plan of intervention which is based on the psychological processes and principles already identified

- Be open to revision and re-formulation

The approach that will be adopted is termed 'SECURE STAIRS', which is an acronym that reflects the key elements of the framework, and links them to the intended outcomes.

Ultimately, the SECURE STAIRS framework is intended to ensure that children and young people receive the same type of care irrespective of location in England, built on a consistent evidence-informed approach. To ensure it remains flexible and has ongoing improvement as a core component element, there will be continuous assessment of the efficacy of SECURE STAIRS as well as the development of an evidence base.

The SECURE STAIRS framework is based on two core elements – the 'SECURE' element emphasises the importance of consistency in the day-to-day care of the young people by front line staff who understand their needs from an attachment/trauma perspective. The 'STAIRS' element emphasises the importance of a coordinated, multi-disciplinary, formulation driven approach to intervention.

SECURE STAIRS comprises the following components and desired outcomes:

S - to have a staff team with the necessary skill set to meet the needs of the young people effectively

E - to have emotionally resilient staff who are able to respond in the child's best interest at all times (and reduce their own sickness and sick leave)

C - to have staff that feel cared for to enable them to provide the most helpful therapeutic environment for these complex young people

U - to have staff with the understanding of psychological theory and the ability to apply this to practice (via training and supervision) to enable young people reach their potential

R - to have reflective systems which enable an improved unit environment - less risky behaviour in units, improved consistency and communication

E – to ensure every interaction matters and is positive

S - to ensure sufficient scoping is done for each young person to guarantee comprehensive assessment

T – targets for stay are collaboratively developed for each young person

A - activators for behaviours are identified as part of a comprehensive psychological formulation

I – informed by the formulation, ensure the interventions that are offered are evidence-based and developed collaboratively with the aim of delivering sustained change post-discharge

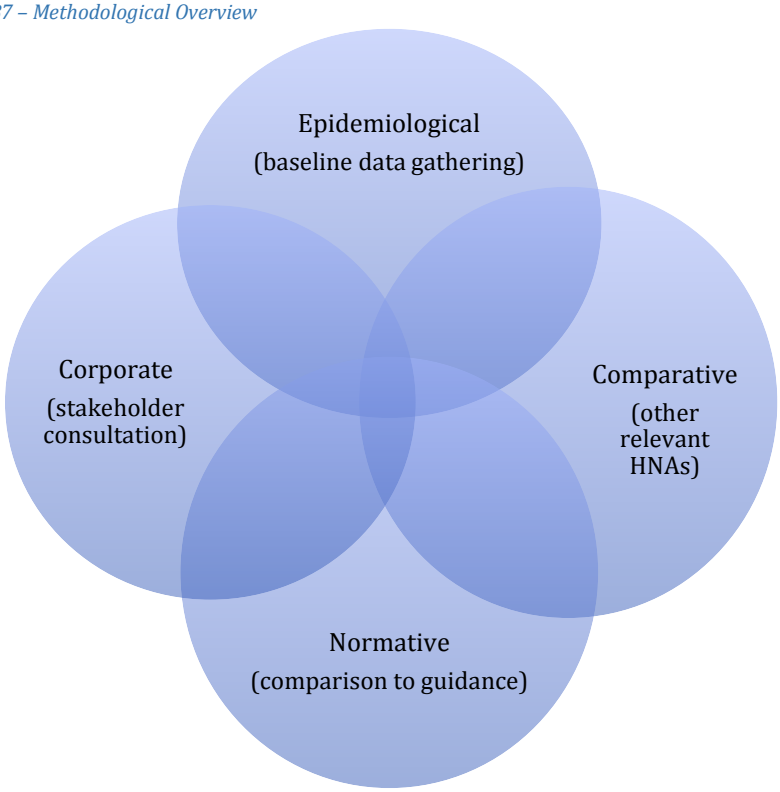
R - progress towards targets/interventions efficacy is review and revised regularly

S - sustainability of change post-discharge remains a key consideration throughout stay in CYPSE, with the aim of long-term improvement of life chances (specifically through reduced likelihood of reoffending; more stability of placements; better health, education, housing and employment opportunities; more effective therapeutic pathways into adulthood and/or community based provision)

Methodology

The methodology acknowledges the guidance described in the health needs assessment toolkit for prescribed places of detention.[72] This is subsequently referred to as the HNA *toolkit*. In addition, we refer to the previous Birmingham toolkit; whilst it is a little dated, this document still provides a useful summary of the literature and highlights the likely major health needs of the prison population.[73]

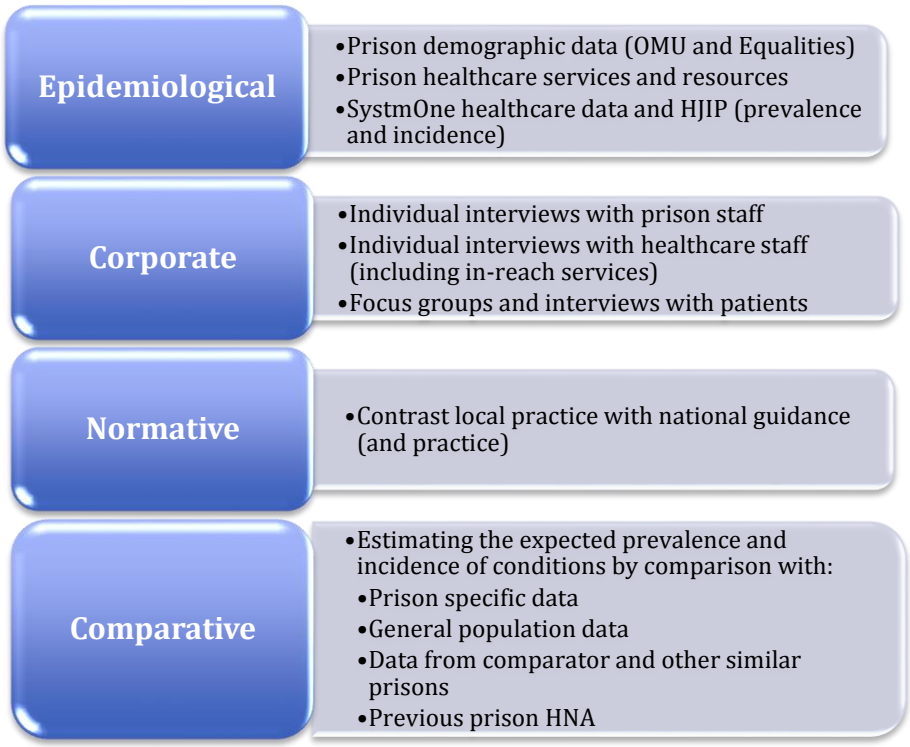
Figure 87 – Methodological Overview



For the purpose of this needs assessment, four distinct exploratory areas were interrogated to develop a full picture of need.

[72] PHE (2014) *Health and Justice health needs assessment toolkit for prescribed places of detention*. Parts 1 and 2.
[73] Marshall, T. *et al.* (2000) *Toolkit for health care needs assessment in prisons*. University of Birmingham.

Figure 88 – Methodology



Epidemiological

Basic demographic data on YOs was obtained from the offender management unit (OMU) in the prison/s.

The prison healthcare database (SystmOne) was interrogated to look at prevalence of health conditions across the YO population. Often, the numbers (i.e. OMU and SystmOne) did not exactly match; the report cites the source at all relevant places and, occasionally, offers both sets of data.

The equalities team was asked to provide data about men with protected characteristics.

Corporate

A series of semi-structured, 1:1 interviews were undertaken with key stakeholders in the prison. These involved a cross-slice of both strategic and operational staff.

Patient (YO) views were gathered in the prison by means of a questionnaire, distributed and collected by healthcare, and in some cases complemented by interviews.

There is a range of measures providing independent scrutiny to prisons, these measures are summarised below. This report draws on the first five:

HM Inspectorate of Prisons (HMIP) reports directly to the government on the treatment of, and conditions for, people in prison in England and Wales, and other matters. Prison establishments holding adults and young adults are inspected once every five years. Establishments holding juveniles are inspected every three years.

The Prisons and Probation Ombudsman (PPO) investigates all deaths that occur in prisons, or young offender institutions, probation approved premises, and immigration removal centres, whatever the cause of death. After each investigation, the PPO produces a fatal incident report, which may provide information on current health services in prisons.

Independent Monitoring Boards (IMBs) are statutory bodies established by the Prison Act 1952 to monitor the welfare of prisoners in the UK to ensure that they are properly cared for within prison and immigration centre rules, whilst in custody and detention. Each IMB produces an annual report, which often makes comments about the state of health services in the prison.

Care Quality Commission (CQC) now conducts joint inspections with HMIP and is working its way around the estate. In addition, when it inspects a community provider who reaches into prison, there may be relevant commentary. CQC inspects against a number of standards: the standards and the number will vary between inspections.

Health and Justice Indicators of Performance (HJIPs). These performance measures have been developed by NHS England, Public Health England (PHE) and HM Prison and Probation Service (HMPPS).

Ofsted also has a role to inspect YOIs and this is done as part of a joint inspection. Its role relates solely to learning and skills work within the establishments.

Comparative

Accompanying the *toolkit* referred to above, Marshall *et al*. conducted a health needs assessment for the entire prison estate.[74] This took the form of a meta-analysis of published work to give both prevalence and incidence estimates for a wide range of conditions that present to healthcare. This document is subsequently referred to as the *Birmingham HNA*. Whilst rather dated, it is so comprehensive that it still forms the baseline comparator data for many conditions across the prison estate. Where there is more recent, or more appropriate, published data we have replaced the *Birmingham HNA* data and made this clear in the referencing.

The demographics of the prison are outlined. Sources may vary depending upon the kinds of comparisons being made; all are acknowledged in the referencing.

Any previous HNA is reviewed and comparisons have been made with the data from this time to illustrate change.

The report contains details of the Ministry of Justice (MOJ) list of 'comparator prisons' (i.e. those which are considered to be similar in size, population type, etc.). Where HNA data is available, the prison is highlighted with bold text. This data is referenced through the report.

The MOJ selection of comparators is largely informed by size and security status. From a health perspective, security status is less relevant than turnover demographic factors. In addition, our

[74] Marshall, T. *et al.* (2000) *Health care in prisons: A health care needs assessment*. University of Birmingham.

team has collated data from over 70 HNAs which we have delivered. We have extracted relevant data from these and include it where applicable.

Defining Prevalence, Incidence and Demand

Throughout this report, where data has been available, there is included both a snapshot, which describes static demand, and also a report of the numbers in any year. This latter figure (incidence) reflects the turnover in the establishment.

Throughout, the report attempts to distinguish between *prevalence*, *incidence* and *demand*.

Prevalence gives a figure at a single point in time. Prevalence is normally expressed as a percentage. For example, based on published studies, we predict that the prevalence of diabetes in a YOI population will be 0.94.[75] Thus, for example, given an operational capacity (op cap) of 500, this predicts five young men will have the condition. It is a *static* prediction and does not take into account possible changes. This is one approach to demand. An additional approach is to think about the turnover, i.e. how many cases healthcare will have to manage in a year. Here, taking the same prevalence estimate of 0.94%, but this time multiplying it by the predicted number of people seen in a one-year period (population on day one plus new receptions), for example (1,500 new receptions per annum + op cap 500) x 0.94% = 19 cases per annum. The latter relates to *incidence*.

Incidence is defined by the Royal College of Nursing as:

> *the number of instances of illnesses commencing, or of persons becoming ill during a given period in a specific population.*[76]

For the purpose of this HSCNA, we define incidence as new cases coming to the prison in a given period (e.g. per year). In a prison setting, this primarily relates to the number of new receptions. Those prisons with higher turnover rates will have higher incidence, so any changes in turnover will significantly impact on healthcare demand.

The prevalence (i.e. the needs of the static population) for many conditions (such as asthma) may have only a small impact on healthcare resources – for example, just performing annual reviews. However, the incidence potentially places a huge demand on healthcare as the result of reception screening identifying new (whether a *new condition* or more likely *new to the prison*), often previously unmanaged conditions.

It is unrealistic, and indeed unsound, to attempt to design a healthcare system to meet every possible need (or manifestation of that need) based on what evidence tells us about prevalence and incidence. The issue of *demand* differs widely depending on the actual health condition. Demand is also, in part, influenced by the service model that commissioners want to commission. For example, a service modelled on wellbeing may well increase demand for certain physical healthcare conditions, as more prisoners prioritise seeking chlamydia testing. This approach typically uncovers previously unidentified and unmet needs.

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[75] Diabetes in the UK (2012) *Key statistics on diabetes*.
[76] Shields, L. and Twycross A (2003) 'The Difference between Incidence and Prevalence'. *Paediatric Nursing.* 15/7. Quoted by the Royal College of Nursing.

In many cases, not all those with a condition will present for treatment. We would expect a high proportion of those with type 1 diabetes to engage with healthcare because they will be insulin dependent. Therefore, the levels of incidence are likely to be similar to demand. However, there will be young men with type 2 diabetes who are undiagnosed and, indeed, some who are aware of their condition and choose to self-manage. The same applies to mental health conditions where we would expect to see a large difference between the prevalence/ incidence and subsequent demand for services.

National studies estimate that 40% of people with mental health problems go undiagnosed.[77] Additionally, a further 11-12% of individuals decline medication/psychosocial interventions and 6.2% of individuals meeting diagnostic criteria for mental health services do not require a service.[78]

In modelling demand for services, for example, the Department of Health (DH) states that fewer than 33% of people with diagnosable depression, and fewer than 25% of people with anxiety disorders, are in treatment.[79]

For the purpose of this HSCNA, we took a combined identification and entry to treatment figure of 50% of incidence for both substance misuse and mental health services.

Continuing with the example of substance misuse services, establishments receiving individuals from the community will be managing acute detoxifications: they will see a greater proportion of untreated conditions. However, establishments that receive YOs only from other prisons will, in general, be seeing a more stable population who have previously been screened by prison healthcare and should have ongoing conditions that are managed. For example, they would not be treating acute alcohol detoxification. In terms of the broader definition of incidence, there will be new cases where YOs develop, or are diagnosed with, conditions at all points throughout the prison system. Thus, any reports and calculations we offer in respect of incidence only present part of the picture and cannot describe the full picture.

[77] Sainsbury Centre for Mental Health (2003) *Primary Solutions: An Independent Policy Review on the Development of Primary Care Mental Health Services.* London.

[78] Boardman, J. *et al.* (2004) 'Needs for mental health treatment among general practice attenders'. British Journal of Psychiatry, 185/4: 318 - 327.

[79] DH (2011) *A Practice-Based Commissioning Business Case for IAPT*.

Young Offender Demographics – Determinants of Health

Age

The age of YOs is particularly relevant to a health needs assessment as some health conditions are highly correlated with age, with the risk/prevalence increasing commensurately with age. This applies to both physical health (e.g. diabetes, coronary heart disease), and mental health (e.g. ADHD and depression). In addition, patterns of substance misuse change with age.

Socio-Economic Status

YOs are stereotypically from the lower socio-economic groups, and health and wellbeing are closely correlated to socio-economic status. For example, someone born in the highest socio-economic group enjoys eight years' longer life expectancy than someone born to the lowest socio-economic group.[80] Therefore, a broad approach for understanding the health needs of YOs is to take health indicators for the most deprived cohort in society and assume YOs will be at the lower end of this.

ACE and Health Outcomes

A study in Wales concluded that comparing adults with no adverse childhood experience (ACE) events to those with four or more ACEs, found that those with four or more were 20 times more likely to have been incarcerated at some point in their lives.[81] ACE events are strongly correlated to health harming behaviours such as smoking, problem drinking or drug use, and consequently to poor physical and mental health outcomes.[82]

Ethnicity and Nationality

It is nationally reported that 26% of the prison population is from a 'non-white' ethnic group, which is a considerably higher proportion than the general population (13%).[83] However, whilst MOJ does not offer a detailed breakdown, HMIP states that 41% of respondents to its surveys in young adult prisons describe themselves as from a minority ethnic group.[84]

Quoting previous research, the Lammy Review states:

> *If the demographics of our prison population reflected that of England and Wales, we could have over 9,000 fewer Black, Asian and Minority Ethnic (BME) people in prison – the equivalent of a dozen average sized prisons. The youth custody population is smaller, but the BME proportion is much higher, at over 40%.* [85]

Whilst there is a direct correlation between ethnicity and some healthcare concerns, in most prisons the numbers are not really great enough to impact overall health needs. The type of

[80] ONS (2016) Trend in life expectancy at birth and at age 65 by socio-economic position based on the National Statistics Socio-economic Classification, England and Wales.
[81] Bellis, M. *et al.* (2015). *Adverse childhood Experiences and their impact on health-harming behaviours in the Welsh adult population.*
[82] Monnat, S. (2015) Long Term Physical Health Consequences of Adverse Childhood Experiences.
[83] House of Commons Briefing Paper (July 2018) Prison Population Statistics.
[84] HMIP (2018) Report on an unannounced inspection of HMYOI Brinsford by HM Chief Inspector of Prisons 6-17 November 2017.
[85] Lammy, D. (2017) The Lammy Review.

issues typically noted include sickle cell anaemia, which is far more prevalent in black Africans and black Afro-Caribbeans.

The Lammy Review raised concerns about under-identification of need amongst young BME prisoners:

> *BME youths were less likely than the white group to be recorded as having health, educational or mental health problems. This may indicate unidentified needs and could have a knock-on effect on the services and support made available to them.*
>
> *BME youths entering prison were less likely to be recorded as at risk of self-harm, or to have problems with their physical or mental health. They were less likely to be recorded as having learning difficulties.*[86]

The Young Review explores how to improve outcomes for black and Muslim young men in custody and made five recommendations.

1. *Rigorously monitored mechanisms need to be developed and implemented to ensure that independent providers address the specific needs of BME offenders*
2. *NOMS publishes its Equality Strategy in order to a) provide transparency for all stakeholders and b) form the basis for action, to include a stringent overhaul of the approach to services for young black and/or Muslim men in the CJS*
3. *Individuals who understand the lived experience of young black and/or Muslim male offenders should play an integral part in the planning and delivery of programmes and interventions to support desistance*
4. *The emphasis should be on dedicated resources for community engagement and partnership working models in prisons, rather than commissioning frameworks and supply chains*
5. *Ministry of Justice should give consideration to potential future opportunities for legislation in regards to BME offenders similar to that which exists to ensure that provision meets the specific needs of women offenders under the Public Sector Equality Duty [Equality Act]*[87]

Across the prison estate nationally, 11% of the prison population consists of foreign nationals[88] (this is a slight decrease on the 13% cited later in this report). We would expect to see higher rates of post-traumatic stress disorder (PTSD) amongst foreign nationals originating from conflict zones; potentially higher rates of HIV, especially amongst those from sub-Saharan Africa; and lower rates of immunisation where programmes are less well developed. In some cases, language barriers add complexity to delivering healthcare.

Disability

The World Health Organisation (WHO) defines disability as the following:

> *Disability is an umbrella term, covering impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and the society in which he or she lives.*[89]

As a result of a move in 2004 to include prisons within the Disability Discrimination Act (DDA), prisons must now ensure that services are accessible for those with disabilities. This duty was

[86] Lammy, D. (2017) The Lammy Review
[87] Young, L. (2014) The Young Review -Improving outcomes for young black and/or Muslim men in the Criminal Justice System.
[88] Ministry of Justice (2018) *Offender management statistics quarterly: April to June 2018.*
[89] WHO (2015) *Disabilities.*

further clarified in Prison Service Instruction 32-2011.[90] Disability is a protected factor, so an aspect of the work of the prison's equalities team.

It is estimated that 34% of prisoners have a disability; this will be highly age correlated. In HMIP reports, 17% of respondents from young adult prisons describe themselves as having a disability.[91]

Armed Forces Veterans

Whilst there will be fewer veterans in a YOI than an adult prison, there may be some.

Military personnel constitute an interesting group of individuals as they are frequently referred to as vulnerable from a healthcare perspective, yet from an equalities perspective, this is not a 'protected factor'. However, it is more likely that the roots of their vulnerabilities are aligned to their social care needs in the community.

The proportion of the prison population who are veterans is not always clear.

> *Within the prison system, although prison data systems do have a question about veteran status, this is not routinely completed. Some veterans are also known to be reluctant to identify themselves in the prison system either due to fears of reprisal or due to stigma.*[92]

HMIP states that 2% of YOI populations self-report as veterans. MOJ estimates for the whole estate of some 2,032 veterans (4% of prisoners) in England and Wales.[93]

Howard League for Penal Reform report states:

- *Armed Forces Veterans are less likely to go to prison than their respective civilian populations, but when they do, veterans are more likely to be serving sentences for violent and sexual offences.*
- *32.9% of veterans are in prison for violence against the person, compared to 28.6% of the non-veteran prison population.*[94]

HMIP describes additional health and social care related issues that are specific to veterans:

- *Ex-service personnel were more likely to report feeling depressed or suicidal on arrival into prison (18% compared with 14%).*
- *The incidence of physical health problems on arrival into prison was higher among ex-service personnel than the general prisoner population (24% compared with 13%).*
- *A higher proportion of prisoners identifying as ex-service personnel stated they had a disability (34% compared with 19% of the general prisoner population).*[95]

A study at King's College London has been investigating the health and wellbeing of UK armed forces personnel since 2003.[96] It reported in 2011 that they have found no major differences in the psychological health of armed forces personnel who have been deployed to Iraq and Afghanistan compared to those who haven't. PTSD is widely publicised by the media as

[90] NOMS (2011) *SSI 32/2011 Ensuring Equality*.
[91] HMIP (2018) Report on an unannounced inspection of HMYOI Brinsford by HM Chief Inspector of Prisons 6-17 November 2017
[92] CEI (2016) From Gate to Gate: Improving the mental health and criminal justice care pathways for veterans and family members.
[93] MOJ (2018) Ex-service personnel in the prison population, England and Wales
[94] Howard League for Penal Reform (2010) Report of the Inquiry into Former Armed Service Personnel in Prison.
[95] HMIP (2014) People in prison: Ex-service personnel A findings paper by HM Inspectorate of Prisons.
[96] Kings College London (2011) Health and Wellbeing Survey of UK Armed Forces Personnel. Newsletter.

affecting many serving personnel but the study found that, while most who had been deployed did not return with a mental health issue, those who do tend to display symptoms of anxiety, depression or alcohol misuse.

Homelessness

There is little published data on the housing status of YOs prior to imprisonment. The Prison Reform Trust[97] quotes 2010 MOJ data to say 15% of prisoners were homeless prior to imprisonment.

Homelessness is strongly correlated with poor outcomes on release*:*

> *Securing stable and appropriate accommodation is essential for enabling people to progress on their journey to desistance.*[98]

[97] Prison Reform Trust (2016) Prison: the facts Bromley Briefings Summer 2016.
[98] Clinks (2017) Clinks Briefing Are the accommodation needs being met for people in contact with the Criminal Justice System?

Physical Health

Long-Term and Chronic Conditions

> *A long-term condition is any medical condition that cannot currently be cured but can be managed with the use of medication and/or other therapies… Currently approximately 70% of the health spend in England is on 30% of the population who have LTCs.*[99]

Studies of the wider community show how the prevalence of a wide range of long-term conditions (LTCs), but not all, are greater in older people.[100] There is a strong link between LTCs and social inequalities – compared to the highest social class, those in the lowest social class have a 60% higher prevalence of LTCs and 30% higher severity of conditions.[101]

> *[A]ll the NICE guidelines, all the pathways, are designed for people allegedly with only one condition, but most people have multiple conditions.*[102]

Prisoners with long-term and chronic diseases are typically repeat users of prison healthcare services.

Following the conventional approach in the *toolkit*, the report largely focuses on individual conditions; however, a patient may have a complex presentation of two or more comorbid conditions.

Asthma

Unlike other chronic conditions, asthma is most prevalent in younger age groups; it is the most common chronic condition in children. In many cases described in the prison population, a YO self-reports the condition, which may have been suggested or given in childhood and is no longer relevant. Therefore, the healthcare screened numbers are typically lower than the self-report numbers.

Research indicates that prevalence may be decreasing over time.[103] The prevalence data in the current *toolkit* is derived from the *Birmingham HNA*.[104] The sources cited data from 1996 - 20 years old - and is based on presentations to general practice in the community, and thus should be noted with caution.

The table below is based on the Birmingham prevalence data and shows the estimated prevalence of asthma among the prison population, broken down by age category.

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[99] BMA Briefing Paper (2016) Living with long term conditions.
[100] The Kings Fund quoting from Department of Health (2012). Report. Long-term conditions Compendium of Information: Third edition.
[101] *Ibid.*
[102] Professor Nigel Mathers, Vice-Chair of the Royal College of General Practitioners, quoted in House of Common Health Committee (2014) Managing the care of people with long–term conditions.
[103] Simpson, C.R. and Sheikh, A. (2010) 'Trends in the epidemiology of asthma in England: a national study of 333,294 patients'. *Journal of the Royal Society of Medicine.* 103/3: 98-106; also Simpson and Sheikh (2014) 'Trends in the Prevalence of Asthma'. *Chest*. 145/2: 219-225.
[104] Marshall, T. *et al.* (2000) *Health care in prisons: A health care needs assessment*. University of Birmingham. Prison population derived from Home Office statistics 31 December 1998. Citing Prescott-Clarke, P. *et al.* (1998) *Health Survey for England 1996.* The Stationery Office; and ONS (1998) *Key Health Statistics from General Practice 1996.*

Figure 89 – Estimated Prevalence of Asthma by Age (male prisoners)

Age Band	Wheezing in the last year	Diagnosed Asthma	Treated Asthma
15-24	20%	19%	7%
25-34	19%	12%	5%
35-44	18%	11%	4%
45+	19%	8%	4%
Total	19%	14%	5%

More recent community data describes 9.65% of under 16 year olds with asthma and 8.68% of over 16 year olds.[105] Alternatively, the British Lung Foundation states 'over 12% of the population' have a diagnosis for asthma.[106]

COPD

COPD is a term that includes a number of conditions, including chronic bronchitis and emphysema.

Smoking tobacco is seen as the major risk factor and smoking rates are high amongst prisoners.[107] Also, there are anecdotal concerns of an increasing prevalence amongst drug users who heeded the message not to inject and instead have been smoking drugs, sometimes for many years.

Prevalence is highly age-correlated and the condition should be very rare in this age group.

Coronary Heart Disease (CHD)

CHD is also referred to as ischaemic heart disease.

A variety of factors, including high rates of smoking, combine to mean that, in contrast to the general population, prisoners are at heightened risk of cardiovascular disease.[108]

The prevalence of CHD is highly age-correlated. In addition, the British Heart Foundation reports that CHD is 2.9 times more prevalent in men from the lowest socioeconomic group compared to the highest.

Figure 90 – CHD (prevalence - males)[109]

	Treated
16-24	0.1%
All ages	6.5%

Many patients with hypertension can manage their care themselves and good outcomes can depend on the patient attending to this. Lifestyle choices significantly impact on risk and the

[105] Asthma UK (accessed 5.4.2019).
[106] British Lung Foundation (accessed 5.4.2019).
[107] NICE (2010) *Chronic Obstructive Pulmonary Disease*.
[108] Aries, E. (2013) Cardiovascular risk factors among prisoners: an integrative review.
[109] *Idem*, Table 2.13.

following are examples of steps that can be taken to reduce risk: discontinuing smoking, making healthier food choices, increasing aerobic exercise, and moderating alcohol consumption.

Figure 91 – Hypertension (prevalence - males)[110]

	Treated	Untreated	Total
16-24	0	5%	5%
All ages	7%	15%	22%

Diabetes

Diabetes prevalence strongly correlates with increasing age. The *Birmingham HNA* states that diabetes could be between two and eight times as prevalent in prisons compared to the community.[111] The rate of diabetes in the community is now described as 6.6% of males and 7.6% of females and continues to rise. There has been no recent study in UK prisons, but a study amongst American prisoners also suggested 4.8% prevalence.[112] Noting these changes, the report draws on recent PHE data below:

Figure 92 – Diabetes Expected Prevalence[113]

Age Band	Prevalence (%)
16-24	0.8%

We would not expect demand to equal prevalence or incidence. The prevalence figure includes both non-insulin dependent, and insulin dependent diabetes. The diabetes service is used more by insulin dependent patients than other patients with diabetes.

National data indicates that 10% of those with diabetes have insulin dependent diabetes (type 1) and that 90% have non-insulin dependent diabetes (type 2).[114]

Epilepsy

The *Birmingham HNA* discusses epilepsy and draws upon community estimates. This is what we would expect to find in prisoners:

Figure 93 – Epilepsy Prevalence by Age (males) and Expected Numbers[115]

Age Band	Prevalence (%)
16-24	0.45%
Total	0.36%

There is little difference in prevalence across age groups. A meta-analysis published in the *British Medical Journal* described a rate of 0.7% in a sample group of 3000 prisoners.[116] More

[110] British Heart Foundation *Coronary Heart Disease Statistics 2012 Edition* Table 5.3.
[111] Marshall, T. *et al.* (2000) *Health care in prisons: A health care needs assessment*. University of Birmingham.
[112] American Diabetes Association: Diabetes Management in Correctional Institutions. Vol. 37, Supplement 1, Jan 2014.
[113] PHE (2015) Diabetes Prevalence Model
[114] Diabetes in the UK (2012) *Key statistics on diabetes*.
[115] Marshall, T. *et al.* (2000) *Health care in prisons: A health care needs assessment*. University of Birmingham. Based on OCPS Morbidity Statistics from General Practice. Fourth National Study 1991-1992.
[116] Fazel, A. *et al.* (2002) 'Prevalence of epilepsy in prisoners: systematic review'. *British Medical Journal.* 324: 1495.

recent data reports an increased prevalence in the community of 0.95%, and the Joint Epilepsy Council also notes that rates are 25% higher in the most deprived populations.[117] Given the above, this report takes the more recent estimate of 0.95% and adds 25% to give a revised figure of 1.19%. Identified rates of epilepsy are usually well above the predicted prevalence; this is down to misdiagnosis in childhood that never leaves the systems.

There is a potential for YOs to be misdiagnosed with epilepsy, as evidenced in an audit of healthcare in prisoners of one UK prison. The diagnoses of epilepsy were reviewed in 19 of the 26 cases identified, and of those, only 11 were believed to have epilepsy after the review. It is interesting to note that in this study, 38.4% of prisoners reported that their seizures developed within 12 months of beginning significant substance misuse, and a number of the prisoners also identified substance abuse as a cause for further seizures.[118]

A French study postulates to a link between traumatic brain injury and the high rate of epilepsy amongst prisoners.[119]

Sickle Cell Disease

Sickle cell disease is an inherited condition, most commonly affecting people of African and Afro Caribbean heritage. The most severe form is sickle cell anaemia. Sickle cell disease is generally detected during pregnancy or shortly after birth.

Patients with sickle cell will experience a range of symptoms[120] and may require regular monitoring. In some cases, they will require care from secondary healthcare services. See NICE quality standard.[121]

It is estimated that 14,000 people in the UK are living with the disease (1 in 4600 people).[122]

The table below describes rates identified via screening of newborn babies and illustrates how the conditions are concentrated in ethnic groups.

[117] Joint Epilepsy Council (2011) *Epilepsy Prevalence, Incidence and Other Statistics*.
[118] Tittensor *et al.* (2008) Audit of healthcare provision for UK prisoners with suspected epilepsy.
[119] Waiter, L. *et al.* (2016) Prevalence of traumatic brain injury and epilepsy among prisoners in France: Results of the Fleury TBI Study
[120] NHS Website (accessed 6.5.2019).
[121] NICE (2014) Sickle cell disease Quality standard 58.
[122] Dormandy, E. *et al.* (2017) How many people have sickle cell disease in the UK?

Figure 94 – Rates of Significant Haemoglobin Conditions by Ethnic Category, 2016 to 2017[123]

Ethnicity Category	Significant Conditions	
	Rate/1000	1 in x
White	0.01	118,676
Mixed	0.41	2,439
Asian	0.23	4,381
Black Caribbean	4.35	230
Black African	7.69	130
Any other black background	4.23	236
Other*	0.20	5,108

Inflammatory Bowel Disease/Crohn's Disease

Crohn's affects people of all ages, but symptoms generally start in childhood or early adulthood, so it tends to be identified from teenage years onwards.

NICE provide guidance.[124] Many patients do not require specific treatment unless the condition flares up,[125] in which case this might be managed by a GP or could require secondary care interventions.

NICE reports that the prevalence rate is 15.7 people per 10,000.[126]

Cancer

The following paragraphs are based on an all-age population. The community incidence of cancer (the number of people diagnosed with cancer each year) is 6.7 per 1,000 for males.[127] Though, it should be noted, this is highly age-correlated, with the peak age for diagnosis being 85 years old.[128]

Lifestyle choices impact on the risk of contracting cancer. As described in the smoking section of this report, rates of smoking in prison are more than double those of the general population. Cancer Research UK attributes smoking as the cause of 28% of cancer deaths.[129]

> *The socioeconomic profile of [the prison] population means that it is at a higher risk of cancers associated with smoking, alcohol and socioeconomic deprivation.*[130]

When a prisoner is diagnosed with cancer, the impact is far more likely to be felt in terms of prisoner escorts and Bedwatches, as opposed to within healthcare, as treatment is largely delivered from hospitals. This is particularly the case for stage-three cancers.

[123] PHE (2017) NHS Sickle Cell and Thalassaemia Screening Programme.
[124] NICE (2019) Crohn's disease: management
[125] NHS Website (accessed 7.5.2019).
[126] NICE (2014) Inflammatory bowel disease.
[127] ONS (2017) Cancer registration statistics, England: first release, 2015.
[128] Cancer UK (2016 Cancer incidence by age.
[129] Cancer Research UK (2015) *Smoking Facts and Evidence*.
[130] Davies, E.A. (2010) 'Cancer in the London prison population, 1986-2005'. *Journal of Public Health.* 32/4: 526-531.

Emergency Codes

A ‘code’ is an emergency call to healthcare. A code blue is where someone is unconscious or having respiratory problems etc.; a code red is where there is blood. The relevant PSI 03/13 requires that each ‘code’ generates an automatic call from the control room to the ambulance service.

Oral Health

Oral Health Amongst Prisoners

There is a dearth of information specifically describing the oral health needs of young offenders. One study showed that young offenders had greater numbers of decayed teeth alongside fewer numbers of filled teeth in comparison to women and older male prisoners.[131]

> *Poor oral health is well documented for this patient group <prisoners> with the prevalence of oral disease being four times higher, on average, than that of the general population. A number of behavioural predisposing factors have been identified such as alcohol, tobacco, substance misuse, high sugar diets, chaotic lifestyles, and poor oral hygiene. These issues are further compounded by the high incidence of learning difficulties and mental health problems. These patients often have had little oral health education, resulting in a low perception of oral health. The oral health of the general population has improved markedly in the last 30 years whilst there has been little or no improvement for this vulnerable, socially excluded group.*[132]

There is a solid evidence base demonstrating that prisoners have poorer dental health than the general population. Prisoners exhibit more decay and fewer filled teeth[133] in addition to experiencing a higher prevalence of oral disease and unmet dental needs than the general population.[134]

> *Prisoners have poorer general and oral health than the non-prison population. Remand prisoners reported a higher level of dental anxiety and were more likely to value their teeth, visit the dentist and opt for restoration of an anterior tooth than convicted prisoners. Convicted prisoners expressed more perceived need than their fellow remand prisoners, even though convicted prisoners' normative need tended to be lower.*[135]

An all-age needs assessment of the oral health of prisoners in Wales found high levels of need.[136] Eighty percent of those screened required dental treatment and 35% had at least one tooth that required extraction, compared with just 10% in the community. Similarly, a study in a Scottish prison revealed that 29% of the prison population had severe dental decay in comparison to 10% of the general public.[137]

Prisoners note poor access to dental health services in comparison to other healthcare services, with appointments and treatments required to fit around the strict prison timetable.[138] Another reason that could explain the poor oral health among prisoners includes the items that are permitted within the prison. Prisoners claim that the toothbrushes and toothpaste they have access to are of inferior quality to those available in shops.[139] Furthermore, floss, mouthwash and regular toothbrushes are not allowed in some prisons due

[131] BDA (2012) Oral healthcare in prisons and secure settings in England.
[132] National Association of Prison Dentistry (2015) Service Specification Prison Dentistry.
[133] SOHIPP The Oral Health and Psychosocial Needs of Scottish Prisoners and Young Offenders.
[134] Marshman *et al.* (2014) Does dental indifference influence the oral health related quality of life of prisoners?
[135] Heidari, E. *et al.* (2008) An investigation into the oral health status of male prisoners in the UK.
[136] NHS Public Health Wales (2014) Oral Health Needs Assessment of the Prison Population in Wales: Executive Summary and Recommendations.
[137] Neville, P. (2015). Oral health among UK prisoners.
[138] *Ibid.*
[139] *Ibid.*

to the risk that they may be used as weapons.

A number of reports also make reference to the prison diet negatively impacting on oral health. Prisoners turn to snacking as a cure for boredom, but the snacks available tend to have a high sugar content.[140] This may increase as an unintended consequence of the smoking ban.

The transient nature of prison populations also prevents effective dental treatment. A prisoner may be released or moved to another prison with limited notice, meaning that dental procedures may not be carried out and courses of treatment may not be completed. Failure to adequately transfer healthcare records when a prisoner is transferred can also negatively impact on a prisoner's treatment, with them having to start from the beginning with a new healthcare professional.

Demographic Factors

> *Oral health is affected by deprivation and, in the more deprived areas of the country, oral health is poorer and edentulousness is higher than in the more affluent areas.*[141]

The Adult Dental Hygiene Survey (ADHS) indicated that adults in households from routine and manual occupations were 11% more likely to have tooth decay than those from managerial and professional occupation households.[142] This emphasises the likelihood that prisoners are more likely to have higher oral health requirements than those in higher socio-economic groups before their prison term even begins.

Oral Health and BME Populations

> *There is evidence that members of ethnic minority communities have generally worse health (Acheson 1998) and are less likely to regularly visit a dentist (DH 1999).*[143]

However other publications contradict this:

> *Contrary to most health inequalities, oral health was better among non-white groups, in spite of lower use of dental services.*[144]

Whilst in the main impacting on older populations, it needs to be borne in mind that risk behaviours associated with oral cancer are more prevalent among certain ethnic groups.[145]

> *The prevalence of oral cancer is particularly high among the South Asian community, correlating with use of smokeless tobacco, though survival rates of these patients reportedly compare favourably with those of oral cancer sufferers in other sections of British society.*[146]

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[140] SOHIPP The Oral Health and Psychosocial Needs of Scottish Prisoners and Young Offenders. See also Heidari *et al.* (2008) An investigation into the oral health status of make prisoners in the UK.
[141] PHE (2015) What is Known About the Oral Health of Older People in England and Wales: A review of oral health surveys of older people.
[142] Steele *et al.* (2009) Adult Dental Health Survey.
[143] BDA (2003) Oral Healthcare for Older People: 2020
[144] Arora, G. *et al.* (2017) *Ethnic differences in oral health and use of dental services: cross-sectional study using the 2009 Adult Dental Health Survey*
[145] BDA (1996) Improving Oral Health Amongst Ethnic Minority Elderly People. London.
[146] BDA (Undated) The British Dental Association Oral Health Inequalities Policy.

The 1998 Adult Dental Health Survey suggested that Bangladeshi, Irish and black Caribbean men were more likely to smoke cigarettes than the general population. In addition, the survey found that individuals from minority ethnic groups were less likely to visit the dentist for a regular check-up and to go only when in pain. This means that oral cancer in these groups is unlikely to be seen until the late stages when the morbidity and mortality associated with its treatment are greater.[147]

Smoking, Alcohol and Drug Use

Prevalence rates for smoking amongst prisoners are four times greater than in the community. Approximately 80% of all prisoners smoke[148] compared with 20% of the general population.[149]

Nineteen percent of all prisoners report having alcohol problems.[150] There are no community equivalent studies but, in the community, 22% of men report drinking more than 21 units per week and 16% of women said they drink more than 14 units per week.[151]

Drinking hazardously is indicated as a cause of oral disease, including cancers of the mouth, larynx, pharynx and oesophagus.[152] Alcohol and lifestyles closely associated with alcohol misuse can also have detrimental effects on dentition: dental erosion, dental caries and periodontal disease.[153]

Twenty nine percent of prisoners report having a drug problem at reception.[154] In the community, 8.6% of people report having taken any drug in the previous 12 months, and just 2.2% were classed by CSEW (Crime Survey for England and Wales) as 'frequent users', 3.2% had consumed a Class A in the last year.[155]

> *Drug abuse is associated with serious oral health problems including generalised dental caries, periodontal diseases, mucosal dysplasia, xerostomia, bruxism, tooth wear, and tooth loss. Oral health care has positive effects in recovery from drug abuse: patients' need for pain control, de-stigmatisation, and HIV transmission.*[156]

Prisoners with any history of previous drug use show greater numbers of decayed teeth when compared to those with no history of drug use.[157]

However, it is also interesting to note that prisoners with substance misuse issues are likely to report toothache soon after entering the prison, because the drugs they took (especially opiates) may have suppressed any pain.[158]

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147 BDA (2003) Oral Healthcare for Older People: 2020.
148 Data from recent TamlynCairns HNAs.
149 DH (2015) Statistics on Smoking England 2015.
150 Community Justice portal (2010) Prison Service Failing to Address Growing Problem of Alcohol Misuse in Prisons.
151 Health and Social Care Information Centre (2015) Health Survey for England – 2014 Trend Tables.
152 Rehm, J. *et al.* (2003). The Relationship of Average Volume of Alcohol Consumption and Patterns of Drinking to Burden of Disease: an overview.
153 Amaral, C.S. *et al.* (2009). The Relationship of Alcohol Dependence and Alcohol Consumption with Periodontitis: A systematic review.
154 HMIP (2013) Her Majesty's Chief Inspector of Prisons for England and Wales. Annual Report 2011–12.
155 CSEW (2015) Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales. Second edition.
156 Shekarchizadeh, H. *et al.* (2013) Oral Health of Drug Abusers: A Review of Health Effects and Care.
157 SOHIPP The Oral Health and Psychosocial Needs of Scottish Prisoners and Young Offenders.
158 BDA (2012) Oral Health in Prisons and Secure Settings in England.

Repeat Prisoners

Although the literature comparing oral health needs among prisoners of differing ages is sparse, there is one study of particular interest which evidenced oral health differences between new and repeat offenders, as well as older and younger prisoners.

Prisoners with a greater experience of remand had greater numbers of teeth missing due to caries, and higher rates of obvious decay. Those with longer current imprisonment had greater obvious decay, fewer decayed teeth, fewer filled teeth and a greater number of missing teeth. This evidence implies that older prisoners who have served multiple, or longer prison sentences, are likely to have poorer oral health than those who have served shorter, or single sentences. This study also indicated that prisoners with a greater experience of prison, or longer current prison sentences, were more likely to have fewer than 20 standing teeth.[159]

[159] BDA (2012) Oral Health in Prisons and Secure Settings in England

Communicable Diseases

National Screening Programme

NICE (2016) recommend that prison healthcare should:

> *offer people equivalent health checks to those offered in the community.*[160]

All new receptions are eligible for both a first and secondary health screen, at these patients should asked about the national screening programme. The PHE population screening programme makes reference to 12 recognised screening programmes in the UK.[161] Seven of these relate to antenatal and newborn babies. The only screening programme which is relevant for the young offender and young adult male prison population is:

- NHS diabetic eye screening (DES) programme (everyone aged over 12 years with type 1 and type 2 diabetes)

There is also a related programme in England that is relevant to the younger prison population. This is:

- The National Chlamydia Screening programme (for under 25s)

Vaccinations Policies

The Health Protection Agency states:[162]

> *Introduced in prisons in England and Wales in 2003 the Hepatitis B vaccination programme has been responsible for a significant reduction in the transmission of the infection in injecting drug users (IDUs) overall.*[163]
>
> *Hepatitis A and B vaccinations are recommended for all prisoners.*
>
> *Individuals who have not completed the five doses of diphtheria, tetanus and polio vaccines should have their remaining doses at the appropriate interval. In addition to the diphtheria, tetanus and polio vaccines and in line with the UK routine childhood immunisation schedule, young adults who are not protected against measles, mumps, and rubella (MMR) and meningococcal C disease, should complete immunisation against these infections. Where there is an unclear history of vaccination, adults should be assumed to be unimmunised and the recommendations for individual vaccines should be followed.*

In prisons with high proportions of young offenders (whether male or female), there will be significant work in terms of catching up on missed childhood immunisations, particularly those relevant in later childhood that may have been missed e.g. HPV vaccine (girls), meningitis, and boosters for tetanus, diphtheria and polio (14 years). As noted above, if there is no clear

[160] NICE (2016) Physical health of people in prison.
[161] PHE (undated) *Population screening programmes*.
[162] Health Protection Agency (2009) *Schedule for Vaccination of Prisoners and Young Offenders in North West Region*.
[163] From March 2011, a '300% increase in Hep B prison vaccine helps to drive down infection rates in injecting drug users'. PHE Press Release (2011).

evidence that vaccinations have been received, individuals should be vaccinated in accordance with the National Immunisation Schedule.[164]

In addition, NICE recommend routine HBV vaccination for

- *staff and inmates of custodial institutions*[165]

The current PHE advice includes the following principles

- *Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned*
- *If the primary course has been started but not completed, resume the course – no need to repeat doses or restart course*
- *Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible*[166]

For those aged 10-25 years, the guidance is:[167]

- Those aged from 14 years old who have never received a MenC-containing vaccine should be offered MenACWY
- Tetanus, diphtheria and polio – 3 in 1 teenage booster at 14 years of age

Blood-Borne Viruses

PHE states that BBV infection rates are four times higher amongst prisoners compared to general population.[168] Figures from Public Health England show that hepatitis B and C cases accounted for 1,174 of 1,268 infectious diseases reported in English prisons during 2014.[169] PHE is promoting opt-out testing for prisoners using dry blood spot testing, this approach is increasing rates of testing.[170]

The comparator data provided in the *toolkit* is largely outdated, so the report draws on more recent work. The prevalence of HIV, hepatitis B and hepatitis C viruses, sexually transmitted infections (STIs) and tuberculosis among people in prisons is estimated to be two to ten times higher than in the general population.[171] The rate of infection for blood-borne viruses, like hepatitis B and C and HIV, is four times higher in prisons than in the general population, while the prevalence rate of TB amongst people in prison in England is nearly five times higher than in the general population.[172] This is likely due to risky behaviour, for example, associated with substance misuse. Over 90% of new hepatitis C cases are believed to be acquired through injecting drug use.[173]

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[164] PHE (2017) The Complete Routine Immunisation Schedule from Autumn 2017.
[165] BNF website (accessed 26.4.2019).
[166] PHE (2017) Vaccination of individuals with uncertain or incomplete immunisation status.
[167] PHE (2019) Immunisations for young people.
[168] PHE & WHO (2018) *Public Health England Health and Justice Annual Review 2017/18.*
[169] Public Health England (2015) Hepatitis cases responsible for 93% of prison disease reports.
[170] PHE (2018) *Hepatitis C in England 2018 Report.*
[171] Public Health England (2017) Infection Inside International.
[172] Prison Reform Trust (2017) Bromley Briefings Prison Factfile.
[173] PHE (2015) Blood-borne Virus Opt-Out Testing in Prisons: Preliminary evaluation of pathfinder programme. Phase 1, April to September 2014.

Figure 95 – BBV Prevalence[174]

Blood-Borne Viruses	Estimated Prevalence (%) Prisons	General Community
Hep B	1.3%	0.3%
Hep C	6.7%	1.6%
HIV	0.6%	0.16%

NICE publishes guidelines on testing for BBVs in prisons.[175] The introduction of dry blood spot testing across the estate is expected to assist implementation of a true opt-out approach and substantially increase testing rates.[176]

At the same time as the push to increase testing, there have been major advances in the treatment of HCV and initiatives to increase uptake.[177]

As noted above, NICE recommends routine HBV vaccination for: '*staff and inmates of custodial institutions.*'[178]

Sexual Health

NHS England states that:

> *anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner.*[179]

Chlamydia is the most common sexually transmitted infection and, whilst not detectable without a test, can lead to long-term health issues including infertility. The PHE published rate of diagnosed sexually transmitted infections amongst prisoners is reported to be low.[180]

Chlamydia is most relevant and pertinent in establishments (both male and female) with a YO population.

[174] PHE & WHO (2018) *Public Health England Health and Justice Annual Review 2017/18*
[175] NICE (2017) Physical health of people in prisons. Quality statement 3: blood borne viruses and sexually transmitted infections
[176] Morey, S *.et al.* (2018) *Increased diagnosis and treatment of hepatitis C in prison by universal offer of testing and use of telemedicine* and PHE (2017) *National engagement event for blood- borne virus (BBV) opt-out testing in prisons in England, 2017.*
[177] PHE (2018) *Hepatitis C in England 2018 report*
[178] BNF website (accessed 26.4.2019)
[179] NHS England (2016) Health Protection Weekly Report 5th July 2016.
[180] PHE (2016) Public Health England Health and Justice Annual Review 2015/16.

Figure 96 – Rate of STI Infection in Males per 100,000 Population (2017)[181]

	15-17 Yrs	20-24 Yrs
All STIs	1276.6	3512.7
Chlamydia	780.4	1713.3
Gonorrhoea	133.7	390.2
Syphilis	7.4	37.3

Tuberculosis (TB)

A 2018 report by PHE found the following:[182]

- a total of 5,102 people were notified with TB, a rate of 9.2 per 100,000 population
- the rate of TB among people born outside the UK in 2017 remained 13 times higher than among those born in the UK.

The measure is a risk factor of imprisonment, 4.4% of those with TB were (or had been) in prison.

PHE states that at 32 cases per 100,00, prisoners are three time more likely to have TB than the general population.[183]

[181] PHE (2018) Table 2 New STI diagnosis and rates by gender, sexual risk and age group: 2013 to 2017
[182] Public Health England (2018) *Tuberculosis in England 2018 report (presenting data to end of 2017)*.
[183] PHE & WHO (2018) *Public Health England Health and Justice Annual Review 2017/18*

Immunisation

The national immunisation programme focuses on children and then on adult specific interventions. For prisoners who have incomplete immunisation status, PHE provides guidance.[184]

Routine vaccinations which should be completed:

Figure 97 – PHE Routine Vaccination Schedule

Age	Vaccination
All age groups	Hepatitis B
Up to 24 years	Measles, mumps, rubella (MMR) Meningococcal ACWY vaccine Tetanus (T), diphtheria (d), and polio (IPV)- Td/IPV

In addition, some vaccines should be offered to patients with certain increased risks:

- Hepatitis A vaccine should be offered to individuals in groups such as injecting drug users (IDUs), men who have sex with men, or in the event of a hepatitis A outbreak
- Flu vaccination should be offered (annually) to those under 65 years of age who are at increased risk due to an underlying health condition
- Pneumococcal vaccine (PPV) should be offered to those under 65 years of age who are at increased risk due to an underlying health condition.
- Human papillomavirus vaccine (HPV) is recommended for men who have sex with men up to the age of 45 and for those at similar risk.

[184] PHE (2017) Vaccination of individuals with incomplete immunisation status.

Substance Misuse

Overview

DH and YJB stated that it is clear that while substance misuse is just one of a host of needs that young people entering custody may have, the prevalence of substance use far exceeds the national average: 44% of the sample were found to be problematic substance misusers, a further 40% displayed signs of potentially problematic use.[185]

Mainly as a response to the correlation between opiate dependency and acquisitive crime, substance misuse services in the criminal justice system have traditionally been opiate focused. Young people's patterns of drug use do not centre on opiates.

The government drug strategy of 2010 championed recovery from both drug and alcohol addiction.[186] In respect of illicit drug use only, HMIP in *'Changing patterns of substance misuse in adult prisons and service responses'* continued to carry the recovery agenda forward, including a focus on psychoactive substances (PS) (previously referred to as NPS).[187]

The Drug Strategy 2017[188] continues to develop the concept of recovery and now includes a focus on PS. The MOJ[189] places a strong emphasis on *'getting offenders off drugs'* and restricting supply within prisons. In 2019, HMPPS issued a new Prison Drugs Strategy,[190] with the stated aim of supporting the national strategy; the three aims are: restrict supply, reduce demand and build recovery.

In 2018, NHS England issued a new service specification, which includes a focus on NPS drug users, dual diagnosis and continuity of care on release.[191]

Forty two percent of female prisoners and 28% of male prisoners report having a drug problem on arrival, while 8% of women and 13% of men reported they had developed a problem with illicit drugs while in prison.[192] The most recent national opiate and cocaine prevalence estimates refer to 2014/15 and describe a slight increase in prevalence since the previous estimates (2.3% since 2011/12). This is in contrast to an estimated 2.4% reduction in prevalence nationally in 2010/11, and a 1.6% reduction in 2011/12; however, as noted, the increase is small.[193] Significantly, 47% of men and 31% of women reported that it was easy to access drugs in their prison and an estimated 225kg of drugs were confiscated from within prisons in 2016.[194]

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[185] DH & YJB (2009) *Guidance for the Pharmacological Management of Substance Misuse Among Young People in Secure Environments.*
[186] HM Government (2010) *Drug Strategy 2010. Reducing Demand Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.*
[187] HMIP (2015) *Changing patterns of substance misuse in adult prisons and service responses.*
[188] HM Government (2017) *2017 Drug Strategy.*
[189] MOJ (2016) Prison Safety and Reform.
[190] HMPPS (2019) Prison Drugs Strategy.
[191] NHS England (2018) Service Specification: Integrated Substance Misuse Treatment Service Provision in Prisons in England.
[192] House of Commons Health and Social Care Committee (2018) Prison health Twelfth Report of Session 2017–19 Report, together with formal minutes relating to the report
[193] Hay, G. *et al.* Estimates of the prevalence of opiate use and/or crack cocaine use (2014/15). , Hay, G. *et al.* (2013) *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12*: Sweep 8 http://www.nta.nhs.uk/facts-prevalence.aspx.
[194] Prison Reform Trust (2017) Bromley Briefings Prison Factfile.

HMIP notes that:

> *A declining number of prisoners needing treatment for opiate misuse reflects trends in the community, although many of those requiring opiate treatment in prison have complex dependence, social, physical, and mental health issues.*[195]

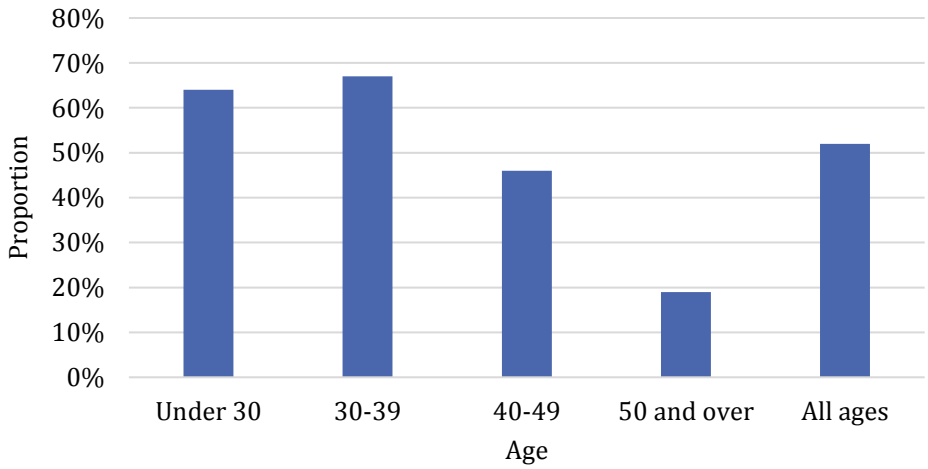
Previously, drug treatment was largely informed by a harm reduction philosophy, the view being that it was better to have people in treatment than using street drugs. The emphasis, therefore, was on engaging people in treatment. Whilst the recovery agenda has shifted the focus to the numbers of individuals who complete treatment and become drug free, recent research identifies that engagement in prison-based opioid substitution programmes results in *'an 85% reduction in fatal drug-related poisoning in the first month after release'*.[196]

Prevalence of Substance Misuse among Younger Prisoners

Whilst dated, Singleton *et al* describe '*more than 70%*' of young offenders having used illicit drugs in the year prior to imprisonment. Thirty percent of remands and 24% of sentenced YOs had used heroin. '*About a sixth had injected drugs.*'[197]

Drug misuse is more prevalent among younger prisoners than in older prisoners, as is illustrated in the latest HMIP thematic report.[198]

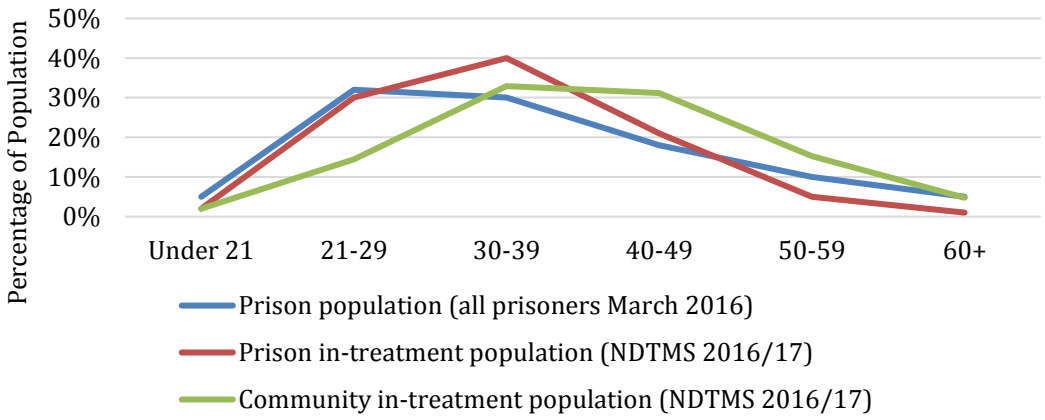
Figure 98 – Prevalence of Drug Misuse by Age[199]



Younger prisoners are also more likely to be in treatment than older prisoners; the in-treatment population in prisons is also notably younger than that in the community.

[195] HMIP (2015) *Changing patterns of substance misuse in adult prisons and service response*.
[196] Marsden, J. *et al.* (2017) *Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England.*
[197] Singleton, N. *et al.* (2000) Psychiatric morbidity among young offenders in England and Wales.
[198] HMIP (2015) *Changing patterns of substance misuse in adult prisons and service responses.*
[199] *Ibid.*

Figure 99 – Age of In-Treatment Populations



NDTMS describes the substance use profile of young people in secure settings who sought treatment.

A study in Wales concluded that comparing adults with no ACE events to those with four or more ACEs found that those with four or more were 11 times more likely to have smoked cannabis and 16 times more likely to have used crack or heroin.[200]

For young people in secure settings during 2017/18, 91% reported cannabis use, 47% described problematic alcohol use, 22% sought help with nicotine and 16% for cocaine.[201]

The 2015 HMIP thematic report[202] states that drug use varies a lot from one prison to another. In a survey, 52% of adult respondents said they had used illicit drugs or medication in the two months prior to imprisonment. HMIP described how this varied by age from 64% of under 30s, to 19% of over 50s.

> *Drug use in prisons will, to some extent, reflect use in the community, but there are some important differences. There is a preference for depressants, rather than stimulants, in prisons. Security measures affect the choice and quality of what is available. The misuse of opiates in prisons appears to be declining but remains an important issue. There has been an increase in the use of diverted medication. Large numbers of prisoners present with chronic pain, and some come into prison taking, or are started in prison on, inappropriately prescribed drugs. In recent years, the use of NPS – in particular, synthetic cannabis, known as 'Spice' or 'Mamba' – has grown significantly*[203]

The HMIP 2017-18 Annual Report states that 24% of males report have a problem with drugs on reception into prison.[204] HMPPS states that:

> *Between 2012/13 and 2017/18, the rate of positive random tests for 'traditional' drugs in prisons increased by 50%, from 7% to 10.6%, and drug use in prisons is now widespread, particularly in male local and category C prisons*[205]

[200] Bellis, M. *et al.* (2015). *Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population.*
[201] PHE (2019) Alcohol and drug treatment in secure settings: statistics summary 2017 to 2018
[202] HMIP (2015) Thematic Report. Changing patterns of substance misuse in adult prisons and service responses.
[203] HMIP (2015) *Changing patterns of substance misuse in adult prisons and service responses.*
[204] HMIP (2018) *HM Inspectorate of Prisons Annual Report 2017-2018.*
[205] HMPPS (2019) Prison Drugs Strategy.

It is important to note that the predicted demand simply gives likely numbers of individuals, not the specific interventions. For example, some individuals may require clinical detoxification, individual psychosocial interventions, and group work. The resources needed for a clinical detoxification are vastly different to those needed to do psychosocial interventions.

Alcohol

Alcohol use is strongly correlated with offending.[206] A study found that up to 41% of young offenders had drunk alcohol at the time of their offence and a high proportion said that drinking less would reduce their offending.[207]

The Transitions to Adulthood project describes how 'drinking rates' among young offenders (18-21 yr. olds) quadrupled between 1979 and 2011 and they are *'particularly likely to have a problem with alcohol'*.[208]

This does not mean they were alcohol dependent or would score highly in tools like AUDIT. Singleton found 62% of remanded young offenders scored eight or more, described as hazardous drinking, the figure for sentenced was 70%.[209]

Our Estimates

Given all of the above, the estimates used to predict rates of drug and alcohol misuse in Part A are the adult figure. The caveat is that numbers may be similar, but presentations and needs will be different.

Figure 100 – Rates of Drug and/or Alcohol Problems used in Prevalence Estimates

	Male Prisoners	Female Prisoners
Alcohol Abuse or Dependence	16[210] to 43%[211] (midpoint 29.5%)	20[212] to 54%[213] (midpoint 37%)
Drug Abuse or Dependence	28[214] to 51%[215] (midpoint 39.5%)	52%[216] to 58%[217] (midpoint 55%)

In a remand setting, the majority of presentations will be people arriving in the prison system who are seeking clinical support for dependence, or who are seeking psycho-social support for a habit developed in the community. In a long-term prison, presentations for clinical interventions will be from transfers in who are currently prescribed opioid substitution treatment or people with 'a prison habit'; plus psycho-social referrals will be largely for support regarding a previous habit or assistance in how to remain substance free after release.

[206] Alcohol Concern (2016) *Alcohol statistics*.
[207] Alcohol Concern (2016) Alcohol in the System.
[208] Devitt, K. (2011). Young Adults Today: Substance Misuse and Young Adults in the Criminal Justice System Fact File. Young People in Focus. Brighton.
[209] Singleton, N. *et al.* (2000) Psychiatric Morbidity among Young Offenders in England and Wales.
[210] Singleton, N. *et al.* (1999) Substance misuse among prisoners in England and Wales.
[211] Newbury-Birch, D. *et al.* (undated) Alcohol Screening and Brief intervention in the prison system
[212] Singleton, N. *et al.* (1999) Substance misuse among prisoners in England and Wales.
[213] Parkes *et al.* (2011) Prison health needs assessment for alcohol problems.
[214] HMIP (2015) HM Inspectorate of Prisons Annual Report 2014-2015
[215] Home Affairs Committee (2012) *Drugs in Prisons: Drug Use in Prisons*.
[216] Women in Prison website Key facts (accessed 20.6.2017).
[217] Light, M. *et al* (2013) Gender differences in substance misuse and mental health amongst prisoners.

Therefore, for this section of the report, we are taking incidence to be the static population plus number of new arrivals (new receptions and/or transfers in) to the prison during the year. This is consistent with the approach to incidence taken throughout the report, but may generate different figures to those seen in some NDTMS reports.

Psychoactive Substances (PS)

Psychoactive substances (PS) drugs are defined as:

> *Psychoactive drugs, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions.*[218]

There have been recent changes in the law regarding possession in the community,[219] though all PS-type drugs have been prohibited in prison for some considerable time.[220] Prison mandatory drug testing (MDT) has very recently evolved to include testing for some forms of PS drugs.

The HMIP Annual Report for 2017-18[221] repeats their previous view that:

> *Much of the violence seemed to be linked to drugs and debt.*[222]

Their thematic report expanded on this to observe that:

> *The extent and the nature of illicit drug misuse vary between individual establishments and can even be different in different parts of the same establishment. Synthetic cannabis is not the only drug issue facing prisons in England and Wales, and its use varies in different prisons. Patterns of use change rapidly at both a national and individual level.*[223]

In the community, CSEW reports that young male adults (aged 16–24 years) accounted for almost half of all the PS users in the previous year.

Data indicates that young people are far more likely to use novel psychoactive substances (NPS) – general population data taken from the Crime Survey England and Wales.[224]

Figure 101 – NPS Used in Last Year (percentage of respondents)

Males	16-24 Year Olds	16-59 Year Olds
Used in last year	3.6%	1.1%
Ever used	8.0%	3.8%

[218] Home Office (2014) *New Psychoactive Substances Review*, New Psychoactive Substances Review Expert Panel. Note also that 'New Psychoactive Substances' are also frequently described as 'Novel Psychoactive Substances' by different agencies.
[219] Psychoactive Substances Act (2016) https://www.gov.uk/government/collections/psychoactive-substances-bill-2015.
[220] Including specific powers under the Courts and Criminal Justice Act (2015) http://www.legislation.gov.uk/ukpga/2015/2/contents/enacted.
[221] HMIP (2017) Annual Report 2016-17.
[222] *Ibid.*
[223] HMIP (2015) Changing patterns of drug use in adult prisons and service responses.
[224] Home Office (2016) Drug misuse findings from the 2015 to 2016 Crime Survey for England and Wales (CSEW)

Figure 102 – NPS Types Percentage for Those who had Used in Last Year

	16-24 Year Olds	16-59 Year Olds
Herbal smoking mixture	55	52
A powder, crystals or tablets	16	22
A liquid	2	3
Other substances	27	22

The HMIP Annual Report for 2015-16 states that:

> *new psychoactive substances (NPS) … are having a dramatic and destabilising effect in many of our prisons.*[225]

Their thematic report expanded on this to observe that:

> *The extent and the nature of illicit drug misuse varies between individual establishments and can even be different in different parts of the same establishment. Synthetic cannabis is not the only drug issue facing prisons in England and Wales, and its use varies in different prisons. Patterns of use change rapidly at both a national and individual level.*[226]

It is misleading to describe PS and particularly 'Spice' as synthetic cannabinoids. The effects and side effects bear little resemblance to those of even the most potent forms of cannabis. Project Neptune[227] has suggested PS and club drugs can be divided into four categories:

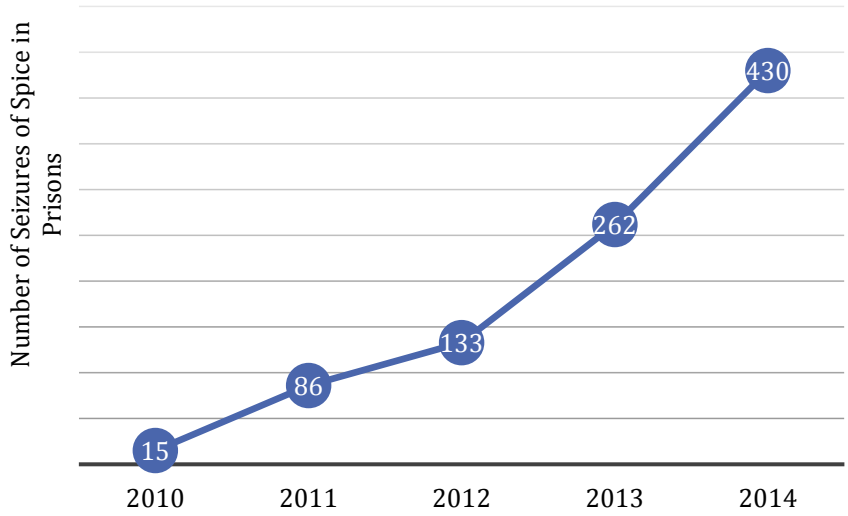
Figure 103 – PS and Club Drug Types

Synthetic Cannabinoids	Depressants	Stimulants	Hallucinogens
Include a large number of drugs, the most widely used being Spice and Black Mamba.	Include such drugs as GHB, GBL, and ketamine - which has dissociative effects in addition to its depressant effects.	Include drugs like MDMA, better known as ecstasy, and ecstasy variants such as PMA and PMMA.	Include drugs such as LSD and assorted tryptamines and phenethylamines.

Of these, the so-called synthetic cannabinoids are most common in prison. Different data sources describe very different numbers of finds. In response to a parliamentary question, data was made available on finds of prohibited substances in prison. Spice was, by far, the most common, and finds have increased significantly over the five years of 2010-2014:

[225] HMIP (2016) Annual Report 2015-16.
[226] HMIP (2015) Changing patterns of drug use in adult prisons and service responses.
[227] Neptune.

Figure 104 – HMPS Seizures of Spice (2010-2014)



During the same period as the above, there were only 21 seizures of ketamine, mephedrone and benzylpiperazine combined.

Separate HMPPS data reports no finds of PS (Black Mamba, Spice, Other) in 2012, 2013, 2014, but then in-between 1 January and 30 November 2015: Black Mamba 126, Other 338, and Spice 921 finds. Overall, this report describes drug finds in prison rising each year and nearly doubling from 2012 to 2015.[228]

Figure 105 – HMPPS Drug Finds 2012-2015

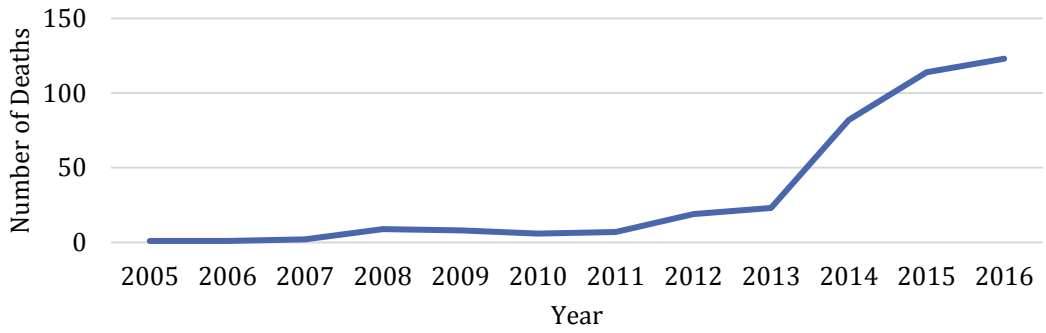
Year	Drug Finds
2012	2,571
2013	2,473
2014	4,235
2015 (first 11 months)	4,700

A separate report described 851 recorded seizures of PS in prison during October and November 2015.[229]

The Prison and Probation Ombudsman reported that, between June 2013 and June 2017, there were 79 deaths where the prisoner was either known, or strongly suspected, to have been using PS drugs. Of these deaths, 58 were self-inflicted.[230] In the community, ONS reports that deaths attributed to PS use across the whole community remain infrequent, but are increasing over time.[231]

[228] Letter from Sam Gyimah MP to Bob Neill MP dated 27 Feb 2017. Prison Safety and Reform.
[229] Prison Reform Trust (2016) Prison: the facts.
[230] Minutes of All Party Parliamentary Group on Penal Affairs 11 July 2017.
[231] ONS (2017) Deaths related to drug poisoning in England and Wales: 2016 registrations.
Also, ONS (2016) Deaths involving legal highs in England and Wales: between 2004 and 2013.

Figure 106 – PS Deaths in England and Wales (2005-2016)



Predicting future demand, common across all establishments, we believe that healthcare will continue to see some impact from the use of PS. Recent changes in MDT may have a positive impact, but the very nature of PS-type drugs is such that chemical formulas can be changed easily, thus evading tests. Keeping up becomes a game of cat and mouse. In some prisons, men have learned and either use less, or less dangerously, because the frequency of incidence has peaked.

Figure 107 – PS Drug Challenges

Challenges for Healthcare Staff	Challenges for Prison Staff/Regime
Unpredictable effects, coupled with covert nature of drug use often mean delay in seeking medical help.	Rapidly increasing prevalence is placing additional demands on prison and security staff resources in terms of supply reduction, searching and detection activities.
Some of the extreme effects of synthetic cannabinoids require immediate response and may require urgent transfer to hospital.	
The adverse effects of synthetic cannabinoids can be long-lasting and healthcare staff may have to manage the consequences for months following the initial presentation.	Prison staff managing long-term challenging or aggressive behaviour has resource implications.
Some prisoners using PS may not see themselves as having 'substance misuse problems' and therefore unlikely to access treatment in prisons.	The need to restrain and control prisoners behaving abnormally or dangerously.
It may be necessary to withhold prescribed medication where PS use is suspected due to interactions with drugs.	PS use in prison is linked to rising problems with debt, bullying and violence, with organised crime groups believed to be supplying PS drugs into prisons.

PHE produced a toolkit[232] and a useful discussion document about PS use in prisons informed by a series of training events.[233]

[232] PHE (2015) NPS Toolkit.
[233] PHE (2017) Thematic analysis of training for prison staff on new psychoactive substances.

Mental Health

Context

The NHS Five Year Forward View for Mental Health (2016)[234] states:

> *The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services … Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.*

As part of this system's overhaul, a new national service specification has been developed for prison mental health services.[235]

The context for this chapter is a recognition that nationally, services for children and young people are inadequate. This is reflected in an NHS England work stream arising out of the Five Year Forward View for Mental Health[236], which is focusing on the mental health needs of very vulnerable young people, including children in YOIs.[237]

In 2016–17, NHS England spent an estimated £400 million on the provision of healthcare to adult prisons in England, of which it estimates £150 million was spent on mental health and substance misuse services (although it could not provide an exact figure).[238]

While all prison officers receive basic training on mental health awareness when they are recruited, 40% of prisons do not offer any mental health awareness refresher training to existing staff.[239]

> *All prison staff, not just those in healthcare, need to be able to recognise the major symptoms of mental ill-health and know where to refer those requiring help. Staff training is, therefore, crucial*[240]

NICE guidelines were issued in March 2017 covering the assessment and management of people (over 18) with mental health problems in prison.[241] Also, specific guidance relating to young adults in prison.[242]

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[234] NHS (2016) The Five Year Forward View for Mental Health.
[235] NHS England (2018) Service specification: Integrated mental health service for prisons in England.
[236] Independent Mental Health Taskforce (2016) Five Year Forward View for Mental Health.
[237] NHS England website (accessed 23.4.2019).
[238] House of Commons Committee of Public Accounts Mental health in prisons Eighth Report of Session 2017–19 *Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 6 December 2017.*
[239] *Ibid.*
[240] PPO (2016) *Prisoner mental health.*
[241] NICE (2017) Mental health of adults in contact with the criminal justice system.
[242] NICE (2019) Further mental health assessment and care planning for people in prisons and young offender institutions.

In June 2017, the head of the National Audit Office stated:

> *Improving the mental health of those in prison will require a step change in effort and resources. The quality of clinical care is generally good for those who can access it, but the rise in prisoner suicide and self-harm suggests a decline in mental health and well-being overall. The data on how many people in prison have mental health problems and how much government is spending to address this is poor.*[243]

In March 2018 NHS England issued a new service specification.[244]

The Independent Advisory Panel on Deaths in Custody undertook interviews with prisoners who stated that mental health treatment and wellbeing could be improved by focusing on prevention work, tailoring drug treatment to the individual, and ensuring timely responses from trained mental health teams.[245] The same report indicates that prisoners suggested that their basic mental health needs could be met through the maintenance of a safe and clean environment, and ensuring access to sanitation, showers, exercise, fresh air, daylight, nourishing food at sensible times and a decent night's sleep.[246]

> *Twenty-five per cent of the prison population, according to the Revolving Doors Agency, a charity specialising in the criminal justice system, have problems communicating or handling complex information, although they might not strictly meet diagnostic criteria for a learning disability and, consequently, are unlikely to be eligible for support.*[247]

An investigation by the PPO found that nearly one in five of those diagnosed with a mental health problem received no care from a mental health professional in prison.[248]

National Evidence Base on Prevalence

There is ongoing discussion about the rate at which young adult offenders mature and the age at which they should be considered to be fully mature.[249]

Ninety five percent of 15-21 year olds in custody suffer from mental health problems and 80% have at least two disorders.[250]

There is a solid evidence base demonstrating that prisoners, in general, are more likely to suffer from mental illness than the general population. For example, UK papers describe the level of psychosis is four times as high among young offenders (12.5%)[251] as in the general adult population.[252]

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[243] Morse A, June 2017 introducing Mental Health in Prisons.
[244] NHS England (2018) Service specification: Integrated mental health service for prisons in England.
[245] Independent Advisory Panel on Deaths in Custody (IAP) (2017) Keeping safe - preventing suicide and self-harm in custody. Prisoners' views collated by the IAP December 2017
[246] Independent Advisory Panel on Deaths in Custody (IAP) (2017) Keeping safe - preventing suicide and self-harm in custody. Prisoners' views collated by the IAP December 2017
[247] House of Commons Health and Social Care Committee (2018) Prison health Twelfth Report of Session 2017–19 Report, together with formal minutes relating to the report.
[248] Prison Reform Trust (2017) Bromley Briefings Prison Factfile.
[249] House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system
[250] Singleton, N. *et al.* (1998) *Psychiatric morbidity among prisoners in England and Wales.* ONS and DH
[251] Degenhardt, L. *et al.* (2015) Associations between psychotic symptoms and substance use in young offenders.
[252] Prison Reform Trust (2016) Bromley Briefings (2016) Prison Factfile Autumn 2016.

A previous systematic review on the mental health of prisoners in the UK found a wide range of prevalence rates for mental health disorders.[253] The updated 2009 descriptive review identified 18 studies reporting on the prevalence of mental health disorders in prison populations and concluded that:

> *… overall, the prevalence of mental health disorders and substance misuse is shown to be substantially higher in prison populations than in community populations around the world.*[254]

The most robust prevalence study in England was conducted in 1998.[255] Although almost two decades old, it remains the most relevant prevalence study, conducted in all the then 131 prisons, and involving in-depth clinical interviews with a large sample of prisoners (men and women, remanded and sentenced).

- Nine out of every ten prisoners in the UK display evidence of one or more mental disorders (including substance misuse)
- 78% of remanded and 64% of sentenced men have some form of personality disorder
- 10% of remanded and 7% of sentenced men have suffered from functional psychosis in the year before being sentenced
- 12-15% of prisoners have four to five co-existing mental disorders
- 7% of the prison population have a serious and enduring mental health problem
- Over 50% of remand and 30% of sentenced young offenders have a diagnosable mental health disorder.[256]

A more recent meta-analysis by NICE found that prescribing rates of psychotropic medications to men in prisons is four times greater than for an equivalent age-adjusted community sample:

> *[P]sychotropic medicines were prescribed for a wider range of clinical indications than currently recommended, with discernible differences in drug choice.*
>
> *There were significant preferences for certain antidepressant and antipsychotic drugs in prison, compared with in the community. In 65.3% of cases, indications for psychotropic drugs were recorded and upheld in the British National Formulary. Antipsychotic prescriptions were less likely than other psychotropics to be supported by a valid indication in the patient note.*[257]

In 2016, this pattern was confirmed to still be the case.[258]

Learning Difficulties and Disabilities

Learning difficulty is a broad term and the majority of people with learning difficulties should receive any assistance they require with education. The *No One Knows* report estimates that

[253] Brooker, C. *et al.* (2002) *Mental Health Services and Prisoners: A Review.* School of Health and Related Research. University of Sheffield.
[254] Sirdeifield, C. *et al.* (2009) 'A Systematic Review of Research on the Epidemiology of Mental Health Disorders in Prison Populations: A Summary of Findings'. *Journal of Forensic Psychiatry and Psychology.* 20/1: 78-101.
[255] Singleton, N. *et al.* (1998) *Psychiatric Morbidity among Prisoners in England and Wales.* ONS and DH.
[256] HMIP and Home Office (1997) *Young Prisoners: A Thematic Review by HM Chief Inspector of Prisons for England and Wales.*
[257] Hassan, L. *et al.* (2014) *A cross-sectional prevalence survey of psychotropic medication prescribing patterns in prisons in England.*
[258] Hassan, L. *et al.* (2016) *Prevalence and appropriateness of psychotropic medication prescribing in a nationally representative cross-sectional survey of male and female prisoners in England.*

20-30% of offenders have learning difficulties or disabilities that interfere with their ability to cope within the criminal justice system.[259] HMIP states:

> *Although believed to be a sizeable minority, possibly as high as 30%, we have no way of knowing the number of people with such conditions within the criminal justice system.*[260]

Learning disability is a more restricted definition, and responsibility for care falls to both healthcare and the prison's equalities team:

> *a learning disability is defined by three criteria: an IQ score of less than 70; significant difficulties with everyday tasks; and onset prior to adulthood.*[261]

It is estimated that between two and 10% of offenders have a learning disability.[262] Supporting this order of prevalence, a study of nearly 3,000 prisoners using the Learning Disability Screening Questionnaire (LDSQ) tool found 7% were screened positive.[263.] In addition, *'a significant percentage of the prison population'*[264] have a borderline learning disability, defined as an IQ between 70 and 80.

The *No One Knows* report suggests that offenders with learning disabilities are particularly vulnerable as:

> *They are at risk of re-offending because of unidentified needs and consequent lack of support and services. They are unlikely to benefit from conventional programmes designed to address offending behaviour. They are targeted by other people when in custody and they present numerous difficulties for the staff who work with them, especially when these staff often lack specialist training or are unfamiliar with the challenges of working with this group of people.*[265]

ADHD

ADHD is a relatively common disorder amongst children, with estimates suggesting a prevalence of 3.62% in boys and 0.85% in girls between 5-15 years. The worldwide prevalence of ADHD in children is 5%.[266]

Of children diagnosed with ADHD, it is estimated that only 15% retain their full diagnosis by the age of 25. Therefore, ADHD in partial remission is far more common from the age of 25 years. Population surveys estimate that 3-4% of the adult population have ADHD.[267]

There is strong evidence to suggest higher rates of ADHD in prison than in the general community:

> *Research suggests there is a disproportionately high concentration of ADHD individuals involved with the CJS, and for these individuals criminal justice procedures often interface with a complex web of behaviour, substance use and mental health issues. International studies … report that up to two-thirds of young*

[259] Prison Reform Trust (2007) *No One Knows: The Prevalence and Associated Needs of Offenders with Learning Difficulties and Learning Disabilities*.
[260] HM Inspectorates of Prisons and Probation (2015) A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system.
[261] Hughes, N. *et al.* (2012) *Nobody made the connection: The prevalence of neurodisability in young people who offend.*
[262] DH (2015) *Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities*.
[263] Murphy *et al.* (2015) *Screening Prisoners for Intellectual Disabilities in Three English Prisons.*
[264] DH (2015) *Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities.*
[265] Prison Reform Trust (2007).
[266] Faraone, S.V. *et al.* (2003). *The worldwide prevalence of ADHD: Is it an American condition?*
[267] NICE (2008) *Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults.*

offenders and half of the adult prison population screen positively for childhood ADHD, and many continue to be symptomatic with rates reported at 14% in adult male offenders and 10% in adult female offenders. In young offenders, rates are around 45%. A UK study of personality disorder wards in Forensic Mental Health Services found similar screening rates (33%), with a sizeable number of individuals in partial remission of symptoms.

UK prison studies have indicated a rate of 43% in 14-year-old youths and 24% in male adults screening positive for a childhood history, 14% of whom had persisting symptoms . Those with persisting symptoms accounted for eight times more aggressive incidents than other prisoners and six times more than prisoners with Antisocial Personality Disorder. They had a significantly younger onset of offending by around 3.5 years (16 vs. 19.5 years); and they had a significantly higher rate of recidivism. ADHD was the most important predictor of violent offending, even above substance misuse.[268]

RCPsych standards say that all those prescribed for ADHD should be reviewed annually.[269]

Personality Disorder

As people age, there is some comment that those with ADHD may go on to be diagnosed with personality disorder. Adult male prisoners are described as being more than ten times as likely to have a personality disorder than a member of the general community.[270]

In custody, the prevalence of any personality disorder is reported to be 84% for male remand and 88% for male sentenced young offenders.[271]

Autism Spectrum Disorders

Whilst often bundled alongside learning disabilities,[272] autism spectrum disorder is quite distinct.

Autism is a lifelong, developmental disability that affects how a person communicates with, and relates to, other people, and how they experience the world around them.[273]

Although it is important to consider that there is no evidence to suggest that individuals with autism are more likely to offend than the 'neurotypical' population, specific vulnerability factors may increase an individual's risk within the context of social exclusion.[274]

It is estimated that a disproportionately high number of prisoners have an autistic spectrum condition, i.e. autism or Asperger's syndrome, however, there is currently no national data to present exact figures. Whilst autistic spectrum conditions are not classed as a learning disability in themselves, recent research from the learning disabilities observatory indicates that around 20-30 per cent of people with a learning disability also have an autistic spectrum condition.[275]

[268] Young *et al*. (2011) *The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies.*
[269] RC Psych (2015) Standards for Prison Mental Health Services.
[270] The Centre for Mental Health (2011) Briefing 39: Mental health and the criminal justice system.
[271] Singleton, N. *et al* (2000) Psychiatric Morbidity Among Young Offenders in England and Wales.
[272] See for example HM Inspectorates of Prisons and Probation (2015) *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system.*
[273] National Autism Society Website.
[274] Murphy, D. (2010) *Understanding offenders with autism-spectrum disorders: what can forensic services do?*
[275] DH (2015) *Equal Access, Equal Care: Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities*.

DH guidance to support the adult autism strategy[276] includes a chapter specifically on working in the criminal justice system.[277] This states that:

> *NHS England is responsible for arranging the provision of health services for such prisoners and detainees. For people with autism this will include offering access to the local diagnosis pathway and* access to assessment of care and support needs in advance of release from prison.
>
> *Local authorities have responsibilities, under the Care Act from April 2015, to assess the care and support needs of adults (including those with autism) who may have such needs in prison.*

There is further detailed guidance available from the National Autistic Society.[278] The evidence about prevalence of autistic conditions shows an increase, which is likely as much to do with better knowledge of the condition as it is to do with increased numbers of people having the condition.

The 2014 Adult Psychiatric Morbidity Survey estimated a UK prevalence rate of 0.8% for all adults, predominantly men; a rate of 1.5% for men nationally. A number of studies have indicated a similar rate (around 1% nationally) of autism spectrum disorder among children.[279]

A study noted:

> *Rates may be different in specific adult populations, such as among people who are homeless or living in prison. Rates were higher in men and in those without educational qualifications.[280]*

People with vulnerabilities including autism, ADHD, or acquired brain injury may suffer linked health problems, but may find it harder to communicate their situation.[281]

ACE and Trauma

There has been growing recognition of the long-term impact of childhood trauma, the concept of:

> *Adverse childhood experiences (ACEs), such as being a victim of violence or neglect, or living with a household member who abuses substances or is involved in criminal activity.*
>
> *A positive relationship was found between ACEs and certain lifestyle factors (smoking and unhealthy weight) and ACEs and long-term health conditions.*
>
> *Patients with ≥2 ACEs were over two and a half times more likely to suffer from asthma and almost three times more likely to have complex health needs and be living with multiple long-term conditions, compared with those with 0-1 ACE(s).*
>
> *Mental health had the strongest association with childhood adversity, with patients with ≥2 ACEs over three and a half times more likely to be experiencing current mental health problems, compared with those*

[276] DH (2015) *Adult Autism Strategy.*
[277] DH (2015) *Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy.*
[278] National Autistic Society (2011) Criminal Justice.
[279] Baird, G. *et al.* Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet, 2006; 368(9531): 210–215; Green, H. *et al.* (2005) Mental Health of Children and Young People in Great Britain, 2004. Hampshire: Palgrave McMillan.
[280] McManus, S. *et al.* (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
[281] NHS England (2018) Service Specification: Integrated Mental Health Service For Prisons in England.

> *with 0-1 ACE(s). ACE count was also found to correlate with severity of depression and anxiety among those being treated for mental health problems.*[282]

Other studies explicitly link ACEs to youth offending:

> *certain vulnerable groups, such as people involved in offending, are known to have experienced higher levels of adversity than others. .... [T]he impact of childhood bereavement which, although known to be a common feature in the lives of young people involved in offending, is rarely documented in Adverse Childhood Experience studies.*[283]

A study in Wales concluded that adults with four or more ACE events were 15 times more likely to have committed violence against another person than those who had no ACEs.[284]

Studies describe how children who experience chronic stress from adverse events can become 'locked' into a state of hyper- arousal, wary of further trauma.[285]

A study[286] examining the backgrounds and psychiatric morbidity of young offenders in custody found:

- 29% of the male sentenced group and 42% of the male remand group had been taken into local authority care as a child.
- Approximately a quarter of the young men who were interviewed reported having suffered from violence at home.
- Approximately 5% of the young men reported having suffered sexual abuse. 13% of male remand and 11% of male sentenced respondents reported having received help for mental or emotional problems in the year before coming to prison.
- Around one in 10 male respondents young offenders had been offered help for mental, nervous or emotional problems which they had turned down in the year before coming to prison.

Another large scale, slightly more recent study[287] also of young people in custody reported that for boys:

- 40–49% had a history of local authority care
- 25% suffered violence at home
- 5% reported sexual abuse
- 66% reported hazardous drinking
- 85% showed signs of personality disorder
- 40% reported anxiety/depression

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[282] Hardcastle, K. and Bellis, M. (2018) Routine enquiry for history of adverse childhood experiences (ACEs) in the adult patient population in a general practice setting: A pathfinder study.
[283] Vaswani (2018) Adverse Childhood Experiences in children at high risk of harm to others. A gendered perspective.
[284] Bellis, M. *et al.* (2015). *Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population.*
[285] Anda, R.F. *et al.* (2006) The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology.
[286] Singleton, N. *et al.* (2000) Psychiatric Morbidity Among Young Offenders in England and Wales.
[287] Stuart, M. and Baines, C. (2004) *Safeguards for Vulnerable Children: Three studies on abusers, disabled children and children in prison. A chapter within Safeguards for vulnerable children*

PTSD

The YJB describes how children and young people can be significantly impacted by trauma yet not meet the diagnostic threshold for PTSD.[288]

Singleton *et al*. identified a 3% prevalence amongst prisoners[289]. A recent international meta-analysis described a higher rate of 6.2% prevalence in male prisoners.[290]

In addition to medication, NICE guidance for the treatment of PTSD recommends CBT interventions including: cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy, prolonged exposure therapy. EMDR is also a recognised treatment.[291]

Speech, Language and Communication Needs (SALT)

The Royal College of Speech and Language Therapists produced a dossier of evidence in 2012 which included examples of best practice, that indicates high prevalence of speech, language and communication disorders amongst offenders, particularly young offenders.[292.] The evidence base (but not best practice) was revisited in 2017, this stated that:

- *In a Youth Offending Service all new entrants to the Intensive Supervision and Surveillance Programme (ISSP) were screened and 65% (49) required speech and language therapy intervention. A significant number (20%) scored at the 'severely delayed' level on standardised assessment and 6% as 'very severely delayed'.*
- *In a recent study in a Secure Training Centre 109 young people were screened for speech, language and communication needs (SLCN). Only two of the participants had previously been identified with SLCN. Of those screened only 28% were found to not require any additional support, whilst 14.4% were identified for 1:1 speech and language therapy intervention.*
- *At a southern Young Offender Institution an audit of 38 young people found that only one young person achieved age equivalence on a language assessment whilst 67% could be classified as having a developmental language disorder (-1.5SD).*
- *66-90% of young offenders have low language skills, with 46-67% of these being in the poor or very poor range.[293]*

A separate study showed that over 60% of service users have speech, language and communication needs (SLCN). This proportion mirrors what previous studies, above, have identified. In comparison, a separate study showed that there is a high level (91%) of communication disability in young people known to the youth offending team. This is significantly greater than in the general population (10%).[294]

A recent study again confirmed these findings:

[288] YJB (2017) In-brief: Trauma-informed youth justice.
[289] Singleton, N. *et al.* (1998) Psychiatric morbidity among prisoners in England and Wales. ONS and DH.
[290] Baranyi, G. *et al.* (2018) Prevalence of Posttraumatic Stress Disorder in Prisoners.
[291] NICE (2018) Post Traumatic Stress Disorder.
[292] Royal College of Speech and Language Therapists (2012) *Speech, Language and Communication Needs in the Criminal Justice System and Best Practice responses to these*.
[293] Coles, H. *et al.* (2017) The Royal College of Speech and Language Therapists Justice Evidence base.
[294] Gregory, J. & Bryan, K. (2011) Speech and Language Therapy Intervention with a Group of Persistent and Prolific Young Offenders in a Non-Custodial Setting with Previously Undiagnosed SLCD.

The statistically significant positive association found between language and offending behaviour relative to other confounds, highlights the important role of language in understanding offending behaviour. YOs displayed high incidences of DLD [developmental language disorder] in their language and expository discourse abilities despite having not received any speech and language intervention prior to their involvement in this study. This has implications for their effective engagement in education and in youth offending and criminal justice services (CJS). Professionals in education, health and social care and youth justice should be made aware of the language needs of both YOs and children with emotional behavioural difficulties, and these language needs should be identified and targeted as early as possible to enable them to be effective communicators who can engage effectively in their provision.[295]

Traumatic Brain Injury

There are around 900,000 hospital admissions for head injuries each year; of these 10% are categorised as severe. Head injuries are proportionately higher among young adults and those over 75 years. Estimates state that some 60% of offenders have a history of traumatic brain injury.[296] Traumatic brain injury is especially associated with offending patterns in young offenders.[297],[298]

Estimated Prevalence of Common Mental Health Problems

The following tables are estimates for young offenders, aged 16 to 20 years; one person can have more than one condition. Across every condition, the prevalence is greater amongst young offenders than the general population, and greater amongst remand prisoners than sentenced.

Figure 108 – Prevalence of Mental Health Conditions (male young offenders)[299]

	Estimated National Prevalence		
	Young Adult Males	Male Young Offenders	
	Community	Remand	Sentenced
Neurotic disorders	11%	52%	41%
Psychotic disorders	0.2%	10%	8%
Fatigue	12%	40%	31%
Sleep problems	22%	60%	52%
Irritability	23%	46%	41%
Worry	11%	50%	39%
Depression	6%	51%	36%
Anxiety	5%	25%	16%
Obsessions	7%	26%	20%
Concentration/forgetfulness	4%	26%	17%
Somatic symptoms	1%	14%	13%
Compulsions	7%	28%	24%
Phobias	4%	17%	15%
Worry about physical health	1%	16%	14%

[295] Hopkins, J. *et al.* (2017) Examining the association between language, expository discourse and offending behaviour: an investigation of direction, strength and independence.
[296] Parsonage, M. (2016) *Traumatic brain injury and offending.*
[297] Williams, H. *et al.* (2010) *Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence?*
[298] House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system.
[299] Singleton, N. *et al* (2000) Psychiatric Morbidity Among Young Offenders in England and Wales.

	Estimated National Prevalence		
	Young Adult Males	Male Young Offenders	
	Community	Remand	Sentenced
Panic	2%	13%	9%
PTSD		4%	4%
Personality Disorder		84%	88%

Another large scale, slightly more recent study[300] also of young people in custody reported that for boys:

- 85% showed signs of personality disorder
- 40% reported anxiety/depression

The Likely Demand for Mental Health Services

National studies estimate that a considerable proportion of people with mental health problems go undiagnosed.[301] A study across UK, Ireland and Australia found a consistently low rate of engagement.[302]

The table below contains estimates of the number of people in the general population presenting with mental health problems each year in different settings.

Strategic decisions about the scope and place of mental health services by commissioners and providers will influence demand, as will access to a range of other support such as listeners, counselling services, exercise and so on.

Figure 109 – Incidence and Identification of Mental Health Disorders[303]

	Percentage of Population	Percentage of those with Mental Health Problems
Mental health problems annual incidence (community)	25%	100%
Attend GP (not necessarily for mental health reasons)	23%	92%
Identified by GP	13%	52%
Referred to outpatients/CMHT	2-3%	8-12%
Admitted	1%	4%

From this, it can be estimated that of the likely annual incidence of mental health disorders, only around 52% will be identified (have a diagnosis). In addition, not all those identified will require - or indeed want - treatment, with as little as 8-12% of those with mental health problems in the community going on to receive specialist treatment (beyond primary care). The Singleton *et al.* study found that, in the 12 months before entering prison, about 20% of

[300] Stuart, M. and Baines, C. (2004) *Safeguards for Vulnerable Children: Three studies on abusers, disabled children and children in prison. A chapter within Safeguards for vulnerable children*

[301] Sainsbury Centre for Mental Health (2003*) Primary Solutions: An independent policy review on the development of primary care mental health services.*

[302] McGorry, P. (2013) Designing Youth Mental Health Services for the 21st century: Examples from Australia, Ireland and the UK.

[303] Sainsbury Centre for Mental Health (2003*) Primary Solutions: An independent policy review on the development of primary care mental health services.* From a table prepared by Muijen, M. after Goldberg, D. and Huxley, P. (1992) *Common Mental Disorders: A Bio-Social Model.* London: Routledge.

male prisoners (both remand and sentenced) had received help or treatment for a mental or emotional problem.

Based on the above estimate of 90% of prisoners with any mental health disorder (including substance misuse), it could be assumed that 52% of these may be diagnosed – giving an anticipated identification level of 47% of prisoners identified as having a mental health condition. As noted, demand for treatment is likely to be less than this.

In 2016, the government set out three priorities in the *Five Year Forward View for Mental Health,* to be achieved by 2020/21:[304]

- *A 7 day NHS – right care, right time, right quality*
- *An integrated mental and physical health approach*
- *Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens.*

The *Count Me In* census involved an assessment of access to mental health services by black and minority ethnic groups in prison.[305] It is interesting to note that the survey found no systematic discrimination in minority populations accessing mental health services in prisons. This contrasts to the access of mental health services by minority groups in the community, where such groups are frequently under-represented.

> *For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement.*[306]

Comorbidity

Over 70% of adult prisoners suffer from two or more mental disorders, including substance misuse.[307] Published sources suggest that, in the community, up to 50% of those in treatment for drug use have concurrent mental health problems; the figure is closer to 100% for those in alcohol treatment.[308]

Transfer Under the Mental Health Act

NHS guidance is that no-one should wait more than 14 days for a transfer under the Mental Health Act.[309] Across the prison estate, patients are waiting for far longer than 14 days. In 2016-17, 366 of the 1083 transfers (33.7%) were completed within 14 days. 717 (66.3%) took longer than 14 days, while 76 prisoners (7.1%) waited 140 days or more.[310] A separate NHS study suggests that in 2017, the mean wait for prisoners, was 100 days.[311] This is an issue which is largely outside the control of prison healthcare teams.

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[304] DH (2016) *The Five Year Forward View For Mental Health.*
[305] CQC (2010) *Count Me In 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*.
[306] DH (2016) *The Five Year Forward View For Mental Health.*
[307] Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners*.
[308] See, for example, Weaver, T. *et al.* (2002) *A Study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse and Mental Health Treatment Populations: Executive Summary*. DH; Farrell, M. *et al.* (1998) *'Substance Misuse and Psychiatric Comorbidity: An Overview of the OPCS National Psychiatric Morbidity Survey'*.
[309] PPO (2016) Learning from PPO Investigations Prisoner Mental Health.
[310] House of Commons Health and Social Care Committee (2018) Prison health Twelfth Report of Session 2017–19 Report, together with formal minutes relating to the report.
[311] NHS Benchmarking Network (2018) Analysis of NHS England Specialised Commissioning and Health & Justice, and Her Majesty's Prison and Probation Services audits.

Safeguarding, Self-Harm and Self-Inflicted Death

Safeguarding

HMPPS PSI 16/2015 Adult Safeguarding in Prison defines safeguarding in a prison context:

> *Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect.*
>
> *Abuse is any act, or failure to act, which results in a significant breach of a prisoner's human rights, civil liberties, bodily integrity, dignity or general wellbeing, whether intended or inadvertent; including sexual relationships or financial transactions to which a person has not or cannot validly consent, or which are deliberately exploitative….*
>
> *Neglect is a failure to identify and meet the needs of a prisoner, for example by ignoring medical, emotional or physical care needs, failing to provide access to appropriate health, care and support or educational services or withholding of the necessities of life, such as medication, adequate nutrition and heating.*

Self–Harm

Discussions in the House of Commons highlighted that:

> *Record high numbers of self-inflicted deaths and incidents of self-harm in prisons are a damning indictment of the current state of the mental health of those in prison and the prison environment overall. More excuses are not good enough. The Ministry of Justice, HM Prison and Probation Service and NHS England have a duty of care to those in prison, yet do not know where they are starting from, how well they are doing or whether their current plans will be enough to succeed.*[312]
>
> *People in prison are more likely to suffer from mental health problems than those in the community. Yet prisoners are less able to manage their mental health conditions because most aspects of their day-to-day life are controlled by the prison. These difficulties are being exacerbated by a deteriorating prison estate, long-standing lack of prison staff and the increased prevalence of drugs in prison.*[313]

Self-harm covers a wide range of behaviours and may be defined as an intentional act of self-poisoning or self-injury, irrespective of the type of motivation, or degree of suicidal intent:

> *Self-harm is behaviour, not an illness, and its management is highly dependent on any underlying problems which could range from an episode of psychosis with intense suicidal urges to an impulsive reaction to a stressful emotional event.*[314]

Self-injury is described as being commonly caused by cutting, burning, hitting or mutilating body parts and attempted hanging or strangulation.

Mangnall and Yurkovich identified that those individuals who self-harm feel that they have no support, and that there is no-one who has the understanding and affection that is required to tackle their underlying emotions.[315] The prison environment can only compound these feelings.

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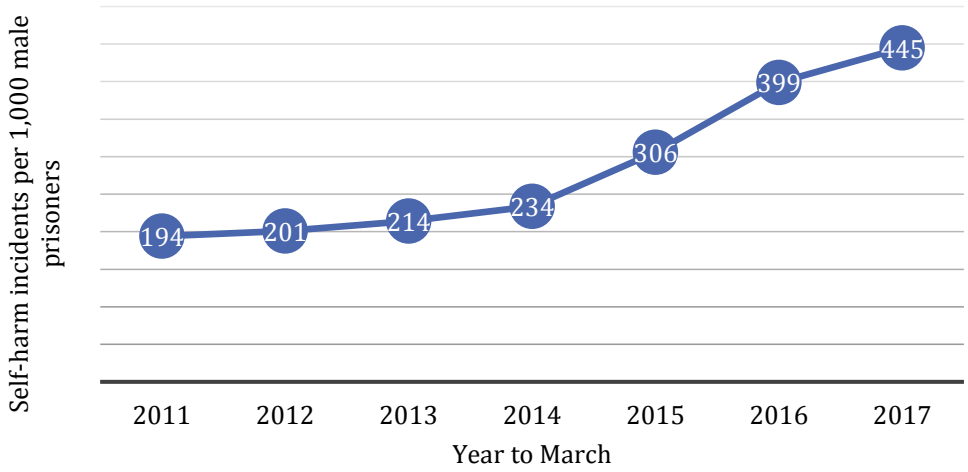
[312] House of Commons Committee of Public Accounts Mental health in prisons Eighth Report of Session 2017–19 *Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 6 December 2017.*
[313] *Ibid.*
[314] Skegg, K. (2005*)* *Self-Harm*.
[315] Mangnall, J. and Yurkovich, E. (2008*)* *A Literature Review of Deliberate Self-Harm*.

Self-harm is common in prison due to the combined increased risks from mental ill-health and being incarcerated.[316] The MOJ provides the following data which describes a marked increase in the last year.

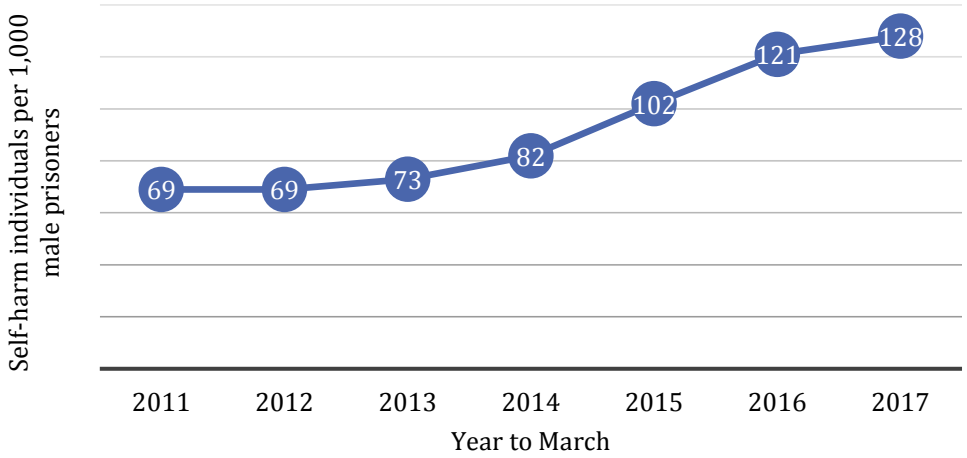
Figure 110 illustrates the increasing number of recorded incidents of self-harm per 1,000 prisoners over the past five years:

Figure 110 – National Rates of Self-Harm Incidents per 1,000 Prisoners[317]



One individual may self-harm multiple times. The graph below describes the same pattern of increase in the number of self-harming individuals.

Figure 111 – National Rates of Self-Harm Individuals per 1,000 Male Prisoners



The MOJ released a report in 2018 indicating that while males represented 95% of prisoners, they accounted for just under 90% of individuals who self-harmed in the 12-month period to December 2017:

[316] Royal College of Psychiatrists (2010) *Self-Harm, Suicide and Risk: Helping People who Self-Harm. Final Report of a Working Group*.
[317] MOJ (2018) Safety in Custody Statistics. Table 2.13 National trend refers to male prisoners only and is standardised based on the op cap of HMP/YOI Hindley, so shows the number of incidents per that number of prisoners.

The rate of self-harm individuals per 1,000 prisoners was substantially higher for females (300 per 1,000 female prisoners) than for males (128 per 1,000 male prisoners). For males, both the number of individuals and the rate of self-harm increased each year from 2012.[318]

Self-Inflicted Deaths

A self-inflicted death is defined by the MOJ as any death of a person who has apparently taken his or her own life, irrespective of intent. This not only includes suicides, but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.

The table below shows the trend, until this year, of increasing numbers of self-inflicted deaths in custody, using statistics from the MOJ. The reporting period for these figures is 12 months ending in September of each year, and therefore the numbers differ slightly from those published by the Prisons and Probation Ombudsman.[319]

Figure 112 – Self-Inflicted Deaths in Custody in England and Wales (males)[320]

Year Ending September	2010	2011	2012	2013	2014	2015	2016	2017
Self-inflicted deaths	59	57	57	62	87	91	101	72

According to the MOJ, prisoners are 8.6 times more likely to take their own lives than members of the general population.[321]

Within prisons, the PPO says the most vulnerable groups include:[322]

- *those who have recently been incarcerated*
- *life or indeterminate sentence prisoners*
- *those with an offence against a family member or someone they were close to*
- *prisoners with mental health issues*
- *substance misuse and withdrawal*
- *history of self-harm.*

The first few days in custody can be highly stressful for prisoners, and this time marks an increased risk of suicide and self-harm. In 2014, almost 30% of self-inflicted deaths and 10% of all self-harm incidents in custody occurred within the first week of being in prison.[323]

Whilst deaths in prison have fallen slightly including self-inflicted deaths, since reaching a peak in 2016, incidences of self-harm continued to rise during 2017 and 2018 and, according to the latest safety indicators, remain at a record high.[324]

Self-Inflicted Deaths Amongst Young Offenders

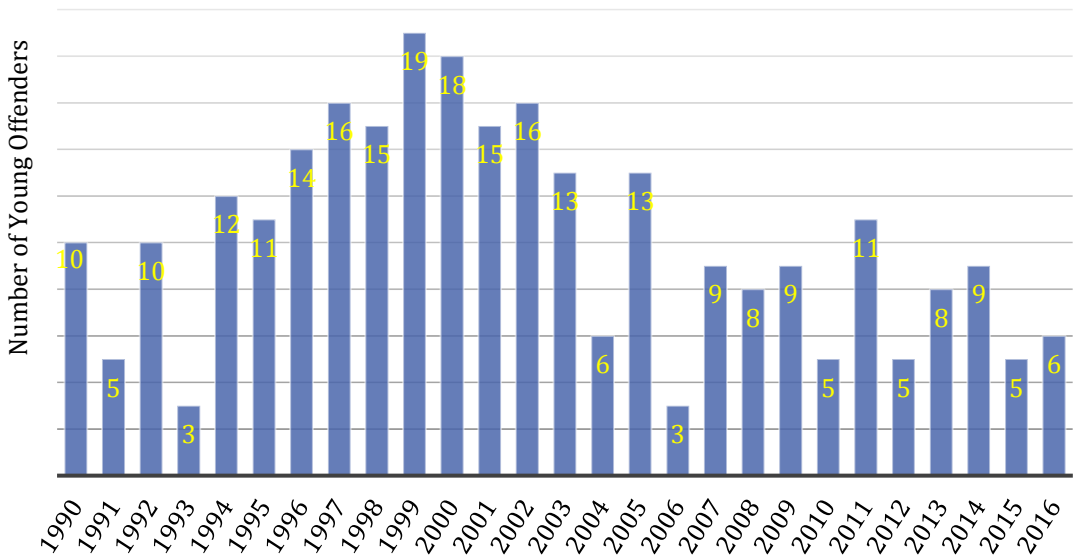
[318] Her Majesty's Prison and Probation Service Offender Equalities Annual Report 2017/18.
[319] Prisons and Probation Ombudsman (2017) *Annual Report 2016-17.*
[320] MOJ (2017) Safety in custody: quarterly update to October 2017. Deaths in prison Custody 1978 to 2016, Table 1.1.
[321] MOJ (2017) *Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to December 2016, Assaults and Self-Harm to September 2016.*
[322] PPO (2014) *Learning from PPO Investigations. Risk factors in self- inflicted deaths in prisons*.
[323] HM Inspectorate of Prisons (2016) Life in prison Peer support A findings paper.
[324] House of Commons Health and Social Care Committee (2018) Prison health Twelfth Report of Session 2017–19 Report, together with formal minutes relating to the report.

Singleton reported that 38% of male YOs had thoughts of suicide in the last year and 20% of remands said they had attempted suicide in the last year.[325]

The Harris Review[326] was a comprehensive piece of work, culminating in a report with a series of recommendations, specifically exploring self-inflicted deaths amongst the 18-24 year old population. Transition to Adulthood also produced a report focusing on this issue and making recommendations.[327]

Whilst the below chart may appear to show reducing numbers of self-inflicted deaths, this should be considered against the significantly reduced numbers of young offenders in custody in more recent years.

Figure 113 – Self-Inflicted Deaths Amongst Young Offenders



Management

The prevention of both suicide and self-harm is the responsibility of HM prison service. However, there are circumstances where either mental ill health precipitates the risk of harm, or healthcare is managing the damage caused by an episode.

Officers should be SASH (Suicide and Self-Harm) trained. The prison service system is 'Assessment, Care in Custody and Teamwork' (ACCT). It aims to improve the quality of care by introducing multi-disciplinary team-working to deliver individual/flexible care-planning. It is supported by improved staff training in both case management and in assessing and understanding at-risk prisoners. If a prisoner is identified as being at risk of suicide or self-harm, or has attempted self-harm, an ACCT case file is opened. In all establishments, healthcare is an important partner in the prison system. The role of healthcare is not uniform, but all

[325] Singleton *et al* (2000) Psychiatric Morbidity among Young Offenders in England and Wales.
[326] Harris, T. (2015) The Harris Review – Changing Prisons Saving Lives Report of the Independent Review into Self Inflicted Deaths in Custody of18-24 year olds.
[327] T2A (2015) Stolen Lives and Missed Opportunities. The deaths of young adults in prison.

prisons operate some form of multi-agency safeguarding meeting to monitor and review ACCTs.

If someone is a subject of 'constant observation', the PSO states they should be seen by a doctor at least every 24 hours. It is difficult to see how prisons that do not have seven day doctor cover can meet this requirement.

Health Promotion

An aspect of health promotion is assisting people in taking responsibility for their own health. Prisoners are a cohort of society who typically assume little personal responsibility for their own health. Consequently, as we see through this report, smoking rates are higher than in the general population, alcohol and drug problems are more prevalent, and there is a greater prevalence of health conditions allied to lifestyle factors.

Prison Service Order (PSO) 3200 requires that governors ensure efforts are made to:[328]

- *Build the physical, mental and social health of prisoners (and, where appropriate, staff) as part of a whole prison approach.*
- *Help prevent the deterioration of prisoners' health during or because of custody, especially by building on the concept of decency in our prisons.*
- *Help prisoners adopt healthy behaviours that can be taken back into the community upon release.*

The PSO goes on to identify five major areas:

- *Mental health promotion and wellbeing*
- *Smoking*
- *Healthy eating and nutrition*
- *Healthy lifestyles, including sex and relationships and active living*
- *Drugs and other substance misuse.*

Health promotion is an activity that is one aspect of delivery within a wellbeing service. Wellbeing covers a wide range of domains, including both physical and mental health (see, for example, the 'wellbeing wheel').[329]

To define wellbeing, the Local Government Association states:

> *Wellbeing is a subjective evaluation of how we feel about and experience our lives. Wellbeing, positive mental health and mental wellbeing are often used interchangeably, although 'wellbeing' is also used in a broader sense to include physical health. In the sense being used here, wellbeing includes how we feel, how we think, relationships and meaning and purpose.*[330]

As the role of prison healthcare evolves, we are seeing many providers embrace a wellbeing model.

All prisons run smoking cessation services, GUM screening and clinics, vaccination programmes etc. These are all components of a wider health promotion strategy.

The NHS Health Promotion Calendar

The national health promotion calendar considers a series of health issues in turn and offers a specific focus on each by date, for example:

[328] HMPS (2003) Prison Service Order 3200: Health Promotion.
[329] Wellbeing wheel (example) (accessed 4.5.2019)
[330] Local Government Association (2015) What Does Wellbeing Mean? Based on Friedli, L. (2009) Mental Health, Resilience and Inequalities. World Health Organisation.

Figure 114 – Health Promotion Calendar[331]

Date	Event
8-14 January	National Obesity Awareness Week
4 February	World Cancer Day
15-19 February	OCD week of action
1-31 March	Prostate Cancer Awareness Month
7 March	No Smoking Day
12-18 March	Brain Awareness Week
15 March	World Sleep Day
26 March	Epilepsy Awareness Purple Day
1-30 April	Bowel Cancer Awareness Month
7 April	World Health Day
10-16 April	Parkinson's Awareness Week
23-29 April	European Immunisation week
24-30 April	MS Awareness Week
27 April	On Your Feet Britain
1-31 May	Action on Stroke Month
2 May	World Asthma Day
14-20 May	Mental Health Awareness Week
15-21 May	Deaf Awareness Week
31 May	World No Tobacco Day
11-17 June	Men's Health Week
28 July	World Hepatitis Day
10 September	World Suicide Prevention Day
11-17 September	Sexual Health Week
2-8 October	National Dyslexia Week
7-13 October	OCD Awareness Week
9-16 October	National Arthritis Week
10 October	World Mental Health Day
20 October	World Osteoporosis Day
1-30 November	Movember Men's Health Awareness Month
1 November	National Stress Awareness Day
6-12 November	National Pathology Week
14 November	World Diabetes Day
13-19 November	Alcohol Awareness Week
19-25 November	National HIV Testing Week
1 December	World Aids Day

Prison healthcare teams are able to access national resources to run local campaigns to follow events throughout the health promotion calendar.

Peer Support/Health Trainers

A meta-analysis published by NICE concluded that:

> *There is consistent evidence from a large number of studies that being a peer worker is associated with positive health. Peer support services can also provide an acceptable source of help within the prison environment and can have a positive effect on recipients. This was confirmed by expert evidence. Research*

[331] NHS Employers (2018) Health Promotion Calendar.

into cost-effectiveness is sparse but a limited HIV-specific economic model, although based on a number of assumptions and evidence of variable quality, showed that peer interventions were cost-effective compared with professionally led interventions.[332]

An HMIP report indicates that peer support is often promoted as a form of support that may be considered preferential to more formal support from staff members.[333] The shared experiences of prisoners mean that peer workers may be able to better empathise with their problems. There is also evidence that becoming a peer worker can have a positive effect on the prisoner, for example by increasing self-esteem and organisational skills.[334]

Health Trainers are prisoners who are trained to fulfil any of a range of health promotion or support functions and can be utilised for a wide range of health promotion-type work. The problem faced by local prisons is that their turnover means men do not stay long enough to train and then be made useful in the establishment, thus the model is more suited to prisons with lower turnover rates. We have seen prisoners running smoking cessation groups, taking height and weight checks, etc. Nearly 20 years ago it was a real challenge for prisons to accept the 'listeners' scheme: now it is nearly universal. Health Trainers is a nationally recognised scheme, which is an extension of the process of partnership with prisoners.

Obesity

One in three children are obese when leaving primary school.[335] Childhood obesity leads on to adult obesity. At year 6 (aged 10-11 years), 26% of children in the most deprived areas are obese compared to 11.7% in the least deprived areas.[336] Childhood obesity is more prevalent in certain BME populations (e.g. black African and Bangladeshi) and amongst children with disabilities - especially LD. Health impacts of childhood obesity include: raised cholesterol, hypertension, pre-diabetes, respiratory problems.[337]

Body mass index (BMI) testing gives a clear indication of the levels of obesity. Across the general population, the average BMI rate for men has been steadily increasing over recent years. In 1996, 15% of men were obese (BMI of 30+). This rose to 25% in 2012-14[338] and again, to 27%, in 2015.[339]

Smoking

Data from several studies suggests that between 64-88% of prisoners in the EU smoke. One Offender Health Research Network report suggests that, because the majority of prisoners are male, prison smoking prevalence rates should be compared to the average male smoking population (40%). These figures illustrate that smoking rates among male prisoners is between one and a half to two times higher than that among the general population.[340]

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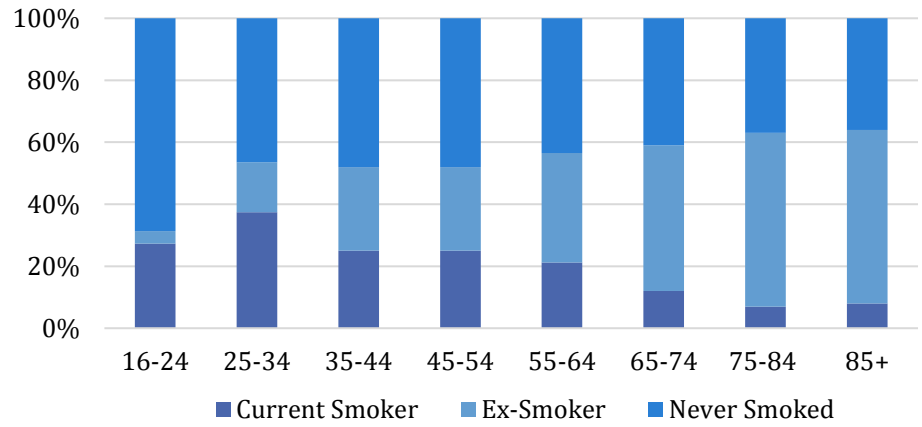
[332] South, J. *et al.* (2014) A systematic review of the effectiveness and cost-effectiveness of peer-based interventions to maintain and improve offender health in prison settings.
[333] HM Inspectorate of Prisons (2016) Life in prison: Peer support A findings paper. January 2016.
[334] *Ibid.*
[335] PHE (2017) National Child Measurement programme.
[336] Baker, C. (2017) Obesity Statistics.
[337] PHE (2015) Childhood obesity: applying All Our Health.
[338] National Obesity Observatory (2016) Adult Weight Data Factsheet.
[339] Baker (2017) Obesity statistics.
[340] OHRN (2008) Report on tobacco smoking in prison.

The Health and Social Care Information Centre published data relating to the smoking status of men in the general population in England. This is shown below, categorised by age band.

Figure 115 – Cigarette Smoking Status by Age (men)[341]



This shows that men in the age group of 25-34 years are the most likely to be current smokers; as men age, they become less likely to be current smokers, with the exception of a 1% increase in the over 85 age band. Similarly, as they age, men are more likely to be ex-smokers.

In September 2015, Public Health England stated that:

> *Reducing smoking should be given the highest priority across the CJS and comprehensive nicotine dependence treatment (cessation and/or harm reduction) should be delivered to all smokers in the CJS.*[342]

HMPPS has rolled out a programme of smoke-free prisons across the entire estate, excepting category D prisons. From September 2015, all canteen lists have included e-cigarettes. This ban is likely to precipitate a jump in obesity, as the NHS states that, on average, people put on 11 pounds after quitting smoking.[343]

Transgender

A growing body of research confirms the significant health inequalities amongst people from gender minority groups:

> *Health inequalities were experienced differently between LGBTI groups and spanned both physical and mental health. LGB people reported significantly worse physical health compared to the general population with gay men showing an increased incidence of long-term conditions that restricted their activities of daily living. Conditions included musculoskeletal problems, arthritis, spinal problems and chronic fatigue syndrome, whereas gay and bisexual men showed a high incidence of long-term gastrointestinal problems, liver and kidney problems. Lesbian women had a higher rate of polycystic ovaries compared to women in general (80 vs. 32%) and lesbian, gay and bisexual people showed weight discrepancies compared to the general population Of LGB groups, the general health of bisexual people was poorer compared to lesbian and gay counterparts due to their minority status in both communities.*
>
> *LGB people are at a higher risk of developing certain types of cancer at a younger age. Gay and bisexual men are twice as likely to report a diagnosis of anal cancer with those who are HIV-positive being at the*

[341] Health and Social Care Information Centre (2014) Health Survey for England 2013: Adult Cigarette Smoking. From Table 8.1.
[342] PHE and King's College London (2015) Reducing Smoking in Prisons: Management of Tobacco Use and Nicotine Withdrawal.
[343] NHS Choices.

highest risk. Rates of anal cancer in gay and bisexual men are similar to the prevalence of cervical cancer in general female populations prior to the introduction of cervical screening programmes. This evidence supports the need for anal screening programmes geared towards gay and bisexual men. In contrast there was no conclusive evidence of higher rates of breast cancer in lesbian and bisexual women. However, LGB people who survived cancer reported the need for psychological and emotional support to address their specific needs. There is a gap in high quality international research on both the cancer burden, general health profile and care needs of trans and intersex people.

In relation to mental health, significant inequalities exist with LGBT people being twice to three times more likely to report enduring psychological or emotional problems compared to the general population. Suicide attempts, suicidal ideation, depression and anxiety disorders were 1.5 times higher for LGB people compared to heterosexual peers with alcohol related substance dependence over the previous 12 months being 1.5 times more common in LGB people. Disparities related to mental distress were most pronounced for LGB people under the age of 35, and people over the age of 55. Intersex people also showed a raised incidence of suicide attempts at 19%, with 60% having considered suicide compared to 3% in mainstream populations. Bisexual and trans people showed even greater disparities in mental health compared to lesbian and gay counterparts, increasing the need for specialist mental health services and counselling support.

Whilst accessing treatment and care, LGBTI people were more likely to report unfavourable experiences. General concerns were around communication with health professionals and overall dissatisfaction with treatment and care provided. Trans people frequently experienced negative interactions with health professionals at gender identity clinics, mental health services and general health services. Where trans people attended gender identity clinics, long waiting times for treatment was shown to negatively impact on their emotional wellbeing.

Like LGBT people, some intersex people experience isolation due to stigma, discrimination or rejection from others. For some intersex people, experiences of adversity were linked to the medicalisation of their bodies and being subjected to 'normalising' surgery at a young age or where their bodies were surgically aligned to male or female sex characteristics. Dissatisfaction about historic treatment was linked to health professionals not openly discussing information or failing to gain informed consent prior to surgical intervention on intersex minors.[344]

Data is not regularly collected, but according to MOJ, there were 139 transgender prisoners in the population. This equates to 1.6 transgender individuals per 1000 prisoners.[345] Forty-four of the 124 public and private prisons in England and Wales house one or more transgender prisoners.[346] An MOJ commissioned review recommended that:

People who are living in a gender different to that of their assigned sex at birth should, as a general presumption, be treated by offender management services according to the gender in which they identify.

Regardless of where prisoners are held, they should be respected in the gender in which they identify, being provided with those items that enable their gender expression.

The prison service should develop a single "facilities list" of items available to be purchased that can be used in either male or female establishments, and standardise rules on what constitutes acceptable clothing.[347]

The review goes on to note both the challenges of managing this population, and the risks they experience, including possible mental health issues and risk of self-harm.

[344] https://academic.oup.com/eurpub/advance-article/doi/10.1093/eurpub/cky226/5151209.
[345] MOJ (2018) *Her Majesty's Prison and Probation Service Offender Equalities Annual Report 2017/18*.
[346] *Ibid.*
[347] MOJ (2016) Review on the Care and Management of Transgender Offenders.

The literature describes how prisons are designed and managed for binary gender considerations; historically a prisoner was housed according to their legal gender identity. The most recent prison service instruction[348] for the care and management of transgender prisoners makes it clear that a prisoner's view of whether they should be in a male or female environment should be taken into account and decisions should not be informed solely by their legal gender. As guidance evolves, and the numbers of prisoners increase, the MOJ states all staff should have access to training on this issue.[349]

Transgender prisoners convicted of sex offences present specific challenges and the MOJ recommends that:

> *there should be specialised support in a small number of sex offender prisons (i.e. not the whole sex offender estate), ideally with reasonable access to appropriate NHS facilities in the community.*[350]

The PPO has recently published a lessons learned commentary on the management of transgender prisoners which explores, in some detail, how prisons should manage transgender prisoners.[351]

MOJ states:

> *An establishment must permit prisoners who consider themselves transsexual and wish to begin gender reassignment to live permanently in their acquired gender.*
>
> *Permitting prisoners to live permanently in their acquired gender will include allowing prisoners to dress in clothes appropriate to their acquired gender and adopting gender-appropriate names and modes of address (e.g. Ms, Mr, Mrs). An establishment must allow transsexual people access to the items they use to maintain their gender appearance, at all times and regardless of their level on the Incentives and Earned Privileges Scheme or any disciplinary punishment being served.*
>
> *Establishments must produce a management care plan outlining how the individual will be managed safely and decently within the prison environment.*[352]

HMPPS has recently issued a new PSI on 'The Care and Management of Transgender Offenders'.[353]

NHS England has ruled that prisoners have a right to appropriate gender re-alignment. The PSI states:

> *6.26 If medical treatment for gender dysphoria is commenced before reception into prison, and the prisoner applies for it to be continued, it should be continued until the prisoner's gender specialist has been consulted on the appropriate way to manage the prisoner's treatment unless the doctor working in the prison has reasonable clinical grounds for not doing so.*
>
> *6.28 The prison health care team must inform the relevant NHS commissioning authority of any request from a prisoner (whether remanded or sentenced) to begin medical treatment for gender dysphoria and request a contact point for liaison purposes.*

[348] NOMS (2016) The Care and Management of Transgender Offenders.
[349] MOJ (2016) Review on the Care and Management of Transgender Offenders.
[350] *Ibid.*
[351] PPO (2017) Learning lesson bulletin Transgender prisoners.
[352] MOJ (2016) Prisoner Transgender Statistics, March/April 2016.
[353] NOMS (2016) The Care and Management of Transgender Offenders.

Annex G8

Every effort should be made to ensure that prisoners with gender dysphoria are retained in one establishment during the period they are on remand, subject to security requirements and population pressures, to provide stability of counselling and other support services and to maintain some aspect of confidentiality concerning their medical status.

Social Care

Definition

It is important to note that while elderly prisoners tend to dominate discussions on social care, the needs of individuals of all ages are included. Age-related conditions make up a large proportion of social care cases, but by no means all. For example, there are duties of care for young adults who have previously been in the care of their local authority (care leavers).

A publication by the Revolving Doors Agency examined the social care needs of short-sentenced prisoners and summarised their key social care needs as follows:

- Accommodation
- Employment, training and education
- Finance, benefit and debt
- Drugs and alcohol
- Family, relationships and social networks
- Emotional wellbeing
- Mental health
- Disabilities requiring social care
- Learning disabilities and difficulties.[354]

The report highlighted that whilst there are systematic screening processes used to assess health needs when an offender enters a prison, no explicit and equivalent process is systematically undertaken to understand many of the above-identified social care needs, which can underpin the presenting health needs.

Some of the above needs are dealt with in this HSCNA from a 'health' perspective and feature in previous sections (e.g. substance misuse, mental health, learning disability and physical disability).

Prison Responsibilities

In his most recent annual report, the PPO comments on the impact of recent changes in the prison population:

> *The challenge is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice.*[355]

The social care responsibilities for the prison are detailed in PSI 03-2016 *Adult Social Care,* which explains the different partners' roles and responsibilities in the delivery of care, both within prison and in preparation for release.[356] The PSI details the relationship that should exist between a prison and its local authority, as informed by the Care Act (2014).

[354] Anderson, S. and Cairns, C. (2011) *The Social Care Needs of Short-Sentence Prisoners.* Revolving Doors Agency.
[355] PPO (2016) *Prison and Probation Ombudsman Annual Report 2015-16.*
[356] NOMS (2015) *PSI 03-2016: Adult Social Care*.

In addition, PSI 16-2015, *Adult Safeguarding in Prisons,* draws together all the pre-existing safeguarding processes for prisoners, highlighting that those with disabilities are at greater risk of abuse.[357]

Background

In the past, social care in prisons had not been clearly addressed by the prison service, leading to sporadic and *ad hoc* developments. It is, however, important to stress that many aspects of social care have been delivered by the prison service and its partners for many years. The Care Act 2014 changed this and clarified responsibilities.

Throughout these changes, the responsibility for the physical environment, including physical adaptions to cells, remains, as ever, with the prisons. The rule of thumb is that anything which is immovable is prison responsibility (e.g. a handrail bolted to a wall). Anything movable is a third-party responsibility (e.g. a walking stick, wheelchair or a hoist). In the past, provision of items such as mobility aids has been *ad hoc* and differed in different establishments. PSI 03-2016 states:

> *Local authorities in England are required by regulations supported by guidance to provide at their cost equipment (e.g. hoists) and personal aids (e.g. to assist mobility); this is up to the value of £1,000.*

Eligibility Criteria

In order to be entitled to care, prisoners must meet the eligibility criteria as defined in *The Care and Support (Eligibility Criteria) Regulations 2014*. Because this is not widely understood, the relevant paragraphs are reproduced in full in below:

Needs which meet the eligibility criteria: adults who need care and support

(1) An adult's needs meet the eligibility criteria if -
- *(a) the adult's needs arise from or are related to a physical or mental impairment or illness;*
- *(b) as a result of the adult's needs the adult is **unable** to achieve two or more of the outcomes specified in paragraph (2); and*
- *(c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being.*

(2) The specified outcomes are -
- *(a) managing and maintaining nutrition;*
- *(b) maintaining personal hygiene;*
- *(c) managing toilet needs;*
- *(d) being appropriately clothed;*
- *(e) being able to make use of the adult's home safely;*
- *(f) maintaining a habitable home environment;*
- *(g) developing and maintaining family or other personal relationships;*
- *(h) accessing and engaging in work, training, education or volunteering;*
- *(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and*
- *(j) carrying out any caring responsibilities the adult has for a child.*

(3) For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult -
- *(a) is unable to achieve it without assistance;*

[357] NOMS (2015) *PSI 16-2015: Adult Safeguarding in Prison.*

(b) is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;

(c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or

(d) is able to achieve it without assistance but takes significantly longer than would normally be expected.

A problem appears to be that in a prison environment, many of the daily living needs are met by the prison. In some local authority areas, this appears to mask actual need. Figure 116 considers this in relation to the outcomes specified in paragraph (2) above:

Figure 116 – Eligibility Criteria and the Prison Environment

Criteria (must be unable to achieve outcomes)	Situation in Prison	Comment
(a) managing and maintaining nutrition	Prisons caters for all prisoners in this respect.	All those assessed will be deemed ineligible in respect of food preparation. They may not be able to collect food, though 'enablers' can do this. A man may not be able to actually feed himself, which is a social care need.
(b) maintaining personal hygiene	Prisons are set up to monitor and encourage personal hygiene.	Prisoners who need assistance to manage intimate care will have a social care need.
(c) managing toilet needs	As in the community.	
(d) being appropriately clothed	Prison service provides clothing.	Limited applicability
(e) being able to make use of the adult's home safely	Prison service largely manages safety.	
(f) maintaining a habitable home environment	Prison contributes to many of the requirements for ensuring a habitable environment.	
(g) developing and maintaining family or other personal relationships	Relationships within prison are unique to the institutional environment.	Limited applicability (in many cases)
(h) accessing and engaging in work, training, education or volunteering	Prisons manage activities, but by virtue of the regime these are limited.	Limited applicability
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services	Prisons manage these. They are all on-site.	
(j) carrying out any caring responsibilities the adult has for a child	Not applicable	

Care Experienced (Under 25s)

HMIP notes that specific provision is in place for those who are care experienced which need '*to be identified and met.'*[358]

The legal definition of a 'looked after child' expires when a child reaches the age of 18 years, however, the Children Act 1989 places duties on the home local authority towards 'looked after' and previously 'looked after' children as they exit the care system, which now continues up to the young person's 25th birthday. The young person's home local authority delivers this duty via its 'leaving care team'. Section 2 of the Children and Social Work Act 2017[359] made a requirement for each local authority in England to publish a 'local offer for care leavers'. Section 3 of the Act[360] requires local authorities to provide personal advisors to care leavers up until they reach the age of 25, this is explained in statutory guidance.[361]

At present, it appears that the social care needs of care leavers are not being addressed in most establishments. Being a care leaver is not a protected characteristic, so identification does not fall within the remit of the equalities team, nor does it logically sit anywhere else. The equalities team should focus on age as a protected factor.

Care leavers are disproportionately over-represented within the prison population, especially young prisoners:

> *23% of the adult prison population has been in care and almost 40% of prisoners under 21 were in care as children (only 2% of the general population spend time in prison)*[362]

T2A (quoted in by House of Commons Justice Committee) offers an even higher figure:

> *Nearly half of young men and two thirds of young women in custody aged between 16 and 21 have recently been in statutory care.* [363]

The particular needs of young adults who are care leavers are acknowledged:

> *The Ministry of Justice (MoJ) and Home Office (HO) recognise that young adults who have been in care can be particularly vulnerable as they transition into adulthood, particularly if they are in the criminal justice system.*[364]

> *It will be essential that continuing leaving care support is available to relevant or former relevant children if they are convicted and sentenced to a community sentence, or imprisonment. In fact, this group of care leavers will be especially vulnerable and will require carefully planned and well-focused support from their responsible authority.*[365]

Who is entitled to support and who should deliver care is a complex issue. There is a range of definitions that bring young care leavers within the remit of local authority responsibility.

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[358] HMIP and Ofsted (2014) *Resettlement provision for adult offenders: Accommodation and education, training and employment*
[359] Section 2 Children and Social Work Act 2017 (accessed 30.4.2019).
[360] Section 3 Children and Social Work Act 2017 (accessed 30.4.2019).
[361] DfE (2018) Extending Personal Adviser support to all care leavers to age 25 Statutory guidance for local authorities.
[362] The Who Cares Trust (now Become) website https://www.becomecharity.org.uk/.
[363] House of Commons Justice Committee (2016) The treatment of young adults in the criminal justice system.
[364] HM Government (2013) Care Leaver Strategy.
[365] DfE (2010) The Children Act 1989 guidance and regulations Volume 3.

A '*qualifying young person'*, is defined as a young person who is:

- *aged at least 16 but is under 21;* and
- *at any time after reaching the age of 16 while he was still a child [under 18] was, but is no longer, looked after, accommodated or fostered.*[366]

> *A young person who was not looked after for 13 weeks may be a qualifying child. If that young person returns home, perhaps as a result of a decision made at their first statutory review as a looked after child, then that young person should not be regarded as "qualifying" under Section 24 of the 1989 Act; rather, support to the young person and his family should be provided under section 17 of the 1989 Act.*[367]

A qualifying young person has the least amount of entitlement to services as a care leaver; however, it is acknowledged in government policy that:

> *[s]ome qualifying children will be as vulnerable and have very similar needs to eligible, relevant or former relevant children.*[368]

This is particularly true of the complexity of needs that young people in custody can present.

A *'former relevant child'* is a young person aged 18 years or over who was in care for at least 13 weeks and did not subsequently return to their parents. Following the Children and Social Work Act (2017),[369] the home local authority duties in relation to former relevant children have been extended so that they now cover a young adult up to their 25th birthday.

For looked after children - and therefore, by extension, care leavers - responsibility rests with the home local authority, not the authority in which the prison is situated. All councils with social services responsibilities are asked to take the following action:

- *Ensure that they fulfil their statutory responsibilities for contact with any children, for whom they have parental responsibility, who are placed in custody;*
- *Where they were previously responsible for accommodating a child who is now in custody, or where a child who is now in custody, who was previously looked after by another local authority under section 20, now plans to live in their area on release, establish arrangements to promote and safeguard his or her welfare on release.*[370]

The home local authority must:

- *Take reasonable steps to keep in touch with the relevant child*
- *Prepare an assessment of the relevant child's needs* and *prepare a pathway plan*
- *Keep the pathway plan under regular review*
- *Appoint a personal advisor*
- *If his welfare requires it, provide financial assistance by contributing to the former relevant child's expenses in living near the place where he is, or will be, employed or seeking employment*
- *If his welfare and education and training needs require it, provide financial assistance to enable him to pursue education or training*

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[366] The Children Act 1989, section 24.
[367] DfE (2010) The Children Act 1989 guidance and regulations Volume 3.
[368] *Ibid.*
[369] Children and Social Work Act (2017).
[370] DfES (2004) Local Authority Circular LAC (2004) 26.

- *If the former relevant child pursues higher education in accordance with his pathway plan, to pay him the higher education bursary.*[371]

  The relevant local authority…must consider whether the person needs help of a kind the local authority can give:
  - *Under section 24A - to advise and befriend and give assistance*
  - *Under section 24B - to give financial assistance.*[372]

Social care needs for care leavers within prison will be limited, unless the person has separate adult social care needs. The need is primarily in respect of a support package for release, for example housing needs. Care needs within prison will be more limited than those on release.

Social Care Enablers/ Buddies

Most prisons now have a clear and well-established programme of peer 'enablers' or 'buddies'. A prison enabler can perform some of the functions that could be delivered by a 'carer' in the community. The role of an enabler is limited by a range of considerations described in PSI 17-2015.

PSI 17-2015 clarifies the role of an enabler, in particular the distinction between personal and intimate care:[373]

> ***A2*** *Prisoners must not be permitted to provide other prisoners with intimate care. They may, however, provide some personal care. It is important to be aware of and sensitive to cultural differences when agreeing the tasks that a prisoner will perform in each case.*
>
> ***A3*** *The term intimate care refers to tasks concerned with personal hygiene and bodily functions and products, particularly those that require contact with or the exposure of intimate parts of the body. These must not be allocated to prisoners to undertake. Some examples of intimate care include:*
> - *Assisting with eating and drinking (in the sense of placing food or drink into the mouth, as distinct from other activities to manage and maintain nutrition such as cutting up food and transporting food);*
> - *Oral care, including teeth cleaning;*
> - *Washing body areas that are usually clothed for privacy and dignity;*
> - *Dressing and undressing body areas that are usually clothed for reasons of privacy and dignity;*
> - *Toileting support, e.g. changing continence pads or sanitary towels;*
> - *Assisting an adult with cleaning himself or herself following a soiling or wetting episode.*
>
> ***A4*** *The term personal care is a broader one that applies to tasks that do not require contact with or the exposure of intimate parts of the body. Some examples of personal care include:*
> - *Dressing and undressing that does not involve body areas that are usually clothed for reasons of privacy and decency, for example helping to put on a pair of socks, or a jacket over a shirt;*
> - *Maintaining hygiene for bodily areas that are normally exposed;*
> - *Providing mental stimulus support for adults that have permanent or temporary mental impairment or diminished mental capacity;*
> - *Support with movement or transportation, including moving an appropriately dressed prisoner to the shower or bathroom;*
> - *Support with nutritional requirements which do not reach the level of regular assistance with eating and drinking;*

[371] DfE (2010) The Children Act 1989 guidance and regulations Volume 3.
[372] *Ibid.*
[373] NOMS (2015) *PSI 17-2015: Prisoners Assisting Other Prisoners.*

- *Applying makeup;*
- *Maintaining personal appearance;*
- *Skin care (of non-intimate areas);*
- *Providing reminders for essential activities like taking medication/going to the toilet.*

As explored above, enablers should be able to assist in delivering a wide range of non-intimate care. The prison should identify suitable men and, dependent on their role, they will need some level of training not least to fully understand what they can and cannot deliver. They should be cognisant of the concept to enable, rather than to do. It is not the role of an enabler to care for someone who is, with help, able to care for themselves.

Enablers will need ongoing support/management to thrive in their roles. Additionally, there will need to be ongoing contact with those they care for to check for any issues. HMPPS sees this as a key contribution of any additional social work input.

Young Parents

There is little written about incarcerated young offenders who are parents. HMIP reports that 23% of survey respondent from 'young adult training prisons' describe being young parents; this finding concurs with published estimates that 1:4 young offenders are fathers.[374] This contrasts to just 2.5% of all children in England and Wales being born to fathers aged 21 or under.[375]

There is little evidence of what works. Examples include Storybook Dads, work by Barnardo's in Scotland and Northern Ireland.[376] Barnardo's also produced a literature review.[377]

Storybook Dads is a simple idea of fathers recording bedtime stories for their children, it runs across many UK prisons and is reported to help maintain family links.[378]

Resettlement

HMIP and CQC state:

> *Prisons and local authorities should ensure that processes are in place for the smooth transfer of prisoners with packages of social care … on release into the community. This should include effective information sharing.*[379]

[374] Buston, K. (2015) Young offenders as fathers: what works in parenting interventions?
[375] ONS (2019) Births by parents' characteristics 2017.
[376] Barnardo's website (accessed 28.4.2019).
[377] Barnardo's website (accessed 28.4.2019).
[378] Storybooks Dads website (accessed 30.4.2019).
[379] HMIP and CQC (2018) *Social care in prisons in England and Wales A thematic report.*