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Paper

Assessing the Health Needs of Offenders Residing in the Community: a mixed-methods approach to reducing criminal behaviour

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Abstract

It is well known that criminal justice issues and health needs are clearly interwoven (Keay, 2014). However, despite this there is very little published evidence on the health needs of offenders in community settings. In 2017 – 2018, a health needs assessment (HNA) was undertaken in Derbyshire to explore the needs of community offenders and to identify the barriers they experience in accessing health and social

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care. This article summarises its key findings, knowledge of which have the potential to improve the understanding of the health needs of community offenders, and ensure that these are adequately addressed. This is an important part of the prevention of further offending (Ministry of Justice Analytical Series, 2013), benefitting not only the individuals at risk of offending or reoffending, but also their families, communities and the wider society.

Key Words:

Health Needs, Community Offenders, Desistance

Introduction

In 2013 'The Balancing Act' (Revolving Doors Agency, 2013) was published, which seeks to highlight the health inequalities experienced by people in contact with the criminal justice system. Revolving Doors Agency have a vision that by 2025 no-one will be stuck in the revolving door of crisis and crime and anyone with multiple problems and poor mental health will be supported to reach their full potential (Revolving Doors Agency, 2016). Although criminal justice issues and public health are widely acknowledged to be interwoven (Keay, 2014), very little has been published about the health profile and needs of offenders in community settings. To explore the needs of this group in the community and identify the barriers they experience in accessing health and social care, a health needs assessment (HNA) was undertaken between 2017 and 2018, in Derbyshire (including the City of Derby), UK. This article summarises the methodological approach taken to the HNA and its key findings.

Literature review

A comprehensive literature search revealed that, whilst the evidence base exploring the mortality of offenders in prison is large, few studies explicitly consider the mortality of offenders in the community (Satter, 2001). Given that until recently there was a requirement for offenders to serve the majority of their sentences whilst incarcerated (Parliament UK, 2014), it is possibly unsurprising that the limited existing literature reveals the substance misuse, physical and mental health needs of offenders serving their sentences in the community more closely resemble those of incarcerated offenders than those of the general population (Brooker et al., 2008). However, although these two offender groups may have similar needs, their access to services differs, with those in the community expected to largely access the same services, and in the same way, as the general population.

Although there is a paucity of published literature exploring the health of community offenders (Sattar, 2001), evidence shows their rate of mortality is extremely high (Ministry of Justice, 2018). We can infer this group experiences a high prevalence of health problems (Brooker, 2008). The wider determinants of health, such as social, economic and environmental factors are recognised influences on health and wellbeing (Public Health England, 2018). The community offender population are reported to experience significant co-morbidities such as poor physical and mental health and substance misuse problems, often complicated by social issues such as unemployment, indebtedness, homelessness or social isolation (Revolving Doors Agency, 2013; Seymour, 2010).

There are no specialist health services routinely commissioned for offenders in the community in England, (Northamptonshire County Council, 2014). Community offenders ’difficulties accessing health care services have been attributed to their chaotic lifestyle and communication challenges (Ebberson, 2015). It is known that they are unlikely to proactively engage with health services (Northamptonshire County Council, 2014) and instead are more likely to over-use crisis services (Brooker et al., 2008). To date, not only is there a lack of evidence relating to the health needs of community offenders, there is also little information to show whether existing services are protecting or improving the health of the community offender population.

There is a well-documented link between offending behaviour and substance misuse (Pierce et al., 2015). Although crime is not an inevitable result of problematic drug use and alcohol consumption, there is a certain association between the two; a large percentage of acquisitive crime (such as shoplifting and burglary) can be attributed to problem drug users (NTA, 2009). Nearly 50% of violent crime (violence, injury and victimisation, domestic violence and sexual assault) victims report the perpetrator to have been under the influence of alcohol at the time (Prison Reform Trust, 2004).

Health Needs Assessment

A Health Needs Assessment (HNA) is a systematic process for assessing the health problems facing a particular population (NICE, 2017). In the HNA discussed in this article, the population of interest was community offenders residing in Derbyshire. Community offenders are offenders who have been sentenced at either a magistrates or Crown Court, and are either: on suspended sentences, serving their

sentences in the community or are on licence having served the first part of their sentence in prison. Care pathways for offenders being released from prison into the community were considered, although offenders in prison or police custody units were excluded due to them having different access to health services than that of community offenders.

Methodology

To capture both quantitative and qualitative data on the health and wellbeing of community offenders in Derbyshire, this HNA employed a mixed methodology. This methodology was adapted from the Stevens and Raftery model (1994), the gold standard model for HNA, which describes three approaches: epidemiological, comparative and corporate. For this HNA, the epidemiological approach included assessment of morbidity (disease incidence) and mortality (death rate) amongst community offenders in Derbyshire. The comparative needs assessment compared morbidity amongst Derbyshire's community offenders to that in the general population of Derbyshire and other areas of England. The corporate needs assessment gathered qualitative evidence from key stakeholders (community offenders and relevant probation and healthcare professionals). All three approaches were underpinned by a comprehensive literature review.

Quantitative methodology

A questionnaire was developed in consultation with a steering group made up of representatives from the local authority's Public Health and Community Safety Departments and the Criminal Justice Board. The content of the questionnaire was also informed by the health needs of offenders as identified from the literature and

previous offender HNAs carried out in other districts (Brooker et al., 2008; Ebberson, 2015; Firth, 2014). The questionnaire was designed to collect data on the demography, lifestyle, mental and physical health of respondents. Information was also collected on:

- Which services offenders required, both whilst serving an entire community sentence and following release from prison;
- How easy offenders found it to access services;
- Their opinion of the care provided to them, in terms of usefulness and satisfaction.

Following an initial pilot, 320 questionnaires were sent to the local branches of the Community Rehabilitation Company (CRC – a private sector supplier of probation and prison-based rehabilitative services), National Probation Service (NPS) and the Youth Offending Service (YOS). Case workers were provided with information sheets and consent forms for potential participants and also with instructions on how to administer the survey to community offenders under their supervision. Community offenders were sampled using convenience sampling, a non-randomised method for selecting participants deemed appropriate for overcoming the challenges inherent in recruiting participants from this hard to reach population. Consent forms were detached from the questionnaire, and respondents were provided with a sealable envelope, which was returned to the local authority, where the information was manually transferred to electronic media and analysed in Excel. For context, each service (CRC, NPS and YOS) also provided anonymised demographic data on their current service user population.

Qualitative methodology

Qualitative data on community offenders' views and perspectives on their health, health needs and current services were collected via semi-structured interviews with nineteen community offenders, recruited using convenience sampling. Due to difficulties in recruiting young offenders for interview, (the Youth Offending Service failed to recruit any interviewees, although reasons for this are unknown), only the views of those aged over 18 years old were included in the qualitative element of the HNA. Interviews were carried out by CRC and NPS staff; an external interviewer was not used as community offenders are traditionally a difficult to engage group and it was felt that using someone with existing rapport as an interviewer would be more likely to facilitate more in-depth conversation and therefore hold greater potential to give them voice. Interviewers were provided with an interview topic guide and a proforma for recording the responses of each participant. A semi-structured interview guide was used to guide the interviewer and enable them to explore issues brought forward by the interviewee. Power dimensions of the interview situation (in particular using a probation professional as the interviewer) were assessed. To overcome this, the probation professional took the time to explain the interview's purpose to the community offender and gave them a chance to ask any questions. Additionally, community offenders were offered the chance to provide their views and perceptions anonymously in a questionnaire, for which they were provided with an envelope they could seal and assurance this would remain sealed until returned to the Local Authority.

Information about existing service provision and potential areas for improvement were captured using an online survey from 49 health care professionals and offender

case workers employed by CRC, NPS, YOS and the National Health Service (NHS). Participants were again recruited using convenience sampling.

The professionals were asked for their views on five main topics:

- Health issues experienced by offenders;
- Offenders' access to health services;
- Health issues offenders do not seek help for;
- Reasons for offenders not seeking help; and
- How services could be improved.

All interviews were transcribed verbatim by a local authority employee in preparation for analysis. Thematic analysis was used to uncover common themes, underlying assumptions and patterns from the responses to the offender interviews and the online survey of professionals. To address bias and improve validity, the identified themes were reviewed by a member of the steering group; no major discrepancies were found.

Results

This HNA brought together information about the health and health needs of Derbyshire's community offenders, the services available to them and the difficulties they experienced in accessing them. Full details of the results can be found in 'A health needs assessment of offenders in the community; Derbyshire and Derby City' (Cooper, R., 2017): the key findings are summarised below.

Quantitative Results

Quantitative information collected from 166 community offenders was analysed in Excel. For the purposes of this HNA, where appropriate, missing responses have

been excluded from the denominator for individual questions. Therefore, it should be noted that the denominators for each calculation may differ between questions. Analysis of the demographic data collected provided an understanding of the age and gender profiles of the community offender population in Derbyshire. Although there were very small numbers in every age group, Figure 1 shows that the majority of offenders (64.5%) were aged 15 to 39 years. The age profile of community offenders is much younger overall than that of Derbyshire's general population (Figure 2).

Figure 1: Age of respondents, by gender

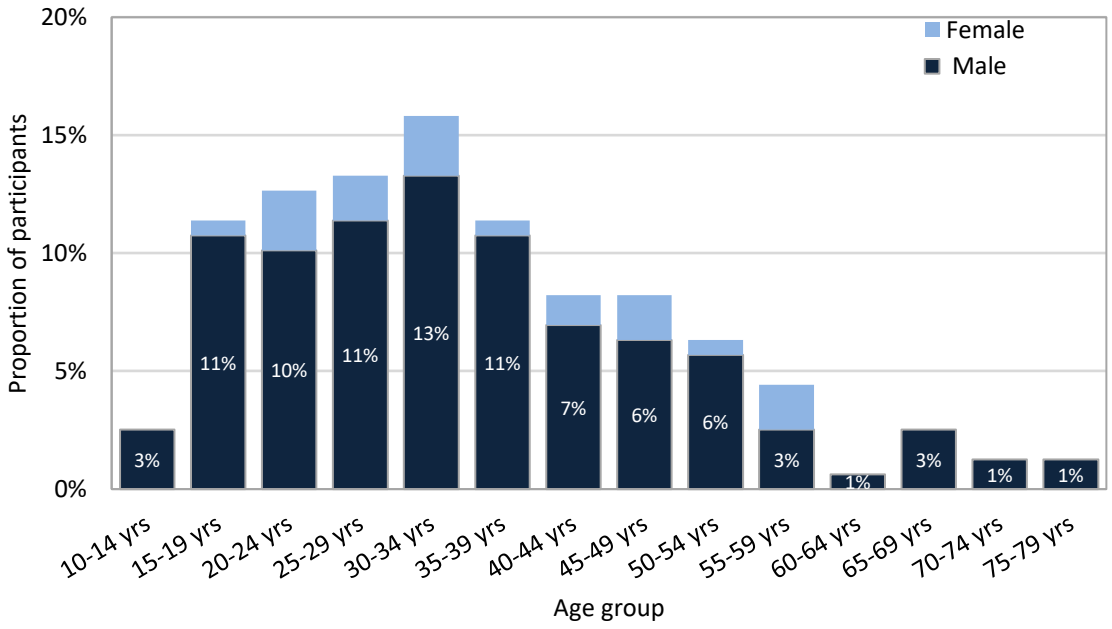
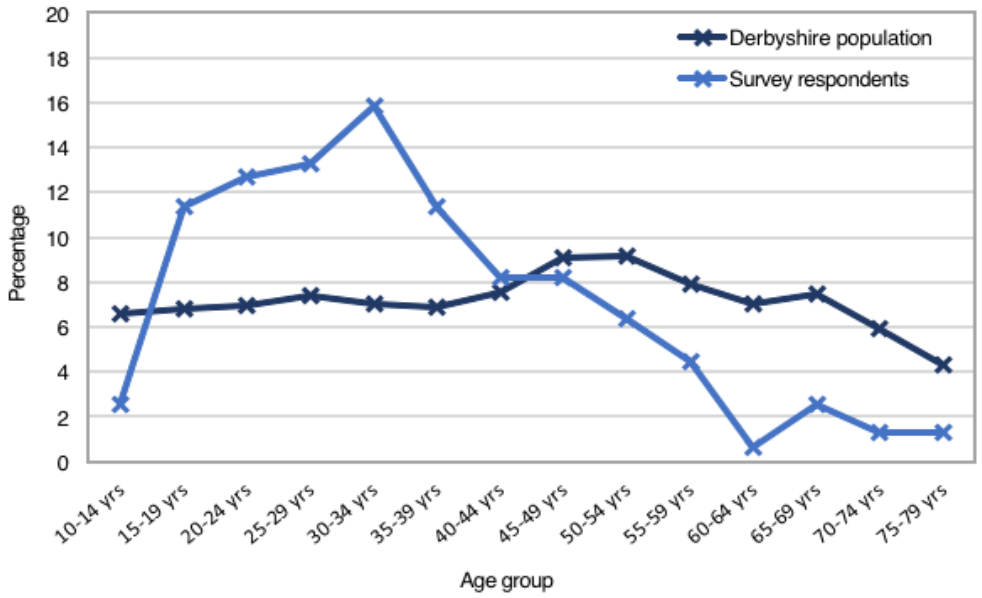


Figure 2: Age profiles - Respondents compared to the Derbyshire population



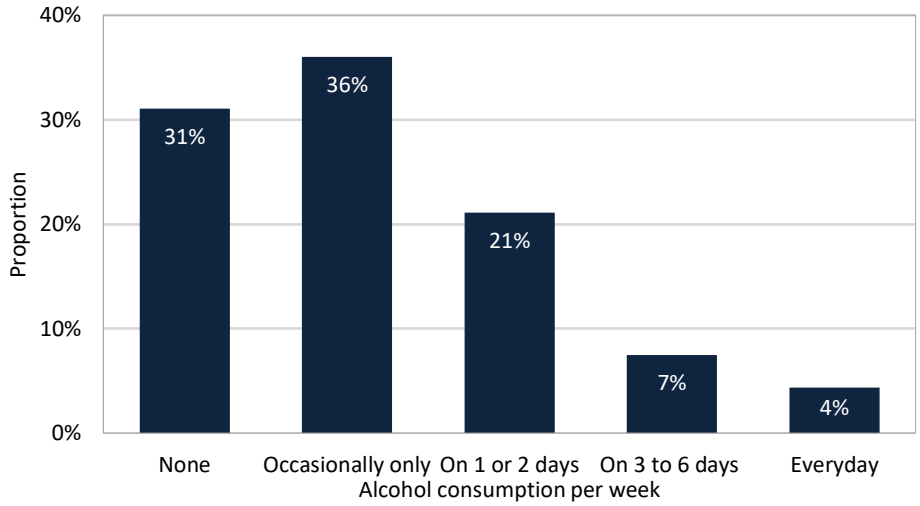
The ethnic origins of respondents broadly reflected those of Derbyshire's general population. Respondents were asked whether they smoked cigarettes or tobacco and if so, how many cigarettes they smoked per day. Of the 159 respondents that responded, 63.5% described themselves as smokers.

This is a much higher proportion than was seen regionally (16.1%) or nationally (15.5%) in 2016 (Public Health England, 2017). The majority of offenders who were smokers were under the age 35; 29.2% were aged 15 to 24 and 34.4% were aged 25 to 34. To assess the quality of their diet, respondents were asked how many portions of fruit or vegetables they ate in a normal day: 9.4% stated that they ate the recommended 5 or more; 76.1% ate between 1 and 4 portions of fruit or vegetables a day and 14.5% reported consuming no fruit or vegetables daily. These results are much lower than those reported for the general population by the Health Survey for England 2015 (NHS Digital, 2016) which found that 26% of the population consumed 5 or more portions daily and only 7% consumed no fruit or vegetables. Survey participants were also asked about their physical activity. Regular exercise, defined

as doing 30 minutes of exercise sufficient to cause shortness of breath, on 5 or more days of the week, was reported by 22.8% of respondents; this is lower than the national average of 65% reported in the 2011 Census (Office for National Statistics (ONS), 2012). However, the proportion of respondents who reported that they did not achieve 30 minutes of exercise on any day of the week was similar to the 22% reported nationally (ONS, 2012).

The survey asked offenders about the number of drinks containing alcohol they consumed per day and their frequency of drinking per week. Alcohol consumption was reported by 68.9% of respondents; their stated levels of consumption are shown in Figure 3.

Figure 3: Frequency of alcohol consumption



Of the 31.1% who said that they abstained from drinking alcohol, 13 reported they were currently receiving help to reduce their alcohol consumption. Of those who reported consuming alcohol, 74.5% respondents provided information on the number of drinks containing alcohol that they consumed on the days that they drank (Figure 4).

Figure 4: Alcohol consumption, by frequency of drinking

Number of drinks containing alcohol consumed	Frequency of alcohol consumption										Total	
	I don't drink alcohol		I only drink alcohol occasionally		1 or 2 days a week		3 to 6 days a week		Everyday			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1-2 drinks	8	6.7%	26	21.7%	7	5.8%	4	3.3%	1	0.8%	46	38.3%
3-5 drinks	3	2.5%	12	10.0%	15	12.5%	8	6.7%	5	4.2%	43	35.8%
6-9 drinks		0.0%	9	7.5%	4	3.3%		0.0%	1	0.8%	14	11.7%
10 or more drinks		0.0%	9	7.5%	8	6.7%		0.0%		0.0%	17	14.2%

It was noted that 11 of the respondents who stated that they did not drink alcohol also reported a level of alcohol consumption; for 8 this was 1-2 drinks and for 3 it was 3-5 drinks. It is possible this reflects known problems with the under reporting of alcohol consumption in surveys (Stockwell et al., 2016).

Unfortunately, this survey did not collect any information from which to gauge the number of units, or the strength of the alcohol consumed. Therefore, to obtain upper and lower levels of alcohol consumption per week for each respondent, conservative estimates for alcohol consumption were calculated by applying the assumption that one reported drink contained 1.5 units of alcohol. Comparing these results to the 2016 guidelines on alcohol consumption (Chief Medical Officer, 2016) suggests that, if the lower limits of the estimates are accepted, 78.0% of respondents may be drinking at low risk levels. Consuming up to 14 units of alcohol per week is considered to be 'low risk', but drinking above this level is regarded as being at 'increased risk'. The more alcohol consumed above the 14 unit threshold, the higher the risk.

Applying these guidelines to the estimated alcohol consumption of respondents suggests that, if the lower limits of the estimates are accepted, 78.0% (85 of 109) of

respondents are drinking at low risk levels and only 22% are drinking at high risk levels. However, if the upper limits of the estimate are applied, the proportion drinking at low risk levels falls to 49.5% (54 of 109). It is therefore possible that up to 50.5% (55 of 109) of the cohort are drinking at high risk levels, putting them at increased risk from their levels of alcohol consumption. Alcohol consumption estimates also revealed that around one third (33.0%) of the cohort had patterns of alcohol consumption that strongly suggested binge drinking, with 15 to 30 units consumed on each occasion. The pattern of alcohol consumption for a further 5.5% could be as much as 50 units or more per week, putting them at very high risk of the sequelae of alcohol misuse.

In this survey, 63.5% of offenders reported that they had used illegal drugs (Figure 5). Cannabis was by far the most commonly used drug reported by respondents, followed by cocaine and amphetamines.

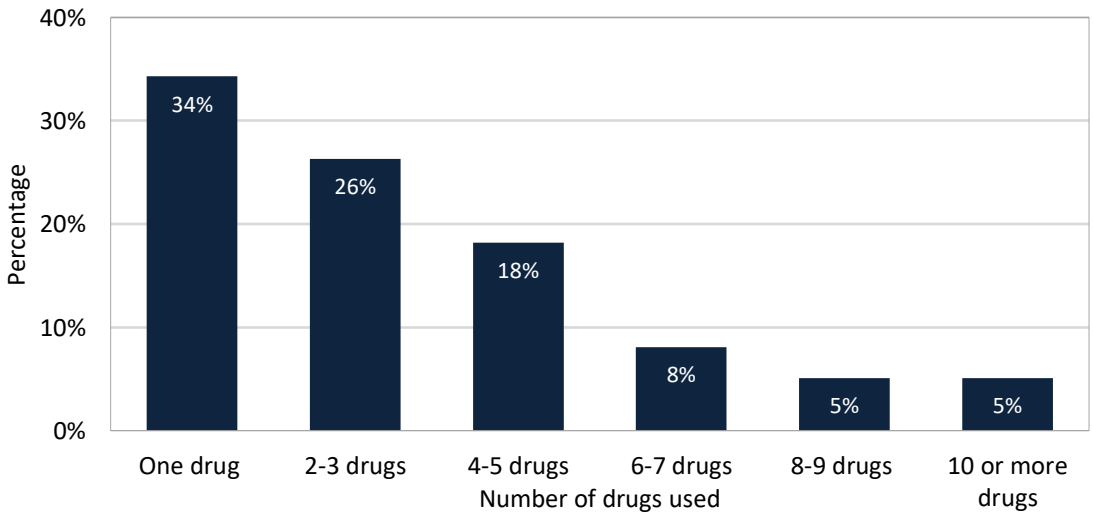
Figure 5: Illegal substances used by respondents

Substance	Number of respondents	Percentage
Cannabis	78	78.8%
Cocaine	55	55.6%
Amphetamine	38	38.4%
Ecstasy	33	33.3%
Heroin	25	25.3%
LSD	22	22.2%

Magic Mushrooms	22	22.2%
Crack	20	20.2%
Solvents / gas / aerosols	13	13.1%
Novel psychoactive substances	13	13.1%
Other drugs	6	6.1%

The majority of respondents who used illegal drugs reported multi-drug use, with nearly 1 in 5 using 6 or more different substances. Figure 6 shows the number and frequency of drug use amongst respondents.

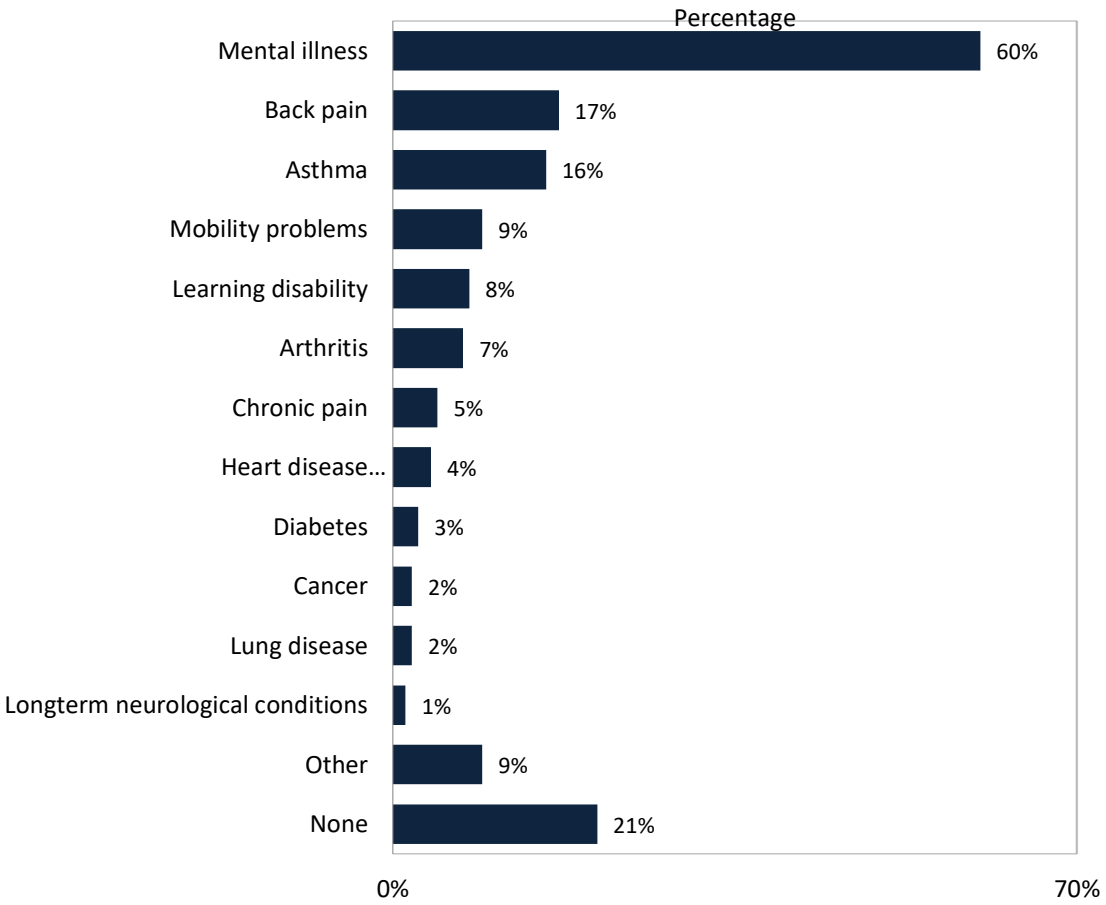
Figure 6: Multiple drug misuse



Respondents were asked to rate their general heath on a scale of 'excellent' to 'poor'. 71.2% of respondents rated their general health status as good to excellent, slightly below the Derbyshire average of 81% reported by the 2011 Census (ONS,

2012), and 6.1% rated their health status as poor. Respondents were also asked about the nature and number of their current health problems. This information was coded and categorised for analysis; where multiple mental health conditions were specified by a respondent, these were counted as one condition for the purposes of this analysis. 79.1% of respondents were found to have one or more health related problems. Figure 7 shows the nature and frequency of the conditions reported.

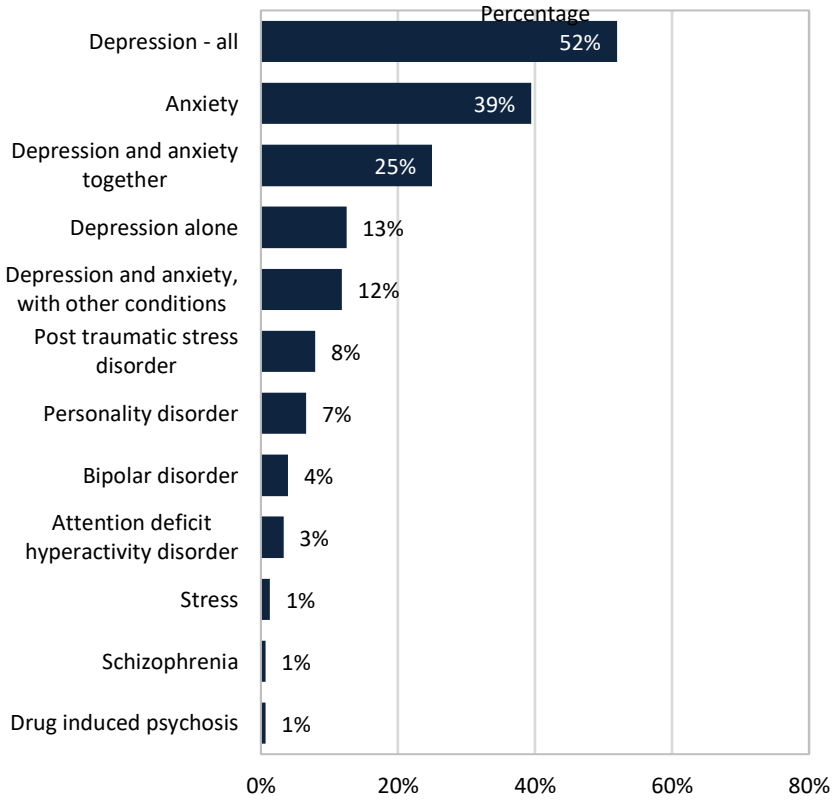
Figure 7: Health problems experienced by offenders, by frequency



Mental health problems were by far the most frequently reported condition, with 60.1% of respondents stating that they had one or more mental health problem. 98.9% of these reported having at least one co-existing physical health related condition. Amongst those respondents who specified a mental illness, depression

was the most common disorder reported (52.0%) with anxiety in second place (39.5%). Both depression and anxiety occurred alone or in combination with other mental health conditions but were reported together by 36.8% of the cohort. Post-traumatic stress disorder and personality disorder were the next most common mental health conditions specified, at 7.9% and 6.6% respectively.

Figure 8: Mental health conditions reported by community offenders



The Adult Psychiatric Morbidity Survey (2014) reported a prevalence of 5.9% for generalised anxiety and 3.3% for depressive episodes in the UK population aged 16 and over (NHS Digital, 2014; NHS Digital 2016). The prevalence of common mental disorders was far higher in this cohort of offenders than is seen in the general population.

When asked whether they were registered with a GP or dental practice, 7.5% of respondents that stated they were not registered with a GP and 39.6% said they were not registered with a dentist. 26.6% reported that they had not seen a GP for 6 months or more and 1.9% said they had never been seen by a GP. 53.6% reported that they had not seen a dentist within the last 6 months; 3.9% had never seen a dentist. Respondents were also asked whether they had experienced problems in getting help from any health services. Although the majority of respondents (74.1%) reported no problems, 13.9% reported that they had experienced problems in getting help.

Qualitative Results

The data collected from 19 semi-structured interviews carried out by probation professionals with community offenders provided insight into both the health profile and health needs of Derbyshire's community offenders. Respondents represented age categories from 18-19 years to 50-59 years. The majority (15 out of 19) were male; 17 reported their ethnicity as White and 2 as Asian/ Asian British.

When asked about their health status, the majority of offenders reported having health problems. These included mental ill health, long-term pain, reduced mobility, sexually transmitted infections, blood borne viruses (BBVs) and ophthalmic and brain conditions. Respondents reported that these conditions affected their daily activities; effects included being prevented from working, difficulties with leaving the house, and walking distances. Problems with aggression, memory loss and with being on time or remembering things were also reported.

Several offenders felt healthcare and probation services had been both good and accessible '*GP has been fabulous – can't fault it*.' '*Probation give me help and keep me out of prison. I don't know what I would do without them*.' However, others expressed mixed opinions about whether they were able to access help for all their health problems and several offenders expressed reluctance to ask for help for specific conditions. Some attributed this to a fear of treatment, previous poor experience, embarrassment, not knowing where to get help and deteriorations in mental health.

Offenders regarded hospitals, dentists and GPs as being difficult to access, and often had problems not knowing '*where to go or who to ask';* they also struggled with the long waiting lists. Getting a GP appointment was found to be particularly problematic with reports of '*waiting up to an hour on phone to get through* [to GP]*, then when you do get through there's no appointments left*.' One respondent reported that he still requires support to avoid relapse/deterioration but was finding it harder to access that support as his mental health improved. Offenders felt that improving communication, and in particular more phone numbers and general practice staff answering the phone more quickly, would help to improve the service they received, as would more staff and appointments. Others felt that flexible services, such as those based in the community or drop-in sessions, would help. Offenders felt that training staff and increased awareness of offenders' needs would result in improved services.

Online questionnaires were completed anonymously by 49 health and probation professionals. These respondents reported a range of factors that they believed had

an impact on the needs of community offenders, including their physical and mental health, their self-confidence, their lifestyles and wider determinants of health, such as housing and financial issues. Many respondents talked about issues with accommodation:

'*Stable accommodation proves to impact the health of offenders both physically and mentally. Unsuitable accommodation can exacerbate existing health problems and also contribute toward the decline in mental health.'* Concerns were also expressed about the effect that homelessness has on both individuals and the wider society. '*Homelessness - creates health concerns - increases mental health [problems], exploits vulnerabilities, increased addictions, increases deeper involvement in drugs and alcohol addiction, increases health issues in relation to prostitution*.'

Accommodation problems were often intertwined with financial issues: '*Housing benefit claims taking a long time to process resulting in some landlords demanding the tenant pays the arrear.'* Financial constraints were also thought to affect offenders 'ability to eat healthily; '*With a limited budget, often only able to buy bare necessities, which is cheap, high sugared and high salted with saturated fats. They lack equipment and opportunity to cook proper healthy foods*.'

Respondents reported that offenders often had difficulty accessing health services and that many lacked the confidence to book and keep appointments. They felt that offenders had difficulty registering with a GP, often attributing this to a lack of knowledge, the transient nature of offenders and lack of acceptable identification. Respondents felt that the rigid primary care framework prevented offenders from seeking or receiving adequate and necessary healthcare:

‘*They are therefore easily overlooked and forgotten. In addition, when our clients present as problematic and complex, there can be a lack of readiness to fully assess their needs, as this does not fit within the five minute appointment.’*

Respondents believed that community offenders often did not seek health care support for their needs, in particular for mental health issues, drugs and alcohol issues and lifestyle issues. It was believed that a large number of offenders require mental health support, but many do not follow this up due to a lack of skills, confidence and motivation. Several respondents discussed the fact that individuals who are unable to get the support they need may reoffend, ‘*They* [community offenders with mental health problems] *do not get the support they need, their lifestyle deteriorates, they commit crime.’*

Respondents felt that services often failed to accommodate the chaotic lifestyle of community offenders; long waiting lists and rigid appointment times were considered particularly problematic. ‘*There are no real dental provision for emergencies, and then if they need a dentist, there are waiting lists to become an NHS patient that is months in advance and, by that time, the person forgets, or gets ‘struck off’.’* Respondents believed services needed to be made easier to access for community offenders and transient populations. More flexible access to services was a recurring theme. Respondents suggested examples to improve access such as drop in clinics where there was no need to book in advance, or appointments with more flexible times. ‘*Some offenders also hold down a job and are unable to attend day-time appointments as the employer won’t allow them time off*.’ In particular, it was felt that GPs and mental health services needed to be more flexible, ‘*Better understanding*

that offenders do not live a conventional life and this impacts on their ability to keep to times/dates etc.'

Discussion

Whilst there is a body of published literature on the health needs of offenders in prison, the health and wellbeing of offenders in the community has not, so far, attracted similar attention. Recent changes in incarceration policies (Parliament UK, 2015) mean it is probable that the number of offenders residing in, or serving part of their sentence in the community will increase, suggesting that there is an urgent need to understand both the health needs of community offenders and how these can be addressed to reduce reoffending behaviour.

An elevated rate of mortality amongst community offenders is frequently reported, suggesting an excessive prevalence of high risk health problems in this population (Brooker *et al*., 2008). This article found that community offenders were less likely to practise healthy behaviours (such as consuming enough fruit and vegetables or undertaking regular physical activity) and are more likely than the general population to smoke, misuse drugs or drink alcohol to excess. This is of particular concern as these behaviours are associated with an increased risk of long term physical health problems and poorer mental health (Schulte and Hser, 2017).

Our finding that community offenders have a higher prevalence of smoking than the general population aligns with the existing evidence base (Brooker *et al*., 2008). This could be attributed to the higher percentage of offenders having a lower socioeconomic status or experiencing health inequalities (ASH, 2016) or their

transient lifestyle, which makes it difficult to offer joined-up cessation support (ASH, 2016). This study also added to the existing evidence, with a finding that the majority of respondents who were smokers were under the age of 35. This is of particular concern because adolescence is a time of rapid neurocognitive and hormonal change, making young people particularly vulnerable to smoking initiation and nicotine addiction (Breslau *et al.,* 1993; Towns *et al.,* 2017). Starting to smoke at an early age is associated with heavier smoking in adulthood (Taioli and Wynder, 1991). This means that adolescent smokers will be at increased risk of the later life health hazards associated with smoking, such as respiratory and cardiovascular disease. In line with this, people in contact with the criminal justice system are known to have high levels of co-morbidities (Revolving Doors Agency, 2013).

This study found a remarkably high burden of physical and mental ill health amongst community offenders and found that their lives are often complicated by multi-morbidity and complex social and personal issues. Evidence has shown that, in some cases, an individual's propensity towards crime is determined by three factors; mental health, alcohol and substance misuse (Keay, 2014), and chronic social exclusion (ASH, 2017). Social exclusion is often attributed to a person being faced with problems like poor health, unemployment, inadequate housing, crime or discrimination (Public Health Wales, 2010). Respondents in this study reported problems with the majority of these factors. Furthermore, a lifetime of social exclusion or its consequences are associated with poor mental health (Seymour, 2010). Community offenders frequently require mental health support (Sainsbury's Centre for Mental Health, 2008) and are reportedly unlikely to engage with services providing mental health support (Northamptonshire County Council, 2014). Failure to

provide sufficient support to those with complex mental health needs allows offenders to fall into a cycle of increased risk of poor health and offending and reoffending (London Assembly Health Committee, 2017).

The alcohol consumption behaviour reported by respondents is of concern as heavy drinkers are known to have an increased risk of long term physical health problems and a higher risk of injury, and also poorer levels of mental health than their low risk or non-drinking counterparts (Public Health England, 2016). Alcohol misuse, as well as other substance misuse often co-exists with common mental disorders such as depression and anxiety (Public Health England, 2016). Whilst little evidence specifically explores the effects of alcohol misuse amongst offenders in the community, it is thought prisoners who have committed alcohol-related crimes are at serious risk of re-offending unless they are provided with adequate care (Prison Reform Trust, 2004). For this reason, the Prison Reform Trust (2004) recommends that an effective screening process should be implemented to identify hazardous drinkers as offenders are received into custody.

In our HNA, we found that 63.5% of offenders reported that they had used illegal drugs. It is possible that a large percentage of acquisitive crime, such as shoplifting and burglary, can be attributed to problem drug users (Firth, 2014). Although it usually takes many years to help an individual overcome an addiction, treatment for substance addiction is reported to have an immediate impact on their offending (National Treatment for Substance Misuse, 2009). In 2017, the National Treatment Agency for Substance Misuse reported that the number of offences committed by

opiate and cocaine users almost halved, with 50% of offenders completely ceasing to offend following the start of treatment.

Despite wide recognition that access to health care services is important for the promotion and maintenance of health, the prevention and management of disease and reducing unnecessary morbidity and premature death (Office of Disease Prevention and Health Promotion, 2019), access to services are a well-known problem for community offenders (Brooker *et al.*, 2008) and many respondents in this paper reported difficulties getting help. Given the large number of both physical and mental health problems reported by this group of community offenders, and the high prevalence of multi-morbidity amongst them, these findings are of concern, not only in relation to the management of existing problems but also for preventing the acquisition of new conditions. In line with this, this paper found that, amongst this cohort, many community offenders reported not being registered with primary care services (7.5% of responders were not registered with a GP and 39.6% were not registered with a dentist). It is possible these numbers are an underestimate as patients may be removed from their GP's list if they move out of the area covered by their practice (NHS, 2018) and may not have necessarily been notified. In part, problems with access to services arise because registration with a general practice or a dentist requires a home address and many offenders are homeless or have only temporary accommodation. The lack of a fixed home address can also be problematic for offenders in contact with secondary care, making it difficult for them to receive appointments or information by post (London Assembly Health Committee, 2017). Health and probation professionals reflected numerous concerns about the housing of community offenders, with particular concern over the number

of community offenders who were homeless. Evidence has shown that homelessness or living in temporary accommodation prior to a prison sentence, unemployment in the 12 months prior to custody, and using class A drugs are important factors in predicting reoffending in those who are released from prison (Brunton-Smith and Hopkins, 2013).

Strengths and Limitations

A particular strength of this health needs assessment is its ability to provide an understanding of the health and wellbeing in a population of interest. It highlights community offenders' unmet needs and reveals the impact their existing ill health has on their lives and employment prospects. It also seeks to assess the adequacy of services now and in the future, and to identify appropriate and effective interventions. This HNA employed a mixed-methods approach; use of both a qualitative and a quantitative approach to the assessment of needs is a particular strength of this HNA. The approach has given emphasis to the offender's first-hand experience (California State University, 2017) and helped capture their experiences and views (Al-Busaidi, 2008; Fitzpatrick and Boulton, 1994; Mays and Pope, 2000). A further strength was felt to be the use of a semi-structured interview guide enabled interviewers to elicit from participants the factors that they felt were important (McGrath *et al.,* 2018). Furthermore, this approach has fostered consistency and continuity, by ensuring that the same questions were posed to each participant, increasing the robustness of the data collection (McGrath *et al*., 2018).

It is widely recognised that offenders are a hard to reach subgroup of the population. Because of these challenges, this study recruited participants using a convenience

sampling methodology. It is possible this sampling method may have resulted in selection bias and the lack of youth offenders interviewed could mean that the findings may not be representative of the views of the wider community offender population. However, these concerns were taken into consideration and relevant professionals for youth offenders have been interviewed. The possibility of bias has been taken into consideration when interpreting the results and given the known problems with engaging this subgroup in research this is felt to be the most appropriate method.

As professionals and service users are known to frequently display divergent views when questioned (Stiggelbout and Van der Weijden, 2012), a significant strength of this HNA is that the views of both professional and service users have been sought and triangulated in the analysis. This HNA has shown that the views of stakeholders largely concur with what literature there is on the health needs of offenders; however, the striking lack of research relating to the health of offenders in the community as opposed to offenders in prison (Brooker et al., 2008) makes it difficult to robustly triangulate the findings of this HNA with established knowledge.

The methodology employed for this HNA was both time-consuming and technically demanding. It required robust project management, both in the preparatory phase and throughout the project. Should the methodology be employed in the future, it is recommended that consideration be given to whether the skills and resources to design, conduct and analyse the data collected are available, to ensure that both quantitative and qualitative data are accurately captured, interpreted and utilised. An important recommendation for future researchers employing a similar methodology is

to ensure they take time to both appropriately design, pilot and analyse their questionnaire; this will help to flag any issues that might lead to challenges in analysing the captured data.

Although a number of caveats with the methodological approach taken to determine the health needs of community offenders in the community for this HNA have been highlighted in this paper, recommendations for strengthening the methodology for future applications have also been identified. This paper has also highlighted the complex and multi-factorial needs of community offenders. Therefore it is evident that all organisations who have contact with community offenders have a duty to act as 'Boundary Spanners,' reaching across organizational boundaries to collaborate and therefore not work in silos (Williams, 2002).

Conclusions

This paper found that community offenders have significant issues with physical and mental health problems and substance misuse, which are complicated by difficulties accessing services and wider determinants of health. This paper sets out the methodological approach taken to understand the health needs of community offenders in Derbyshire. Methods for assessing the health and health care needs of a population may be limited by time and resource. However, where is it possible to overcome these obstacles, pursuing the goal of undertaking a robust and comprehensive HNA facilitates the planning and delivery of effective care and services to those in greatest need, ensuring that scarce resources are allocated where they can give maximum health benefit. This approach provides a practical and transferable framework for identifying, understanding and addressing health needs,

which we believe can be used to provide a comprehensive assessment of the health and social care needs of community offenders.

This paper sought to share the methodology used to understand the health needs of a community offender population and some of the key findings we have found about their health needs. These findings may have implications for policymakers, commissioners and providers of health services ensuring these are accessible and acceptable for offenders in the community. We hope that this paper will facilitate further research within this particular population group, thereby improving both the comprehension of community offenders' health needs and the ability to adequately address these needs. We believe further research in this area alongside addressing these needs is an important part of the prevention of further offending and will benefit not only the individuals at risk of offending or reoffending, but also their families, communities and the wider society.

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