A report on the findings of the ADASS survey of social care activity in prisons and approved premises - Quarter 1 2015/16

1. Introduction

The Care Act 2014 "clarified" local authority responsibilities for people living in prisons and approved premises and this report describes what happened in the first 3 months from when the legislation was implemented in April 2015.

From April 2015 all local authorities with a prison in their area received an additional non-ring-fenced funding allocation to support these new responsibilities. Each authority's allocation was based upon modelling undertaken jointly by the Department of Health and NOMS based on:

I. The number of prisons in the local authority area
II. The age profile of the individual prison
III. The prison's role i.e. a local prison with a high turnover of prisoners may generate more referrals but a specialist unit for sex offenders will have a lower turnover of prisoners but with more of them being older they were assumed to require more care and support services.

As well as answering specific questions, respondents were also invited to make comments on any issues that they considered relevant to the survey and these have been included in the script of this report where appropriate.

No individual local authority is named within this report as is the convention with other such surveys undertaken by ADASS.

It was hoped that this survey may indicate whether the modelling reflected practice and if not what changes in allocations needed to be made for 2016/17

This ADASS survey invited all local authorities in England with either a prison or approved premises to submit information on the following areas of activity for the 3 months April-June 2015:

I. Referrals
II. Assessments
III. Eligibility for care and support
IV. Nature of care and support provided
V. Cost of provision
VI. Use of advocacy
VII. Charging of individual prisoners

2. Response rates - Prisons

The survey was returned by 33 of the 59 authorities (56%) with prisons and data provided for 79 of the 115 (69%) prisons in England.

3. Prison referrals

In the 3 months surveyed the 79 prisons had generated 542 referrals with 14 prisons not having generated any and 60 having generated 10 or less.

Table 1 – Distribution of referrals from prisons

Number of referrals generated by prison	Number of prisons
Nil	14
1-5	27
6-10	19
11-15	7
16-20	7
21-25	2
26-30	2
30+	1
TOTAL	**79**

We have provided professional support only in a variety of cases, to facilitate safe hospital discharge co-ordination, assistance to access other services within the prison environment, and provide information and advice with regard to benefits.

Development sessions booked in with the Prison and Approved Premise Manager to understand better the social work and prison/MOJ systems and practice and to continue to establish better relationships as an on-going piece of work.

For quarter one we have a nil response as no activity recorded, although we believe that there may be activity relating to mental health that we have not been able to trace for the purposes of this survey.

Working closely with our partners within the prisons and healthcare has helped us to understand each other's roles.

As well and completing assessments, the principal practitioner also attends safer custody meetings and attends Multi-disciplinary meetings to discuss complex cases, and provide ongoing support and advice to the prisons with regards to adult care.

The arrangements involve a group of link social workers attending the prisons for a half day each week to provide access to social care advice, information and assessment for prisoners who self-refer or who are referred by staff…. the model is working well and referrals could rise with some additional information being made available to staff and prisoners.

Issues of who's responsible for what - particularly with healthcare in one of the prisons, lack of co-operation with regard to sharing information, unco-operative with care. Issues with one prison about their duty of care and their officers responsibilities. A lot of time spent communicating and trying to find someone to communicate with, significant council resource in the first quarter implementation. I'm hoping it will change once dedicated Social Workers are in place.

There is close working with all prisons to support and educate re the remit of social care and also to ensure referrals that should be being referred are. There remains further work to be undertaken to ensure this is so

Although we have had no referrals from our prison this is likely due to the lack of understanding from the local prison than lack of need.

Respondents were asked to indicate the primary client category of the referrals although it should be noted that local authorities classify people aged 65+ as "older" whereas in prisons the age of 50 is usually taken to indicate older prisoners on the basis that their life experiences will generally lead to the onset of conditions associated with older age at around 10 years earlier than the rest of the population

Table 2 – Distribution of referrals by primary client category excluding "other/unspecified"

Primary client category	Number of referrals	% of total referrals
Older physically disabled/frail	186	39.8
Older mental health	13	2.8
Adult physically disabled	224	48.0
Adult learning disabled	20	4.3
Adult mental health	20	4.3
Autistic spectrum condition	2	0.4
Substance misuse	2	0.4
Total	**467**	**100**

The distribution of referrals, where a primary client category was identified indicates that the majority (87.8%) were related to physical conditions. The numbers of "adult physically disabled" surpassing that of older prisoners is perhaps a little surprising but would possibly benefit from more detailed examination to ascertain what proportion are in the 50-64 year range and therefore in prison terms would be considered as older.

The low referral rates for mental health and substance misuse is probably a reflection of there being dedicated health services for these conditions established within prisons prior to April 2015 which may also be meeting the social care needs of prisoners. We do however need to be confident that such an assumption is correct and that the potential contribution of social care to support such prisoners is not overlooked.

In March 2015 HMIP published its thematic report "*A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system - phase two in custody and the community*" This report expressed serious concerns about the identification of prisoners with a learning disability or autistic spectrum condition and therefore the prisons' abilities to respond to their specific needs, keep them safe and provide appropriate therapeutic inputs. There is no definitive assessment of the number of prisoners living with a learning disability or autistic spectrum condition and many will undoubtedly be on the cusp of a clinical diagnosis but the author is advised that the most reliable assessment suggests that some 7% of the prison population may have a learning disability or autistic spectrum condition. Other researchers have put the figure much higher (up to 30%).

With less than 5% of referrals being identified as potentially having a learning disability or autistic spectrum condition the suggestion that there is an under identification of such individuals would appear to have some validity.

We are aware of a huge untapped area of work for LD and MH which we are keen to deliver

4. Conversion of referrals into care and support assessments

A referral does not automatically lead to a full care and support assessment being undertaken as they are screened first to see if the presenting issue is one that is appropriate for a social care response. As a consequence an average of 74% of the referrals led to a care and support assessment being undertaken but there were significant difference across the client categories with physical disability/frailty and adult mental health averaging around 80% but learning disability and autistic spectrum conditions only averaging around 50% and older prisoners with mental health issues only scoring 38%

Not all referrals have been appropriate however all individuals have been seen by social care professionals and advice and information given in the instance where assessment is not appropriate.

OT and sensory services have been proactive in the delivery of advice and information and there has been some good collaborative work with colleagues in the prison looking at the overall needs of the prison in relation to sensory equipment i.e. hearing aids.

Table 3 – Conversion rates of referrals to care and support assessments

Primary client category	**Number of assessments**	**Conversion rate from referral to assessment (%)**
Older physically disabled/frail	148	80
Older mental health	5	38
Adult physically disabled	182	81
Adult learning disabled	11	55
Adult mental health	16	80
Autistic spectrum condition	12	50
Substance misuse	2	100
Other	0	-
Total	365	74%

Looking at individual local authorities, there are clear differences in approach which probably indicate the degree of pre-assessment that is undertaken within the prison, usually by prison healthcare staff.

Table 4 – Conversion rates by prison

% of referrals converted to assessment	Number
0-25	12
26-50	6
51-75	5
76-100	42
Total	**65**

An important element of the Care Act is the provision of information, advice and guidance to support wellbeing and those local authorities that have a low conversion rate from referral to assessment need to satisfy themselves that they are still delivering this element of their responsibilities.

5. Conversion of referrals and assessments to eligibility for care and support services

The Care Act introduced a national eligibility scheme for care and support services with the aim of reducing the effect of "postcode lottery." The intention behind this is that while individual local authorities may meet eligible needs in different ways, the entitlement to having those needs met should be consistent across the country. This is particularly important for prisoners who may move between local authorities during the course of their sentence.

To be eligible for care and support services an individual must:

I. Have needs that arise from or are related to a physical or mental impairment or illness
II. As a result of their needs be unable to achieve 2 or more of a list of 10 specified outcomes
III. As a consequence of not being able to achieve these outcomes there is, or there is likely to be, a significant impact upon the individual's wellbeing

The findings from this survey indicates that the average conversion rate from referral to eligibility is 45% but that within this there is a wide range of scores from 0 to 100%.

Recognising that there are different approaches to pre-assessment activity across the country, it is then perhaps more valuable to look at the conversion rate from assessment to eligibility but this tells a similar story albeit that the conversion rate now increases to 60%.

Whilst in some cases the numbers of referrals and assessments are too small to be statistically significant the variation in the conversion rates of assessments to eligibility does suggest varying practices across the country with the possibility, as is being identified in the broader community, that there is more work to be done to ensure a consistent interpretation of the national eligibility criteria.

Another way of looking at conversion rates to eligibility is to do so by primary client category and this suggests significant differences again.

Table 5 conversion rates to eligibility by primary client category

Primary client category	Number of assessments completed	Number eligible for care & support services	% eligible for care & support services	% of total eligible for care & support
Older physically disabled/frail	148	100	68	45
Older mental health	5	4	80	2
Adult physically disabled	182	98	54	45
Adult learning disabled	11	8	73	4
Adult mental health	16	9	56	4
Autistic spectrum condition	1	0	0	0
Substance misuse	2	1	50	Less than 1
Total	**365**	**220**	**60**	**100**

It is clear that older prisoners are more likely to be assessed as eligible for care and support than those who are younger and 90% of those eligible have either a physical disability or frailty.

As referred to earlier, the identification of prisoners with a learning disability or autistic spectrum condition is lower than one would reasonably expect within this population and the fact that local authorities have only found 67% of those people that they assessed as having either a learning disability or autistic spectrum condition eligible for care and support might suggest that they too are operating to a high threshold and maybe not recognising the vulnerability of those on the cusp of a clinical diagnosis.

6. Activity compared to DH/NOMS modelling to inform individual local authority allocations

The slow start made by many prisons and local authorities means that it is not practicable to draw firm conclusions on whether the levels of activity are in line with the modelling expectations either as a whole or in individual prisons. It is hoped that colleagues in NOMS may be able to do some work to indicate where there may be particular prisons that are performing significantly either above or below expectations so that the reasons for this can be explored in more detail i.e. if some prisons are performing at a higher level than anticipated, this may indicate where good practice should lead the others, especially where there is a high conversion rate from referral to assessment and then to eligibility.

7. Provision of advocacy support

The Care Act made provision for people who were unable to fully engage in the assessment and care and support planning processes to be provided with an independent advocate by the local authority and this provision also applies to prisoners.

For prisons where responses were provided there were only 6 examples recorded of individuals requiring this level of support, 5 older physically frail prisoners and one adult with physical disabilities.

This is a low level of take up, but many authorities are reporting similarly low levels in the wider community although there are much higher levels of activity under the Mental Capacity Act (MCA) provisions but MCA was not sought in this survey.

8. Charging for care and support

The Care Act clarified that as well as proving for the care and support needs of prisoners, local authorities also had the discretion to seek financial contributions from them towards the cost of their care and support as they do for citizens in the wider community. Before the implementation of the Act there was much debate within local authorities as to whether it was worthwhile pursuing the charging of prisoners given that many of them were unlikely to have sufficient income to make them eligible to pay. Most authorities decided that they would retain the right to charge prisoners in the same way as other citizens but would take a “proportionate” approach to how they addressed this.

The survey asked authorities to indicate how many of those prisoners eligible for care and support services for whom they could charge they had actually undertaken financial assessments of. It must be remembered here that authorities cannot charge for most items of equipment or for the provision of reablement services so the actual number of prisoners who could have been financially assessed during this first quarter period would be small.

Only 11 prisoners are reported as having been subject to a financial assessment (4 older frail and 7 physically disabled) and only one of these has been assessed as eligible to contribute to their care and support costs.

9. Meeting eligible needs for care and support

The survey sought information on 3 aspects of meeting eligible needs for care and support:

I. The relative proportions of prisoners whose needs were met by a one off or short term intervention versus those who are likely to require ongoing support
II. The numbers of prisoners whose needs were met by the provision of equipment
III. The weekly costs of meeting ongoing care and support needs

16 authorities indicated the relative proportion of prisoners whose needs were met by a time limited intervention versus those requiring ongoing support and no clear picture emerged. In part this was because of the limited numbers of individuals supported but it may also reflect different approaches by authorities in how they meet needs. It is worth noting however that those authorities that have assessed the highest numbers of prisoners as eligible for care and support are also generally, but not exclusively, those that have reported the highest proportion of prisoners requiring ongoing care and support provision.

Local authorities report 86 prisoners as having their needs met by equipment alone although the survey did not make sufficiently clear whether this was just meeting eligible need as opposed to providing equipment as a preventive measure and therefore there may have been differing interpretations from respondents. However, even at the most conservative of interpretations i.e. the proportion of those assessed whose needs were met by equipment alone, the suggestion that 24% (86/365) had their needs met in this way suggests that a strong occupational therapy capacity within prisons is of value

Only 11 local authorities submitted information on the costs of meeting eligible care and support needs but these 11 authorities accounted for 41 individual prisons.

Calculating an average cost for meeting the ongoing care and support needs of a prisoner is difficult as some individuals may have very high levels of need and therefore distort an average figure when there are only small numbers receiving services. For this reason one authority's return for older prisoners with physical disability or frailty has been removed from this analysis as it was very much as outsider.

The cost of 1 person is equivalent of approximately half the allocated budget, not inclusive of staff time and equipment costs.

Table 6 – Average weekly cost of meeting ongoing eligible care and support needs by primary client category

Primary client category	**Older physical disability/frailty**	**Older mental health**	**Adult Physical Disability**	**Adult Mental Health**
Average weekly cost per prisoner	£233	£240	£200	£200

10. Prisons – conclusions and recommendations

I. Looking at the first quarter of activity it is apparent that whilst some prisons and local authorities have made a good start in identifying and responding to need, others are still to make a start. Those authorities that have still not received more than say 10 referrals from any of their prisons might want to meet with the prison and healthcare management to satisfy themselves that not only are systems and processes understood but also that key staff understand the local authority's responsibilities and the value that social care input can provide,

II. Although not investigated as part of this survey, local authorities, prisons and healthcare providers might wish to review the provision of information for prisoners to enable them to self-refer for assessment. Colleagues are reminded that RECOOP have produced a suite of information leaflets and posters in easy read format that can be downloaded for free and re-printed with only minor additions (how to contact the local authority).

III. There is evidence that people with a learning disability or autistic spectrum condition are often not recognised as having specific needs within the prison system. Local authorities, prisons and healthcare providers are advised to consider how effective local approaches are in respect of this population

IV. In the community there is well established practice of health and social care professionals working together in an integrated way to respond to the needs of people with mental health issues, substance misuse, learning disabilities or autistic spectrum conditions but this is not the experience in prisons in recent years. Local authorities and prison health care commissioners and providers might wish to explore how a more integrated approach to meeting prisoners with these needs might be developed

V. The Care Act places a responsibility on local authorities to provide advice, information and guidance to citizens to enhance their wellbeing and provide preventive support to reduce either the timing or severity of social care needs developing later. Local authorities need to assure themselves that they understand what this means in the context of prisoners and are providing it and not setting so a high threshold for eligibility for a care and support assessment that it effectively denies prisoners access to this valuable entitlement.

VI. Local authority allocations for meeting the costs of their new responsibilities for prisoners were calculated on a model developed jointly by the Department of Health and NOMS. It was hoped that this survey would help identify any changes that might be required to be made to these allocations based on real experiences. Unfortunately this survey does not indicate that we have yet reached a fully implemented state of activity for the prison population. Consequently there may be merit in revisiting the modelling based on the best performing prison systems and using the costings for ongoing care and support provision which indicate figures of around £240 a week for older adults and £200 for adults of working age.

VII. As in the wider community, the provision of advocacy support under the Care Act (as opposed to Mental Capacity Act) is still bedding down and numbers are probably lower

than they should be. Local authorities may wish to review their thresholds for providing advocacy to ensure that they are compliant with the Care Act.

VIII. Finally, with so many prisons and local authorities still really to start working together effectively, there may be some value in undertaking some detailed reviews of systems that appear to be working well to develop learning from their successes that can be shared with others to accelerate their progress

11. Approved premises – Response rates

For authorities with approved premises, the response rate to the survey not as good as for those with prisons. There are 73 authorities in England with approved premises accounting for 99 establishments. In the survey, 30 authorities (41% of national total) indicated that they had one or more approved premises accounting for 39 (40%) establishments.

12. Referrals, assessments & eligibility

Across the 39 individual establishments named there had only been 7 referrals for assessment in the first 3 months of the financial year (older frail -2, older MH – 1, adult PD – 2, adult MH – 1, autistic spectrum condition (ASC) – 1).

These referrals had in turn generated 5 assessments with 4 individuals being considered as eligible for care and support services (1 each of older frail, adult PD, adult MH and ASC).

The individual with physical disability had been recalled to prison as the approved premises was an unsuitable environment given the nature of his disabilities. The adult with mental health issues was also recalled to prison.

Approved premises was not a suitable location for the delivery of intimate personal care. Customer was an amputee and the facilities at the AP were challenging.

We have had 2 people identified as qualifying for assessment and the individuals have been offered an assessment, both have declined and not considered at risk under safeguarding - , we have met their wellbeing requirements through liaison with the manager at the AP

To date we have received no referrals or requests for assessments. The approved premises staff are aware of how to refer if necessary.

13. Advocacy

Only the individual with an autistic spectrum condition was considered to require advocacy support.

14. Charging

One individual was financially assessed was not considered eligible to contribute towards the cost of their care and support

15. Approved premises – conclusions and recommendations

I. The number of responses and the level of activity in relation to referrals and assessments indicates that there is very little demand being generated by approved premises. The population in approved premises is much smaller than that in prison and lower referral rates are therefore understandable but local authorities and approved premises providers may wish to review that not only are systems and processes

understood but also that key staff understand the local authority's responsibilities and the value that social care input can provide

II. The small number of referrals and assessments undertaken to date and reported in this survey does not make any further analysis worthwhile at this stage but there may be value in attempting a further survey just of approved premises based on the first year's activity to gain a fuller picture then.

16. Summary of recommendations

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