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COCOA: Care for Offenders Continuity of Access

Richard Byng,[1] Cath Quinn,[1] Rod Sheaff,[2] Chiara Samele,[3] Sean Duggan, [3] Dean Harrison, Christabel Owens,[4] Philippa Smithson, Christine Wright,[4] Jill Annison,[2] Chris Brown,[5] Rod Taylor,[4] William Henley,[4] Adam Qureshi,[1] Deborah Shenton,[1] Ian Porter,[1] Claire Warrington,[3] and John Campbell.[4]

[1] Peninsula College of Medicine and Dentistry, University of Plymouth, England
[2] University of Plymouth, England
[3] Centre for Mental Health, London, England
[4] Peninsula Medical School, University of Exeter, England
[5] University of Swansea, UK

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Address for correspondence:

Richard Byng
Primary Care Group
Health Services Research
Peninsula College of Medicine and Dentistry
Room N32, ITTC Building, Tamar Science Park
Derriford, Plymouth, Devon, PL6 8BX

Email: richard.byng@pms.ac.uk

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Contents

List of tables 8
List of figures 10
Glossary of terms 11
Explanation of codes used for research data sources 14
Abbreviations 15
Acknowledgements 18
Executive Summary 20
Background 20
Aims 20
Methods 20
Results 21
Conclusions 22
The Report 25
1 Introduction 25
1.1 The problem of providing healthcare for offenders 25
1.2 Aims and objectives 25
1.3 Theoretical orientation 26
1.4 Overview of the study 28
2 Background 31
2.1 The Criminal Justice System 31
2.2 Health status of offenders 32
2.3 Healthcare for offenders 33
2.4 Continuity of care 35
2.5 Defining continuity for offenders 36
3 Provisional programme theory for continuity of care for offenders 38
3.1 Realistic Evaluation 38
3.2 Method for developing the 'provisional programme theory' 39
3.3 'Provisional programme theory' 43
3.3.1 Policy presumptions 43
3.3.2 Packages and components 45
3.3.3 Discussion 48

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4 Method 49
4.1 Overall Design 49
4.1.1 Changes to protocol 51
4.2 Offender Level Data Collection 51
4.2.1 Individual Offender Interview (data collection) 52
4.2.2 Focus Groups (Data collection) 57
4.2.3 Health records (Data extraction) 58
4.3 Analysis of data from offenders 58
4.3.1 Analysis of quantitative data 59
4.3.2 Qualitative Analysis of Interview Data and Focus Groups: 61
4.4 Peer research contributions 64
4.5 System Wide Organisational case studies 65
4.5.1 Analysis of whole system case studies 66
4.6 Best practice mini-case studies 67
4.6.1 Selection and data collection 67
4.6.2 Analysis 68
4.7 Integration and mixed methods synthesis 68
4.7.1 Theoretical issues for mixing methods 69
4.7.2 Developing theoretical perspectives on continuity and access 70
4.7.3 Revising 'Programme Theory' for continuity of care for offenders 71
5 Results 72
5.1 Overview of results 72
5.1.1 Quantitative offender longitudinal interview study 72
5.1.2 Description of the sample 75
5.1.3 Contact with criminal justice system 77
5.1.4 Perceived health problems 78
5.1.5 Views on healthcare provision and continuity of care 85
5.1.6 Continuity of access 91
5.1.7 Duration of healthcare contact 95
5.1.8 Quality ratings 96
5.1.9 Continuity of access rates 99
5.1.10 Validation study 100
5.2 Offender perspectives 103

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5.2.1 Peer researcher focus group findings 103
5.2.2 Access 103
5.2.3 Longitudinal continuity (following patients over an extended period of time) 104
5.2.4 Relational continuity 104
5.2.5 Flexible continuity 105
5.2.6 Communication 105
5.2.7 Recommendations 106
5.3 Depth analysis of interview and focus group data 106
5.3.1 The link between health and criminal justice involvement 107
5.3.2 Reducing reoffending: aspirations, motivators and other priorities 108
5.3.3 Conflicts with healthcare practitioners 109
5.4 Analysis of access and continuity 111
5.4.1 Initial access 111
5.4.2 Continuity of access 115
5.4.3 Longitudinal continuity 118
5.4.4 Relational continuity 119
5.4.5 Flexible/Holistic continuity 122
5.4.6 Communication 124
6 Organisational case studies 127
6.1 South West whole system case study 127
6.1.1 Case study context 127
6.1.2 Healthcare in the case study site 128
6.1.3 Police 130
6.1.4 Court facilities in the South West 133
6.1.5 Probation 135
6.1.6 Prison 138
6.1.7 Healthcare on entry 138
6.1.8 Medication and substance misuse prescribing 139
6.1.9 On-going healthcare in prison 141
6.1.10 Care during release period 142
6.1.11 No contact with Criminal Justice System 143
6.1.12 Relationships between criminal justice services and healthcare 143

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6.2 South East case study 144
6.2.1 Innovations beyond standard services 144
6.2.2 How is access to, and continuity of, healthcare for offenders promoted? 146
6.2.3 Limitations and challenges. 148
6.3 Mini Case Study: Probation Service – Health Support Service 149
6.4 Private young offenders institute 152
6.5 Whole system drugs project 155
6.6 Police – offender health programme 157
6.7 Court based multi-agency project 160
6.8 Prison – resettlement strategy 163
6.9 Summary of mini-case study findings 165
7 Access and continuity of care for offenders 168
7.1 Recent continuity of care literature 168
7.1.1 Initial access and continuity of access 169
7.1.2 Mechanisms for delivering access and continuity 170
7.2 Towards a revised programme theory for access and continuity of health for offenders 176
8 Discussion 183
8.1 Evaluation of results against previous literature 183
8.1.1 Prevalence and access 183
8.1.2 Narrative accounts 185
8.2 Strengths and limitations 185
8.2.1 Longitudinal offender study 186
8.2.2 Qualitative studies 187
8.3 Implications for policy and practice 189
8.3.1 Importance of engagement and relationships 190
8.3.2 Wider implications of the causal model for access and continuity 190
8.3.3 Developing a shared concept of self care and independence 191
8.3.4 Mental health 192
8.3.5 Care for substance misuse 193
8.3.6 Information Management & Technology (IM&T) 194
8.3.7 Joint commissioning and interdepartmental collaboration 194
8.4 Implications for research 195

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8.5 Conclusions 198
References 199
.....211
Appendix A: Friendly Invitation Letter 211
Appendix B: Offender longitudinal study questionnaire 213
Appendix C: Ethical Issues 240
Appendix D: Quantitative analyses 244
Appendix E: Peer researcher contributions 254
Appendix F: Offender vignettes 255
Appendix G: Pictorial representation of the relationship between criminal justice practitioners and healthcare 257
Appendix H: Implementation of policy presumptions in SW case study area 260
Appendix I: List of Peer Researchers 264

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List of tables

Table 1. Research Questions 29

Table 2. Policy presumptions across criminal justice settings 44

Table 3. Composition of initial study sample 52

Table 4. Inclusion and exclusion criteria for the study 54

Table 5. Socio-Demographic descriptors 76

Table 6. Sentences and duration 77

Table 7. Health problems by number of contacts and percentage of participants 80

Table 8. Health problem contact rate by co-morbidity group 84

Table 9. Co-ordination of care and sharing of information 88

Table 10. Proportions of healthcare problems influenced by CJS contact 89

Table 11. Proportion of healthcare contacts influenced by CJS contact by CJS setting 89

Table 12. Proportion of contacts influenced by the CJS by healthcare provider 90

Table 13. Number of healthcare contacts, person-months and contact rate for each CJS setting 91

Table 14. Number of contacts for different categories of providers 93

Table 15. Frequency of contacts for each category of health problem for each type of health service 94

Table 16. Number of contacts across CJS setting by broad care group 95

Table 17. Quality assessment of healthcare contacts in each CJ setting 96

Table 18. Quality assessment of healthcare contacts for each type of health service 98

Table 19. Quality scores of healthcare contacts by type of encounter 98

Table 20. Agreement values for self-report and records by category of contact 101

Table 21. Summary of mini-case study findings 166

Table 22. Revised policy requirements/objectives for healthcare across criminal justice settings 178

Table 23. Key continuity mechanisms to promote initial and on-going access to healthcare through the criminal justice process 179

Table 24. Age by group and sex 244

Table 25. Sentence type with duration (%) 244

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Table 26. Previous sentences 245

Table 27. Healthcare need (according to health services) and whether met..246

Table 28. Unadjusted Poisson random effects regression models for number of healthcare encounters by health problem category (showing *IRR* (*SE*); *p-value*) 247

Table 29. Average duration of healthcare contacts for each major category of health problem in each CJS setting (in minutes (SD)) 248

Table 30. Average duration of healthcare contacts for each health service type 249

Table 31. Number of contacts and participants in each broad care group with total contact time (in minutes).....250

Table 32. Average duration of healthcare contacts for each CJS setting 250

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List of figures

Figure 1. Process of developing programme theory 27
Figure 2. Process of 'provisional programme theory' 40
Figure 3. Transitions through the CJS 41
Figure 4. Screen shot of provisional programme theory (1) 46
Figure 5. Screenshot of 'provisional programme theory' (2) 47
Figure 6. Relationship between data sets 50
Figure 7. Completed Section C of interview questionnaire 56
Figure 8. Individual analyses and integration of findings. 70
Figure 9. Relationship between the different sections of the results 73
Figure 10. 'CONSORT-style' diagram 74
Figure 11. Co-morbidity in overall sample 82
Figure 12. Co-morbidity in prison 82
Figure 13. Co-morbidity in probation 82
Figure 14. Encounter rate by number of health problems reported and healthcare provider seen 86
Figure 15. Pictorial representation of access and continuity of healthcare for offenders…….. 169
Figure 16. Access and continuity (individual and service level) 171
Figure 17. Scatter plot of offender's self reported contacts with primary care services and GP records 251
Figure 18. Scatter plot of offender's self reported contacts with drug services and GP records 252
Figure 19. Scatter plot of offender's self reported prison contacts and prison records……. 252
Figure 20. Scatter plot of offender's self reported prison contacts and prison records (excluding prison initiated contacts) 253

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Glossary of terms

Age Concern	A charity specifically concerned with the needs and interests of all elderly people. Age Concern and Help the Aged have now collaborated to become Age UK.
Amphetamine	A psychostimulant drug which produces increased wakefulness and focus in association with decreased fatigue and appetite.
Amitriptyline	A type of medicine which acts on nerve cells in the brain, preventing serotonin and noradrenaline from being reabsorbed back into the nerve cells.
Benzodiazepines	(colloquially Benzo's) a psychoactive drug which results in sedative, hypnotic (sleep-inducing), anxiolytic (anti-anxiety), anticonvulsant, muscle relaxant and amnesic action. Benzodiazepines are useful in treating anxiety, insomnia, agitation, seizures, muscle spasms, alcohol withdrawal and as a premedication for medical or dental procedures.
Bio-psycho-social model	Relating to, or concerned with the biological, psychological, and social aspects in contrast to the strictly biomedical aspects of disease.
Category B prison	Prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult.
Category C prison	Prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.
Category D prison	Prisoners are those who can be trusted to be in an open prison.
Ensure	A dietary supplement drink.

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Health Champion	Offenders who have undertaken the Understanding Health Programme and exam. The Health Champion works like a volunteer health trainer, offering support on health issues and sign-posting to other services.
Health Support Service	A service based in a Probation Trust with health promotion workshops covering issues such as self-perception, relationship skills, alcohol awareness, conflict management, relaxation, and healthy eating.
Hepatology	Branch of medicine that incorporates the study of liver, gallbladder, biliary tree, and pancreas as well as management of their disorders.
Holistic	Emphasises the importance of the whole and the interdependence of its parts.
Inter-rater reliability	Denotes degree of agreement. It gives a score of how much homogeneity, or consensus, there is in the ratings given by judges.
Intraclass correlation coefficient	A descriptive statistic that can be used when quantitative measurements are made on units that are organised into groups. It describes how strongly units in the same group resemble each other.
Librium	A prescription drug used for relieving anxiety disorders and supporting withdrawal from alcohol dependence.
Methadone	A prescription replacement for heroin to prevent or reduce withdrawal symptoms.
Methadrone	A synthetic stimulant, now illegal.
Multivariate statistical analysis	Observation and analysis of more than one statistical variable at a time.
Olanzapine	An anti-psychotic prescription drug.

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Peer researcher	Person with a lived experience of the criminal justice system who contributed to the project.
Prince's Trust	A charity that works with young people.
Programme Theory	An assumption, implicit in the way the programme is designed, about how the programme's actions are supposed to achieve the outcomes it intends.
Prolific offenders scheme	Partnership working to identify people causing most harm to their communities and to deter potential offenders, and to facilitate rehabilitation and resettlement.
Purposive sampling	A selection based on the particular purpose of the experiment.
Recidivism	The tendency to relapse into a previous mode of, especially criminal, behaviour.
Remand	To be held in prison before being tried or given a sentence.
Revolving door offender	Someone with numerous short term prison sentences.
Subutex	Treatment for the withdrawal symptoms of opiate addiction.
Terrence Higgins Trust	Charity that campaigns on various issues related to AIDS and HIV.
Valium	A prescription drug to treat anxiety disorders.

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Explanation of codes used for research data sources

1xxx	SW offender interview	e.g. 1004
2xxx	SE offender interview	e.g. 2048
1xxxa/2xxxa	SW/SE first offender interview	e.g. 1027a
1xxxb/2xxxb	SW/SE follow up offender interview	e.g. 1117b
3xxx	Focus group	e.g. 3001
4xxx	SW staff interview	e.g. 4013
6xxx	SE staff interview	e.g. 6002
7xxx	Mini case study interview	e.g. 7101
PPxx	Policy document	e.g. PP7
Mxy	M = mini case studies, x = mini case study number, y = document number	
MCS1 (probation)	Mini Case Study 1, Probation based health promotion service	
MCS2 (YOI)	Mini Case Study 2, private youth offenders institute	
MCS3 (substance misuse)	Mini Case Study 3, drugs project working across CJA settings	
MCS4 (police)	Mini Case Study 4, police offender health programme	
MCS5 (courts)	Mini Case Study 5, court based multi-agency project	
MCS6 (prison)	Mini Case Study 6, prison resettlement programme	

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Abbreviations

AA	Alcoholics Anonymous
A&E	Accident and Emergency
AGM	Annual General Meeting
ATR	Alcohol Treatment Requirement
CALM	Controlling Anger and Learning to Manage it
CAMHS	Child and Adolescent Mental Health Service
CARATs	Counselling, Assessment, Referral, Advice and Throughcare
CBT	Cognitive – Behavioural Therapy
CFMHT	Community Forensic Mental Health Team
CI	Confidence Interval
CJA	Criminal Justice Agencies
CJS	Criminal Justice System
CMHT	Community Mental Health Team
CNS	Central Nervous System
COCOA	Care for Offenders: Continuity of Access
COCOA RICH	Care for Offenders: Continuity of Access, Research Into Change Highlighted
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CPN	Community Psychiatric Nurse
CRB	Criminal Records Bureau
DAAT	Drugs and Alcohol Action Team
DBT	Dialectical Behaviour Therapy
DH	Department of Health
DIPs	Drug Intervention Programme
DRR	Drug Rehabilitation Requirement
DVT	Deep Vein Thrombosis
EMDR	Eye Movement Desensitisation and Reprocessing
FME	Forensic Medical Examiner
GP	General Practitioner
HA	Housing Association

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HCP	Healthcare Professional
HMCS	Her Majesty's Courts Service
HMPS	Her Majesty's Prison Service
IAPT	Improving Access to Psychological Therapies
ICC	Interclass Correlation
IDTS	Integrated Drug Treatment System
IM&T	Information Management and Technology
LA	Local Authority
LCJB	Local Criminal Justice Boards
LD	Learning Disability
MDO	Mentally Disordered Offenders
MI	Motivational Interviewing
MHT	Mental Health Trust
MHTR	Mental Health Treatment Requirement
MoJ	Ministry of Justice
MRC	Medical Research Council
MREC	Multi-Centre Research Ethics Committee
NAS	National Autistic Society
NHS	National Health Service
NIHR	National Institute for Health Research
NOMS	National Offenders Management Service
OASys	Offender Assessment System
OHRN	Offender Health Research Network
OT	Occupational Therapist
PASRO	Prisoners Addressing Substance Related Offending
PCT	Primary Care Trust
PD	Personality Disorder
PNC	Police National Computer
PSR	Pre-sentence report
PTSD	Post Traumatic Stress Disorder
RMN	Registered Mental Nurse
RQA	Research Quality Assurance
RSPH	Royal Society of Public Health

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Serco	Government services company
SD	Standard Deviation
SDO	Service Delivery and Organisation
SE	South East
SECS	South East Case Study
SMI	Serious Mental Illness
SOVA	Supporting Others through Volunteer Action
SW	South West
SWCS	South West Case Study
UK	United Kingdom
YOI	Young Offenders Institute
YOS	Youth Offender Services
YOT	Youth Offending Team

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Contributions of authors

Richard Byng	Original concept, project lead, overall design, data analysis, drafting and revising
Cath Quinn	Design, project co-ordination, data collection, data analysis, drafting and revising
Rod Sheaff	Design, data analysis, drafting and revising
Chiara Samele	Design, data analysis, drafting and revising
Sean Duggan	Design, drafting and revising
Dean Harrison	Design, data collection, data analysis, drafting and revising
Christabel Owens	Design, data analysis, drafting and revising
Philippa Smithson	Data collection, data analysis, drafting and revising
Christine Wright	Design, drafting and revising

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Jill Annison	Design, drafting and revising
Chris Brown	Design, drafting and revising
Rod Taylor	Design, data analysis, drafting and revising
William Henley	Design, data analysis, drafting and revising
Adam Qureshi	Data analysis, drafting and revising
Deborah Shenton	Data collection, data analysis, drafting and revising
Ian Porter	Data collection, data analysis, drafting and revising
Claire Warrington	Data collection, data analysis, drafting and revising
John Campbell	Design, drafting and revising

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Executive Summary

Background

Offenders have a high prevalence of many health problems, particularly mental illness and substance misuse. Passage through the various elements of the criminal justice system (CJS) provides both the potential for initial access to healthcare and also the disruption of existing care.

Aims

The Care for Offenders: Continuity of Access (COCOA) project aimed to examine how, and in what situations, the health and criminal justice systems can best work together to improve health and resettlement

The objectives, as articulated in the original proposal were to determine:

(a) The current status of continuity of care for offenders

(b) The essential elements of, and facilitators for, continuity of care for offenders

(c) Potentially effective models of healthcare service delivery for offenders

Methods

This multi-method investigation of continuity of healthcare for offenders used the Realistic Evaluation framework and included:

- A provisional programme theory based on policy guidance
- A longitudinal interview (n=200) and health records study (n=50) of offenders' healthcare incorporating qualitative and quantitative analyses
- Two system wide, and six mini organisational case studies.

The final synthesis of qualitative and quantitative data at organisational and offender levels yielded:

- Development of theory about access and continuity of care for offenders, potentially of relevance to other marginalised groups
- A revised programme theory detailing how the health and criminal justice systems could work together to improve access and continuity of care.

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Results

Quantitative analysis of offender data

The study population (prisoners and probationers), were predominantly male, white, skewed to 18-25 age range. Many had partners and children. 23% were employed and 20% homeless. Twenty seven percent had been in prison more than five times.

Within the previous six months 37% rated their current health as poor. Fifty three percent reported drug misuse, 36% alcohol misuse, 15% severe and 59% moderate mental health problems. Only 4% believed they had no physical problems. Co-morbidity was typical.

The majority of offenders were happy for health services to know about their CJS contact (79%), were willing to share medical information between services (82%), and preferred one person to have an overview of all their healthcare needs (81%).

There were significantly more healthcare contacts in probation than in other CJS settings; predominantly for heroin, dependence forming 40% of all health contacts. However for physical problems, healthcare contact rates were significantly higher for prison when compared to other CJS settings. Overall contact rates for mental health problems were low, particularly for those without heroin misuse. Treatment recommended by health services for current health issues across the whole sample was received for the majority of dependency related (74%) and physical health (71%) problems, but for only 50% of the mental health problems reported.

Participants in prison rated the quality of their healthcare contacts as significantly lower than in other contexts. Quality was rated higher for drug and mental health services. Participant reports and healthcare records of healthcare contacts were similar. Generally, participants recall was better for substance misuse services than others.

Qualitative analysis of offender data

Offenders reported a range of health needs, particularly drug, alcohol and mental health problems. Although they saw these issues as causing them difficulties, healthcare was not perceived as being part of the solution. Offenders prioritised other needs and ambitions over healthcare, including employment, accommodation, family and relationships. They did value 'care' when it was shown. Offenders' often chaotic and complex lives meant that health and other needs could, and did, exacerbate or support one another. Offenders' self-knowledge and greater understanding of the difficulties they face often emerged in discussing conflicts with medical practitioners. The interviews highlighted the importance of control for participants, who presented themselves as polarised towards the ends of a 'spectrum of control'. Those emphasising self-reliance were at one end, even if the experiences they described did not support this, and those who were highly dependent on services were at the other.

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Case studies

The whole system case studies and mini-case studies of best practice demonstrated a number of facilitators of, and barriers to, continuity and good healthcare at the organisational level.

Practitioners from both health and criminal justice settings described high levels of uncertainty about other people's roles, and their ability to communicate effectively. They were also concerned about access to mental health services, which were seen as poorly equipped to deal with complex, comorbid 'reluctant' patients. In contrast, relatively good funding arrangements for substance misuse care, both in the prisons and the community, meant that access was considered satisfactory although continuity, when moving between prison and the community, could be improved.

The mini-case studies demonstrated potential for improved continuity across healthcare and along the criminal justice pathways, and identified further barriers and facilitators (for example, police awareness training, improved recognition referral, signposting and a shared understanding). Integrated substance misuse care throughout the CJS was shown to be possible. Engagement during incarceration and follow up in the community was demonstrated for mental healthcare, whilst probation was used as a context to engage offenders in mental health promotion. Courts provided an opportunity for collaborative sentencing plans.

Conclusions

Causal model for access and continuity of care

A mixed methods synthesis led to the development of a causal model for access to and continuity of care for offenders and other marginalised or vulnerable groups. Past experience and varied coping styles are significant inhibitors of access for mental health problems, and require powerful healthcare mechanisms to be overcome. These can be interpersonal or organisational.

Continuity of access included on-going care with the same practitioner (longitudinal continuity), within the same teams or on to a different team. Continuity of information is critical. A range of interpersonal and organisational mechanisms can deliver on-going access. At the practitioner level, respectful interactions, flexibility and an integrated approach (holistic, bio-psycho-social) were important in their own right and also contribute to access and continuity.

Organisationally, service configuration contributed to initial access and on-going continuity. Access could be enhanced by having flexible opening times, non-stigmatising services, co-location with criminal justice services, and tolerant policies.

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Organisational mechanisms for integrated care and continuity include:good communication (particularly to the offender but also between services to ensure continuity of assessment); liaison between services; clear pathways to and from services; collaborative arrangements for sharing responsibility between services.

Collaborative care beyond health can be seen as the institutionalisation of holistic individual care.

Initiating access and creating continuity in the criminal justice system

Each of the criminal justice settings has the potential to contribute to ensuring access and continuity:

- Police – pre arrest and in custody, whether charged or not
- Courts – pre-sentence reports can highlight health problems and both mental health and substance misuse management can be integrated into community orders
- Probation – collaborative care between offender managers and health practitioners working towards social inclusion outcomes is a real possibility
- Prisons – identification of problems at the start of sentence needs to be followed up with engagement in treatment, and then a change of focus prior to release co-ordinating with wider resettlement planning

On-going access to mental healthcare will require the development in each locality of a health service which has the following characteristics:

- Non stigmatising and flexible
- Repeated opportunities for engagement
- Integrates mental health and substance misuse care
- Ensures information transfer, allowing 'continuity of assessment' through health providers in each part of the criminal justice system
- Builds on offenders priorities and strengths
- Works collaboratively with criminal justice services

Current health services will need to work together more closely, particularly mental health, primary care and substance misuse teams. We suggest that the liaison and diversion teams proposed in the Bradley Report will not be effective unless they either take on some case management responsibilities or ensure that specialist mental health services have the skills, pathways and capacity to work with offenders. As well as specialist services, the locus of mental health care could also reside in:

- Primary care based teams for vulnerable groups (e.g. homeless) incorporating specialist workers
- Improving Access to Psychological Therapy services (in and out of prison)
- Third sector organisations focussed on social inclusion

Such a service may have long term financial benefits beyond health which will require incentives. Training of health and criminal justice practitioners,

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both about how to work together and for specific skills, will be required to ensure these ambitions are met.

Summary

In summary this project has i) described the current status of continuity of healthcare for offenders and identified areas of best practice, ii) identified some clear mechanisms for ensuring initial access and continuity of care throughout the health and criminal justice systems and iii) produced some conjectured hypotheses of the essential elements of effective models of healthcare service delivery for offenders. The relative absence of both clinical and health service research for offenders with common health problems suggests the need for focused clinical studies and on-going service evaluation to test these theories and determine best models of care.

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The Report

1 Introduction

1.1 The problem of providing healthcare for offenders

Adult offenders have a high incidence and prevalence of many illnesses, particularly poor mental health and substance misuse. This prevalence in prison is relatively well documented compared to probation[1]. Many offenders leave prison without a permanent address or employment. Only those with sentences of more than a year are subject to probation supervision following release. Offenders in the community are reported to have difficulty accessing health services[2]. This might be the result of stigma and the reluctance of this group to trust health agencies[3], as well as the design of services. Passage through the many elements of the CJS provides potential for initial access and disruption of existing care.

Every year 700,000 convictions occur in criminal courts, with an increasing number of crown court appearances and a decreasing number of magistrates court appearances. Approximately 250,000 offenders are under supervision in the community at any one time with a myriad of sentencing arrangements. The prison population in England reached 85,000 in 2009, with 15% on remand. Reconviction rates for adults released from prison or starting a community sentence have varied between 38.6% and 45.4% between 2000 and 2008; rates are 60% for those on short sentences[4].

Cycles of offending and worsening health represent a significant burden on resources for health and criminal justice agencies (CJAs). This appears to be as true for women and young adult offenders as it is for men. The project is based on one key assumption: that improved healthcare can contribute to improved health and resettlement opportunities. A second assumption is that contact with the CJS is an opportunity to facilitate access to healthcare. This project aims to examine how and in what situations the health and criminal justice systems can best work together.

1.2 Aims and objectives

The Care for Offenders: Continuity of Access (COCOA) project aimed to improve policy and practice by examining how access to, and continuity of, healthcare for offenders can enhance health and reduce recidivism.

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The research questions, as articulated in the original proposal were as follows:

(a) Current status of continuity of care for offenders:

- What is the current situation concerning continuity of care for offenders during their contact with CJAs, both in custody and in the community?
- To what extent does contact with CJAs promote offenders' access to and continuity of care?

(b) Essential elements of continuity of care for offenders:

- Which elements of continuity of care are (i) most important for improving health and recidivism and (ii) most important to offenders?
- Does the relative importance of these elements vary for different CJAs and different offender groups?

(c) Effective models of service delivery for offenders:

- To what extent have prison service guidelines on continuity of care been adopted and what are the barriers to achieving this?
- What are the key facilitators (e.g. practitioner behaviour and organisational models) required to increase continuity?
- What models of care are likely to improve health and reduce recidivism, and what are the resource implications?

While continuity ran as a thread through the study, and was addressed in its own right, we decided from the outset to be inclusive rather than restrictive in our examination of the provision of healthcare for those moving in and out of contact with the CJS. Access was identified in the original proposal as being critical and along with the elements of continuity was the focus of this study of healthcare for offenders.

We have focused more on men and particularly younger men with community and shorter prison sentences, the 'revolving door' offenders.

1.3 Theoretical orientation

This study, focusing on the models of care and the experiences of offenders and practitioners, was pragmatic and took what Hammersley[5] describes as a 'subtle realist' perspective. This allowed a focus on real organisations and pathways of care and incorporation of individual perspectives and aggregated quantitative outcomes. In order to capture both the range of perspectives and levels of concern (organisation, practitioner, individual) a range of qualitative and quantitative methods were used in an integrated and coherent way. Design, analysis and synthesis of findings were

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influenced by Pawson and Tilley's[6] Realistic Evaluation methodology which stresses the mediating effect of context on programmes of intervention, and questions 'what works, for whom, in what situation?'

The Realistic Evaluation framework supported links through the initial review of policy, refinement of questions, data collection, analysis and interpretation. A key part of the study was the development of 'programme theory' about how to improve continuity in healthcare for offenders. 'Programme theory' infers bringing together theoretical propositions in a coherent whole. It has been used as a way to define how policies and interventions can make a difference. This aggregation of 'middle range' theories[7] derived from research or policy into a comprehensive package has similarities with modelling of complex interventions[8].

In our research, the 'provisional programme theory' was based on an analysis of policy and so can be considered 'normative'. As well as being a product of our research, it provided a framework for developing further questions, and for collecting and analysing the primary data.

The initial theories were outlined in the original proposal and related to the research questions; they were further developed prior to data collection as described in Section 0. The data collection and analysis allowed us to test, appraise and further develop the provisional theories into a more empirically based programme theory, designed to provide guidance for those involved in commissioning policy development, service redesign and practice. Thus:

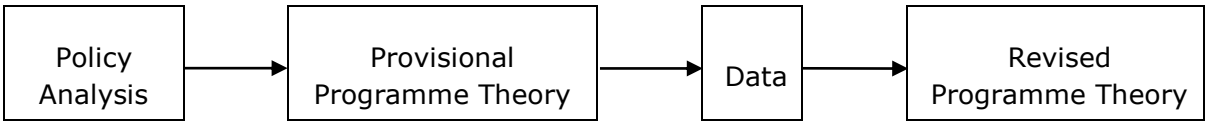


Figure 1. Process of developing programme theory

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1.4 Overview of the study

The study comprised the following investigative strands:

- A multi-method investigation of continuity of healthcare for offenders, including:
  - Two system wide and six mini innovative organisational case studies.
  - A longitudinal interview and health records study of 200 offenders' healthcare and five focus groups.
- A user-led offender health research group.
- The development and refinement of 'programme theory' for continuity of care for offenders.

The 'mixed-methods' used in the study were equally weighted and integrated at the data collection and initial analysis stages as well as in the final synthesis, with no methodology taking primacy.

A quantitative analysis of offender interviews demonstrated the extent of the deficit in access and also provided important contextual information. A qualitative analysis, the interviews and focus groups data, provided insights into how offenders view healthcare and the potential impact on achieving access and continuity. The organisational case studies provided information about the barriers and facilitators from an institutional viewpoint. The relationship between the research questions and different data streams is shown in Table 1 along with the sections of the report where the results are found.

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Table 1. Research Questions

	Data analysis stream					
Research Questions	Quantitative analysis	Continuity analysis (qualitative)	Depth qualitative analysis	System wide case studies	Best practice mini case studies	Report section ref(s)
(a) Current status of continuity of care for offenders:						
What is the current situation concerning continuity of care for offenders during their contact with CJAs, both in custody and in the community?	x			x		5.1 6.1 6.2
To what extent does contact with CJAs promote offenders' access to and continuity of care?	x			x	x	5.1 6
(b) Essential elements of continuity of care for offenders:						
Which elements of continuity of care are (i) most important for improving health and recidivism and (ii) most important to offenders?		X	x	x	x	5.3 5.4 6
Does the relative importance of these elements vary for different CJAs and different offender groups (e.g. men, women, young offenders, offenders from ethnic minorities)?	x	X	x			5.1 5.3 5.4
(c) Effective models of service delivery for offenders:						
To what extent have prison service guidelines on continuity been adopted and what are the barriers to achieving this?		X		x	x	5.4 6
What are the key facilitators (practitioners' behaviours and organisational models) required to increase continuity?	x	X	x	x	x	5.1 5.3 5.4 6
What models of care are likely to improve health and reduce recidivism, and what are the resource implications?				x	x	6

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The final synthesis of qualitative and quantitative data at organisational and offender levels yielded:

- Development of theory about access and continuity of care for offenders, potentially of relevance to other marginalised groups (Section 7.1).
- A revised programme theory detailing how the health and criminal justice systems could work together to achieve access and continuity of care (section 7.2).

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2 Background

This research was broad in scope so a detailed background has not been possible for all areas. Thus we provide a brief overview of the CJS for those from healthcare who may have little contact with it, and focus on the health and healthcare of offenders, recent work on continuity and the limited research about the organisation of care for offenders. Section 0 describes both the methods and results of our analysis of policy documents related to continuity of healthcare for offenders.

2.1 The Criminal Justice System

The CJS is composed of three main parts: law enforcement (the police)[3], adjudication (the courts)[9], and corrections (prisons, probation and parole)[10].

At the time of this study, the CJS at a local level was co-ordinated by 42local criminal justice boards (LCJB) across England and Wales. These boards gathered the chief officers of the CJS agencies to coordinate activity and responsibility for delivering criminal justice in their areas. The agencies include the police, the Crown Prosecution Service (CPS), Her Majesty's Courts Service (HMCS), probation services, youth offending teams (YOT) and HM Prison Service (HMPS). Victim support agencies and the National Health Service (NHS) are often co-opted onto these boards. Since this time some LCJBs have been replaced by Criminal Justice Strategic Leaders Groups, which similarly are constituted of multiple agencies.

The police are responsible for the policing of the local area, and once a crime is reported, for investigating and when advised by the CPS, for charging suspects and preparing a file for the CPS.

The CPS is responsible for reviewing all criminal case files throughout England and Wales and deciding whether it is in the public interest to prosecute. Where this decision is affirmative they prosecute cases in court.

The prosecutor attends court to present the case to a panel of magistrates, or a district judge in the magistrates' court, or to a judge and jury in the crown court. The courts are run by HMCS, which is an executive agency of the Ministry of Justice (MoJ). The remit of the MoJ is to deliver justice effectively and efficiently to the public. HMCS provides administration and support for the court of appeal, the high court, the crown court, magistrates' courts and the county courts.

If a defendant is found guilty the court may request a pre-sentence report (PSR) provided by the probation service. This is a statutory CJA mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing

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duties. The aims of the service are to protect the public, reduce reoffending, provide for the proper punishment of offenders, ensure that offenders are aware of the effects of their crimes on victims and the public, and to rehabilitate offenders.

If a defendant is sentenced to custody they will be sent to a penal establishment. HMPS serves the public by keeping in custody those committed by the courts and their responsibility is to look after offenders with humanity and help them lead law abiding and useful lives in custody and on their release. For the purposes of this study, the CJS was divided into four settings: police, court, prison and probation.

2.2 Health status of offenders

The health status of offenders has been compared to population norms, and reports[11] have suggested that offenders (in this specific case, those in prisons) have poor health across a range of conditions as compared to these norms. The majority of prisoners experience at least one chronic health condition, many with multiple health problems. The gender difference is also stark; with two fifths of female prisoners and approximately a third of male prisoners reporting a long-standing physical condition[12]. Other health studies of offenders have shown that mental illness, cardiovascular conditions, asthma and epilepsy are frequently reported. In a recent study over a quarter of newly sentenced prisoners (27%) reported having at least one long-standing physical health problem or disability[13]. Offenders often exhibit risk-taking behaviours such as smoking, drug use and high levels of alcohol consumption that can have negative effects on their health.

Studies consistently indicate high levels of mental health problems in prisoners[14]. Around 8% suffer from schizophrenia and delusional disorder, 66% from a personality disorder, 45% from neurosis, 45% with substance misuse problems and 30% with alcohol dependency[12]. These numbers far exceed those found in the general population. Many prisoners have more than one mental health problem with only one in ten, or fewer, with no evidence of these five problems. Remand prisoners have far higher rates of multiple problems than sentenced prisoners[12]. One survey on newly sentenced prisoners found much greater levels of psychosis (18% vs. 9% respectively), anxiety and depression (56% vs. 34%), self-harm (14% vs 5%) and suicidal attempts (19% vs 7%) among women than men[13]. Co-morbidity is increased in young offenders (aged 16-20 years). One survey suggested at least 95% were assessed as having one or more disorders of which about 80%, were assessed as having more than one[15].

Rates of self-harm and attempted suicide have been high, with the greatest risk of suicide or self-harm being among newly arrived prisoners in the first seven days and within a month following release[16]. Two thirds of prisoners

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were unemployed before coming to prison, approximately 30% were homeless prior to prison and a similar proportion will be so on release. Many prisoners have little in the way of basic education with 52% having no qualifications, 65% have numeracy skills at or below the level expected of an 11-year-old and 48% have reading skills at or below this level[17 18]. The prevalence of learning difficulties is hard to estimate, largely due to variation in definitions. Estimates range from 53% in offenders in probation[19], to 20-50% of male prisoners [20]. There is also a high incidence of acquired head injury, possibly in as many as 60% of offenders[21].

Figures for the prevalence and incidence of health problems in the prison population were derived from epidemiological studies of UK prisoners as summarised in Healthcare in Prisons: a healthcare needs assessment[22]. The prevalence of mental disorders, childhood factors, adverse experiences and victimisation in prison were derived from the Psychiatric Morbidity among Prisoners in England and Wales[12].

2.3 Healthcare for offenders

Healthcare for individuals in contact with the CJS includes standard NHS care, as well as prison healthcare and care provided while in police custody. Healthcare in police custody is still commissioned by local police and provided in the main by private agencies. It is variable in quality and there are moves to bring it under the NHS.

On entry into prison there is an assessment at the 'at reception' stage for both health and mental health. This is an important first step in the provision of effective healthcare. After this point, there are mental health facilities provided within the prison, in the form of in-reach services, and in addition the potential to transfer to the NHS outside of the prison. However, little research has examined the organisation, culture and service systems within prison[23].

Within the pathway there are numerous points at which transfer of information concerning the offender occurs and at which continuity issues can arise. This is the case for community and prison settings.

The primary functions of prison include separation from society and confinement for the safety of society, punishment for crime, correction and rehabilitation to the community. Prisons are not primarily concerned with the health of the prison population. Previously, the prison service had established its own healthcare facilities for prisoners who become patients, with its own doctors and nurses. This has reinforced the image of prisoners (who are patients) as being separate from the general population even in relation to healthcare.

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More recently the separation of prison healthcare from the NHS has been lessened through the integration of services. In April 2004 local primary care trusts (PCT) began to take over the commissioning responsibility for prison health services; this was completed in April 2006, and in many cases by 2005. The aim of this was to give prisoners 'access to the same quality and range of healthcare services as the general public receives from the National Health Service'[24] (p.5). The prison service and the NHS were challenged to work together to develop prison mental healthcare in accordance with national policy on mental health[25]. Although, it is likely that moving beyond the notion of 'equivalent' healthcare is a key priority given the shortfall in prison healthcare[26 27]. More specifically, there remains a continued lack of treatment facilities, absence of a clear legal framework for treating prisoners with severe mental illness, inadequate prison hospital wings, and significant delays in hospital transfers[28]. This increases the challenge of reducing inequalities.

Considerable work has gone into mapping out the sort of 'path' a prisoner with mental health problems might follow and this mapping is summed up in the offender mental healthcare pathway[29]. There has been no consideration of pathways for physical healthcare. To date, prisoners face considerable difficulties registering with a General Practitioner (GP) before leaving prison despite this being identified as a barrier to accessing healthcare on release from custody[30].

'The provision of healthcare in prisons faces many uniquely difficult challenges e.g. high consulting rates, prisoner reliability as historians, poor prisoner concordance with treatment planning, prisoner personal health neglect and health damaging behaviours, poor clinical information and support systems, staff shortages, poor planning of service integration'[2] (p.4).

Recent research indicates that men who have been incarcerated have significantly higher rates of mental illness and suicide and under-utilise mental health services compared to the rest of the population[3]. Healthcare is delivered to prisoners by models that are dependent on the location and the type of institution. In the UK, the model involves nurses, though whether these are registered with the Nursing and Midwifery Council varies. Healthcare is now rarely delivered by prison service employees, and is usually delivered by local NHS organisations (both primary and secondary care).

Healthcare in prisons is primarily concerned with solving immediate health problems of prisoners, but has the potential both to be more proactive in anticipating problems on release and promoting wellbeing and a more positive attitude towards personal health; this has potential benefits to the wider community.

Recommendations by review papers have suggested that better and further partnerships between prisons and hospitals should be established, as

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healthcare expertise needed for a prisoner is unlikely to be found in one prison alone. Other aspects of prison healthcare that could be improved include an emphasis on mental health, learning disability (as this has a high prevalence among prisoners), the education of prison staff (including healthcare staff) about the health needs of prisoners, and the development of a model of prison healthcare that not only takes the prison environment into account, but also the communities which the prison serves[30].

The study aimed to investigate both policy and practice through the examination of how access to, and continuity of, healthcare for offenders can enhance health and reduce recidivism. The aim was to propose a model of healthcare that encompasses all aspects of the CJS.

2.4 Continuity of care

In the general population continuity is valued by most health professionals and patients[31-36], although the concept is not always clearly defined[37 38]. Whilst convenient access is important, patients also value being able to see the same trusted practitioner who knows their medical history and understands their personal situation[39 40]. This particularly appears to be the case for patients with more chronic or serious conditions, psychological or social problems[32 34 40-42]. Primary care research has focused on the benefits of longitudinal and relational elements of continuity of care, in terms of trust[31 43 44], adherence[45 46], enablement[47] and satisfaction[31 42 48], more efficient use of resources[49 50], facilitation of disclosure of psychosocial problems[51], cross-boundary coordination of services[37], and effective information transfer between services[37]. In studies examining continuity for people with long-term mental illness, a group into which many offenders fall, the success of services in monitoring patients has often been included in continuity of care discourse[52 53]. Continuity of care for people with serious mental illness (SMI) has been reported to frequently break down because of high user mobility[54] and dissatisfaction[55]. Relatively little is known about how such patients perceive continuity of care[37], however, studies have highlighted that service users value access to services at all hours, continuing relationships over time[56 57], flexibility of practitioners to act beyond their normal role[58] and a partnership model of care delivery[59]. Freeman et al[37] concluded that service delivery models that maximised continuity, such as case management, community mental health teams and crisis intervention, reduced disengagement from aftercare. Evidence has long demonstrated the importance of linking hospital and community services[60], failure to provide continuity of care for people with SMI has been linked with higher rates of institutional readmission[61] and untoward incidents[62]. Assertive outreach teams are recognised as the best model of care for difficult to engage mental health service users. These teams deliver improved mental health and social inclusion outcomes[63], by utilising

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comprehensive care, having committed staff with sufficient time to focus on building and maintaining solid working relationships with their clients[59].

2.5 Defining continuity for offenders

While various forms of continuity have been recognised[37 52 64], it is not clear which of these is critical in terms of continuity for offenders. The reading of the literature and understanding of the offender experience led to the utilisation in this study of an adapted version of Freeman et al's revised definition[37 65], which maintains that 'experienced continuity of care' (the experience of a co-ordinated and smooth progression) will depend on the social context being taken into account. This central element depends on four sub-components:

- relational (personal and therapeutic) continuity
- longitudinal continuity
- flexible continuity
- effective communication (referred to as continuity of communication).

Each of the four elements above are dependent on 'continuity of access'[52], distinct from longitudinal access, which is operationalised by examining rates of overall contact or gaps[53 65]. The inherent distrust that offenders have of the establishment[3] suggests that the development of relational and longitudinal continuity is important.

Longitudinal continuity is the provision of care over time from as few professionals as possible (thought to be a precondition for relational continuity) and can be measured by the proportion of contacts with the same practitioner or assessed subjectively. Being seen by the same practitioner is likely to be of importance to those with long-term problems in prison. Usually this continuity is broken when the offender is released into the community and relationships with new practitioners must be forged.

In the view of the current study, 'flexible continuity' (the ability of care to adjust to changes in a person's life over time) should also include the need to ensure that a system of care can meet a broad range of needs at any one time. Flexible continuity therefore includes the concept of 'comprehensiveness', 'holistic' or 'cross-sectional' continuity referred to elsewhere [37 52 64].

'Continuity of communication' requires excellence in both transfer of information and working relationships between different professions within and across teams and statutory boundaries; this also includes informal care networks. Information transfer appears to be particularly weak for

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offenders[2] and hampered by health practitioners' concerns regarding confidentiality and information sharing with CJAs. In a recent case study, by the authors, of a probation team, co-ordination with and support from healthcare agencies was seen as ineffective[66].

For offenders with mental health problems, 'continuity of access' is of major concern[2 3 29]. The development of mental health in-reach teams aimed to maximise continuity of care for mentally disordered offenders (MDO)[29] and is a relatively recent initiative. How effective they are in helping offenders maintain contact with services after release from prisons is yet to be reported[67].

The evident discontinuities in healthcare for offenders are caused by factors at the offender, practitioner and organisational levels. Guidelines have been introduced to attempt to co-ordinate healthcare pathways in prisons[29 68] but their effectiveness remains to be determined. Community sentencing now often involves drug rehabilitation requirement (DRR) and a limited use of the mental health treatment requirement (MHTR)[69]; licence orders may require abstinence, but robust local links with healthcare are not always available[2]. Nationally the joint Home Office, the Department of Health (DH) and offender health and social care strategy project is aiming to address some of the issues by examining potential schemes for ensuring offenders are registered with a GP when leaving prison, electronic and paper based transfer of records and joint working between healthcare, substance misuse teams, social care, the voluntary sector, and the CJAs.

The offender mental healthcare pathway[29] aims to bridge the community/custody care divide and ensure continuity of mental health services for those 'judged to have the greatest need'. Regional and local groups were established for co-ordinating partnerships between health, social care and CJAs to improve health and reduce recidivism. In addition, there are small schemes - such as aftercare and advocacy - which appear to improve effective collaboration, information flow and choice and flexibility of care both around the United Kingdom (UK) and internationally[70].

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3 Provisional programme theory for continuity of care for offenders

This chapter provides an introduction to Realistic Evaluation, describes the method for developing the provisional 'programme theory', outlines its architecture and describes how it influences the remainder of the research.

3.1 Realistic Evaluation

This project used Realistic Evaluation[6], one of the theory based evaluation methods as a framework. While the research is not a classic evaluation of a local intervention, it is in effect an evaluation of a range of policy interventions across the area of health and criminal justice.

Realistic Evaluation, developed by Pawson and Tilley[6], is a framework to help researchers understand what works, when, and for whom. In Realistic Evaluation, 'programme theory' refers to the coherent aggregation of 'middle range theories'[7]. These theories, or conjectures, are generally composed of 'mechanisms' which bring about change and therefore produce an outcome, but which may be 'context' sensitive and therefore will only work in certain situations. The mechanisms may be overt, such as the use of a screening tool to aid recognition of an illness, or more subtle and hidden, for example 'being there and just listening', one of the generic components of therapy believed to result in better outcomes[71]. The challenge for the researcher is to identify and find evidence to support or refute these theories so that interventions can be used in other settings. When the context is similar, the intervention is more likely to work; if it is dissimilar, either the intervention or the context may need to be changed where appropriate.

Realistic Evaluation also emphasises the on-going accrual of evidence and refining of theories over time. This process of 'accumulation' has been embodied and formalised in Realist Synthesis[72], a technique for bringing together multiple data sets and diverse evidence in order to answer a complex policy question.

This project used some of the ideas from Realistic Evaluation for the following reasons:

- The original National Institute for Health Research (NIHR) Service Delivery and Organisation (SDO) call emphasised the need to examine continuity in terms of organisational and individual factors.

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- The call inferred a need to understand what worked and what might be possible, even though a formal evaluation was not required.
- There is very little research in this area and the proposal needed to be a broad study across the wide area of healthcare for offenders crossing multiple criminal justice and healthcare organisational boundaries.

In order to address these requirements, Realistic Evaluation was selected to provide a strong framework for the examination of continuity across its various domains and the interaction between multiple statutory organisations within two major Government departments.

3.2 Method for developing the 'provisional programme theory'

Developing the 'provisional programme theory' is the first step in the overall theoretical framework for the research depicted in Figure 1. This section describes the method for this preliminary part of our research. The methodology for the primary data collection is described in Section 4, as is the method for developing the 'revised programme theory' based on the results of each part of the study.

The 'provisional programme theory' is an integrated articulation of policies and protocols, defining how continuity of care should be provided for prisoners and offenders in contact with the CJS in the community. This summary of what should be happening was utilised to inform the data collection for the primary research within the project and was the basis for developing the 'revised programme theory'.

Figure 2 depicts the process undertaken by the research team to generate this 'provisional programme theory'.

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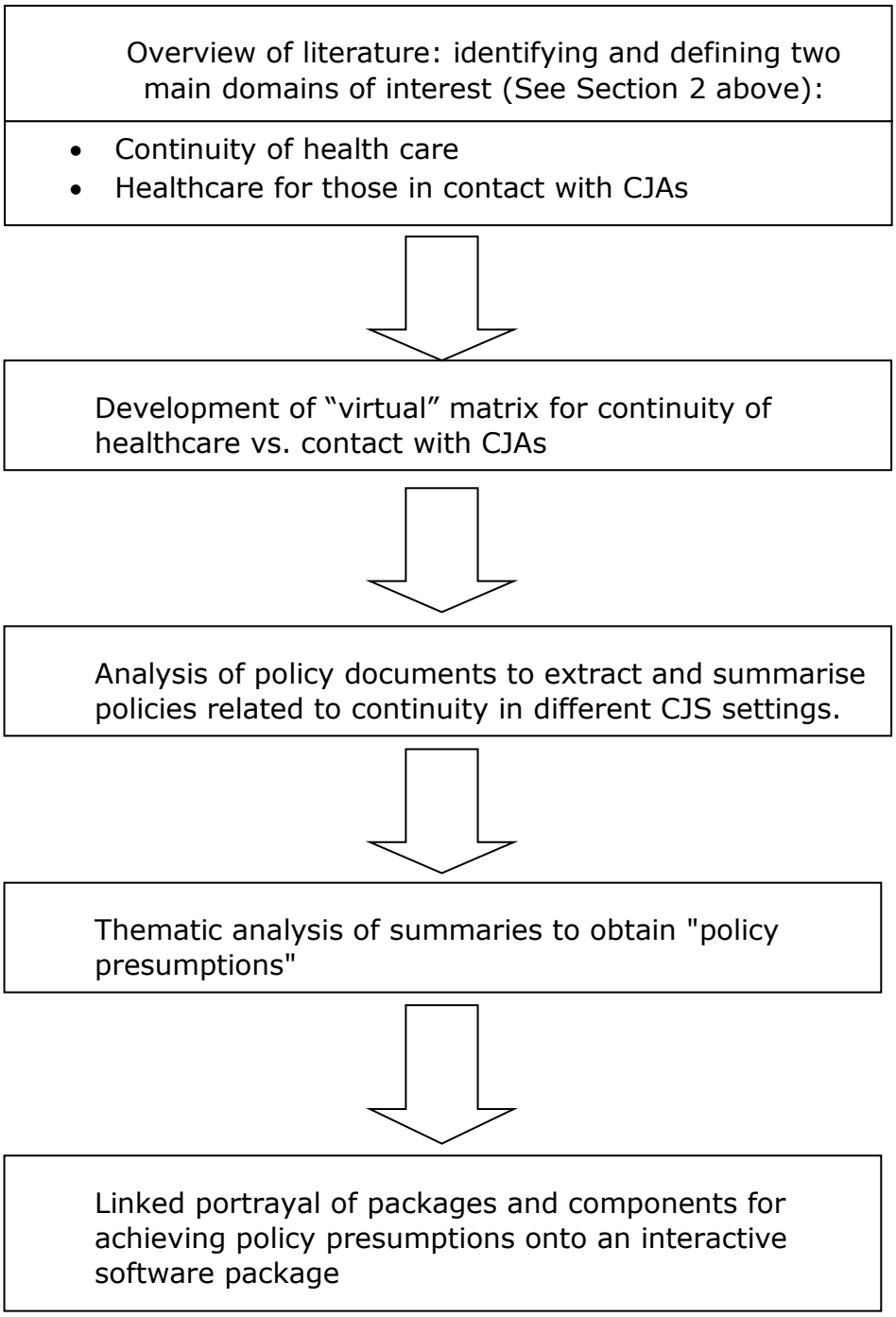


Figure 2. Process of 'provisional programme theory'

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Section 2 provided an overview of the literature review and how continuity of healthcare and healthcare contact were defined. The next stage was to review relevant policies. Applying a Realistic Evaluation approach, policy was considered in terms of how it related to 'continuity of healthcare' and different points of 'healthcare contact with criminal justice systems' (illustrated in Figure 3). In this way, a "virtual matrix" was produced exploring how policy fits the current understanding of continuity and healthcare at different contact points within the CJS.

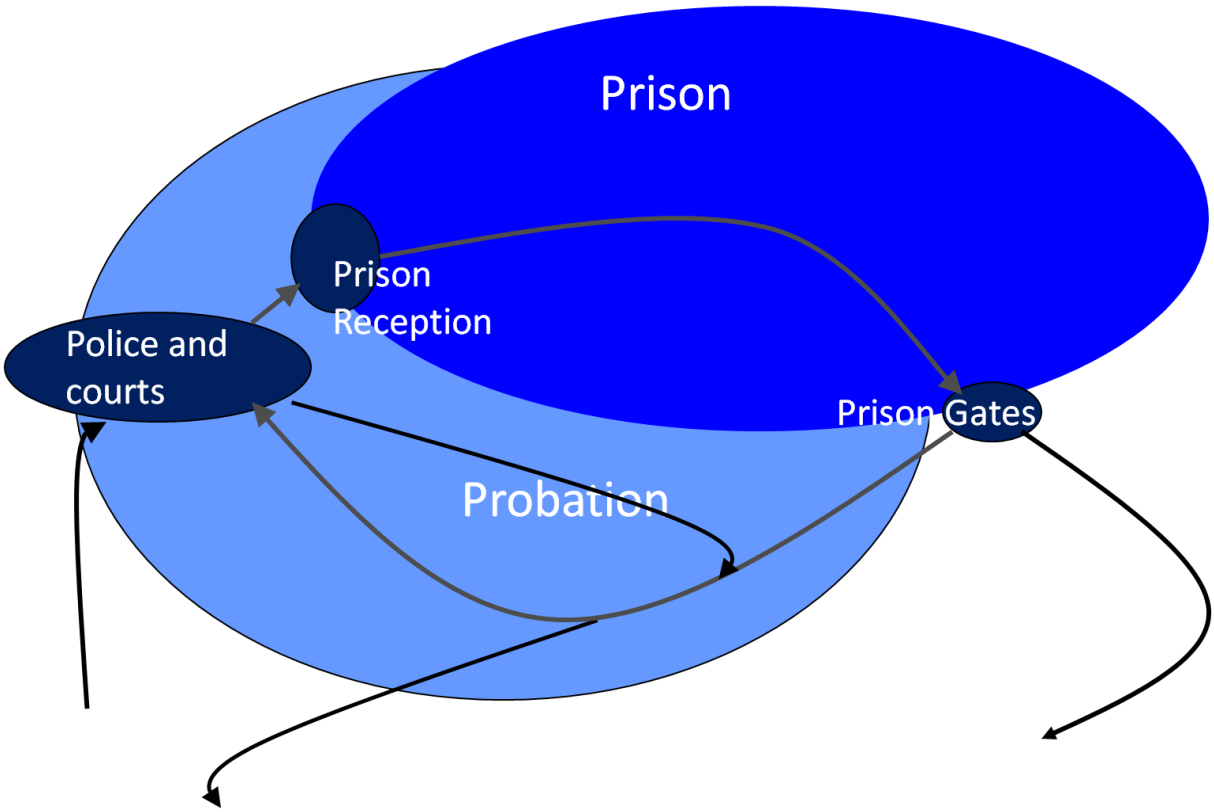


Figure 3. Transitions through the CJS

This model illustrates the on-going phases of periods of time when an offender is within prison, in contact with probation in the community, or finally in the community with no CJS contact. The nodes are either: transition points between phases - entry to prison, entry to probation, leaving prison and leaving probation; or more intermittent contact with the CJS: police contact, or attendance at the courts.

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Policy documents were identified via DH and MoJ websites, the academic literature and the Offender Health Research Network (OHRN) website. Each policy document was read by two researchers, and policy and protocol recommendations which corresponded to an element of continuity were summarised and coded according to the type of continuity, as well as the phase and node of CJS. The recommendations were summarised in a way which articulated the mechanism for achieving improved outcomes and, if relevant, the context in which they were likely to work. Subsequently they were entered into an Access database.

For example, a recommendation for the transfer of information about suicide risk between police and courts would document the mechanism for achieving transfer of information, the context in which it was particularly relevant, and the anticipated outcome. It would be coded by both 'continuity of communication' and 'police and courts'. Multiple coding of recommendations was permissible because each document was likely to contain several recommendations of a different nature. In this way, the "virtual matrix" was constructed.

The summaries were analysed in order to develop high level themes. These themes were called 'policy presumptions' and are based around key outcomes of interest to policy makers, such as reducing crime and reducing deaths in police custody. From a Realistic Evaluation perspective, these policy presumptions incorporated high level outcomes and often also alluded to mechanisms of action.

Policy presumptions were listed under the relevant phase of CJS contact, and included those policy presumptions relevant to the nodes preceding and ending the phase. An analysis of the summarised findings for each phase was carried out, with recommendations developed into coherent packages for each policy presumption, in order to make up the 'provisional programme theory'.

Packages of care of relevance to each setting were defined and the components within each package detailed. While packages of care were unique to each setting, components could be placed in several packages. For example, asking about previous mental health problems is a component which could occur within prison, probation and court settings. Generally the components corresponded to Realistic Evaluation's 'mechanisms' at an individual practitioner or offender level.

The whole of the 'provisional programme theory' was entered into a software program which allowed the researcher to examine the individual components and packages and identify their location under each policy presumption.

Finally in addition to this deliberative component-by-component construction, an analysis of the entire provisional programme theory was carried out examining 'silences' where policy was lacking, and contradictions between packages and settings. These helped inform the nature of the

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empirical data collection and analysis, particularly within the organisational case studies.

3.3 'Provisional programme theory'

3.3.1 Policy presumptions

The policy presumptions (intentions rather than what happens) derived in the first stage of analysis are shown in Table 2. These include a range of issues for different phases of individuals' journeys through the CJS. The overriding themes included firstly the need to prevent deaths and harm while in contact with the CJS; and secondly, the need for healthcare to contribute to the aims of the CJS (e.g. ensuring fitness to plead). However, there was also an emphasis on ambitions to ensure equality of access to healthcare and to facilitate good communication.

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Table 2. Policy presumptions across criminal justice settings

Police
PP1: Identifying healthcare needs can contribute to rehabilitation.
PP2: The police service should provide urgent and immediate healthcare input while someone is under their care.
PP3: The police service should ensure or facilitate on-going healthcare for people who pass through their care.
PP4: The police service should provide healthcare input to determine fitness to be interviewed.

Courts
PP5: Health and social care service provision in or through courts will be based upon assessed needs and provided at an equivalent standard to that in the wider community.
PP6: The court is a conduit for passing patient healthcare information and medication between the community and the CJS and between different parts of the CJS.
PP7: The court should sometimes facilitate the availability of healthcare information or assessments to determine someone's fitness or ability to stand trial or to inform appropriate sentencing.

Probation
PP8: Health and social care service provision in, or through, probation will be based upon assessed needs and provided at an equivalent standard to that in the wider community.
PP9: Supporting offenders to access healthcare can contribute to rehabilitation.
PP10: Identifying healthcare needs can contribute to rehabilitation.
PP11: Addressing healthcare needs can contribute to rehabilitation.
PP12: Effective partnerships are required across criminal justice and health agencies.

Prison
PP13: Knowledge of an individual's healthcare from before their reception into prison will support both their settling into prison and their pre-release planning.
PP14: Prison Healthcare should proactively identify healthcare needs.
PP15: Planning for release should begin at prison reception. Information about healthcare that has been received in prison should be passed to the community to support resettlement.
PP16: Healthcare in prison should be equivalent to healthcare available in the community in meeting needs.
PP17: Healthcare in prison prioritises harm minimisation and reduction of self destructive behaviours.

No CJS support
PP18: Populations vulnerable to offending include: Illegal drug users, alcoholics, homeless people, people with previous CJS contact, people with untreated mental health needs, women who have experienced domestic violence, sex workers, people with learning disabilities, and local authority care leavers.

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3.3.2 Packages and components

'Packages' refer to a cluster of components from which the policy presumption aims can be achieved. Some packages were specified clearly within the policy documents, with a range of specific 'components'. Others were developed and named by us to incorporate a range of components specified at a detailed level within policy documents but lacking an overall framework in which to work. For example, policy documents included great detail about mechanisms (components) for preventing suicide and documenting healthcare in police stations (context).

The packages and components alongside the policy presumptions were integrated into a software program. This allows users to navigate from policy presumption through packages to individual components which specify how the aims of packages and presumptions can be achieved.

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Figure 4 is a 'screenshot' from the software package and demonstrates Prison Policy Presumption 5: *'Healthcare in prison should contribute to harm minimisation and reduction of self destructive behaviours'.* The left hand panel lists the packages addressing harm minimisation in prison, the top right panel gives a detailed breakdown of an individual package (in this example, *'Safe management of prisoners for drug withdrawal'*), and the bottom right panel lists specific components identified to achieve this. In this case, *'Specialist dual diagnosis services are provided for prisoners'* is linked as a component for the coordinated care package, but also forms a component within another package, *'Co-ordinated care for vulnerable prisoners'*. This demonstrates that the packages are not always activities which are related to the single aim within the package or policy presumption.

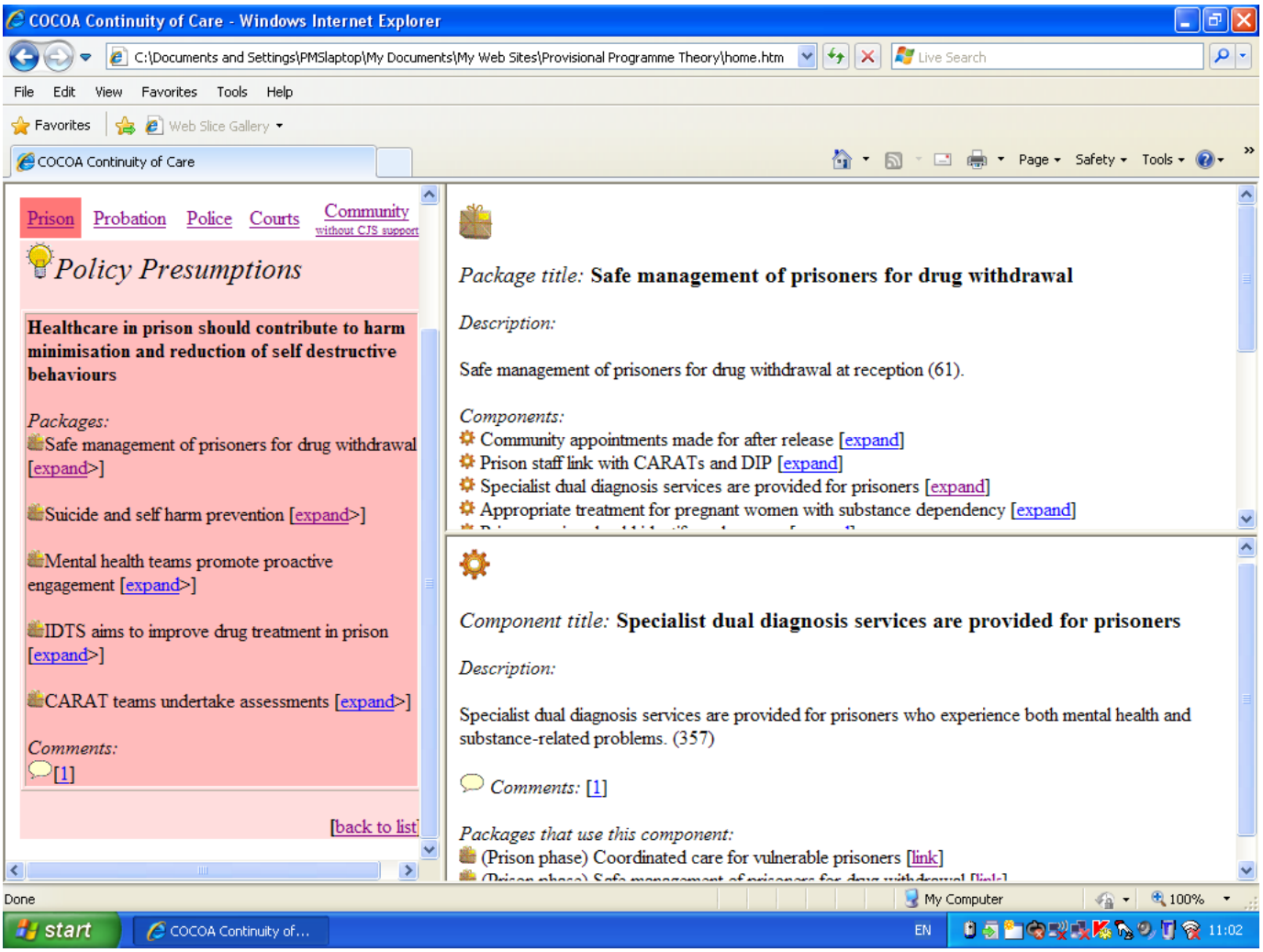


Figure 4. Screen shot of provisional programme theory (1)

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Figure 5 is another screenshot from the 'provisional programme theory' software package illustrating the policy presumption, '*The police service should provide urgent and immediate healthcare input while someone is under their care*.' The component demonstrated is, '*Custody officer responsible for ascertaining whether detained person in need of medical attention*', within the package, '*Ensuring detainee receives appropriate level of care*'. This example contextualises the evolving healthcare agenda within the police, directed at ascertaining whether detainees pose a risk to themselves, others or require medical attention. The service model has short-term aims, working along mechanistic 'identify and treat' principles. There is little in terms of continuity of assessment as a process along with pathways carried across criminal justice settings and into the community. Another feature is a lack of engagement with wider lifestyle factors associated with offending behaviour which, if addressed, would potentially facilitate future resettlement and diversion away from future criminal justice contact.

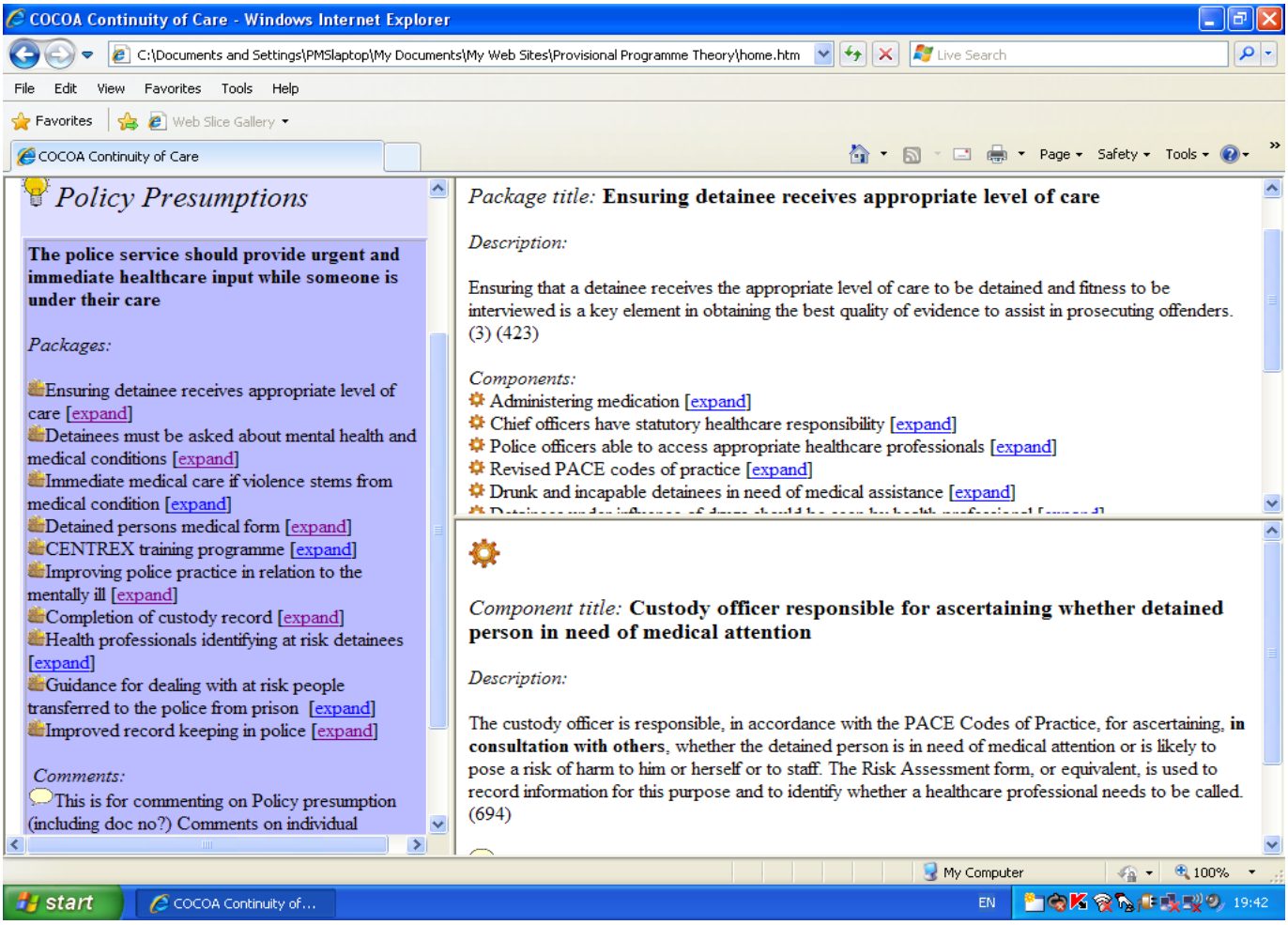


Figure 5. Screenshot of 'provisional programme theory' (2)

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3.3.3 Discussion

Once we had located the components and packages for each policy presumption within the overall architecture of the programme theory, we conducted an analysis of silences, that is, areas that are implicit, but not directly addressed by policy, and contradictions.

We found few contradictions between the policies. However, gaps in policies were identified with respect to some of the wider literature on continuity and health in the CJS. For example, there were a considerable number of policy documents and detailed mechanisms promoting standardisation of record keeping and information transfer between courts, prison and the police. This suggested that an emphasis was placed on mechanistic procedures, with a lack of attention given to policies recognising the importance of the relationship between offenders and health and criminal justice staff and the impact this might have on sustained engagement with healthcare. Similarly, the emphasis within many of the documents was on detailed strategy, roles and procedures designed to prioritise risk management and reduce self-destructive behaviour, but remarkably little in the way of detailed procedures designed to ensure that offenders with common mental health problems obtained a mental health assessment which would contribute to care once released. Whilst there was a mention of the requirement to follow the Care Programme Approach (CPA) from community in to prison and out again for those with severe mental illness, there was no mention of how care pathways and packages should be created for those with anxiety and depression.

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4 Method

4.1 Overall Design

The study combines quantitative and qualitative methods to examine the CJS at the organisational level and also at individual offender level. The individual level examines offender pathways and factors affecting continuity of healthcare. The organisational level details data on systems of care available to offenders across healthcare organisations and CJAs and provides the basis for describing how these agencies interact to provide care. In the current study,[37] the definition 'experienced continuity of care' (the experience of a co-ordinated and smooth progression) was used to plan the research.

An analysis of policy documents to ascertain the 'policy presumptions', and detailed recommendations in what we termed the 'provisional programme theory' was carried out as described in Section 0.

A peer research group was set up, both to contribute to design and analysis and to collect and analyse data contributing to the main research questions (see Section 4.4). The main research strands proceeded in parallel at both organisational and individual offender levels. As described in the following individual sections, both quantitative and qualitative data were collected, at times through the same data collection tool. The quantitative and qualitative findings were allowed to inform one another to allow a more integrative approach prior to synthesis. The following sets of data were collected:

- Offender longitudinal study (Section 4.2.1) – a partially structured interview questionnaire of 200 offenders about their healthcare in the previous six months and a follow up study, of 84 offenders, for up to six months . This provided data for quantitative and qualitative analysis.
- Five additional focus groups were used alongside the interview questionnaires, including 25 offenders' purposively selected narratives from the interviews for the qualitative analysis (Section 4.2.2).
- Health records were examined (from n=49 offenders) (Section 4.2.3) – these were used to validate offenders' reported use of health services, and also to explore the continuity of communication between prison healthcare services and general practice.
- Peer researcher contributions (Section 4.4).
- Organisational case studies (Section 4.5) in-depth case studies of two systems.
- Mini-case studies (Section 4.6) – further sites in England and Wales purposively selected as reporting high levels of continuity.

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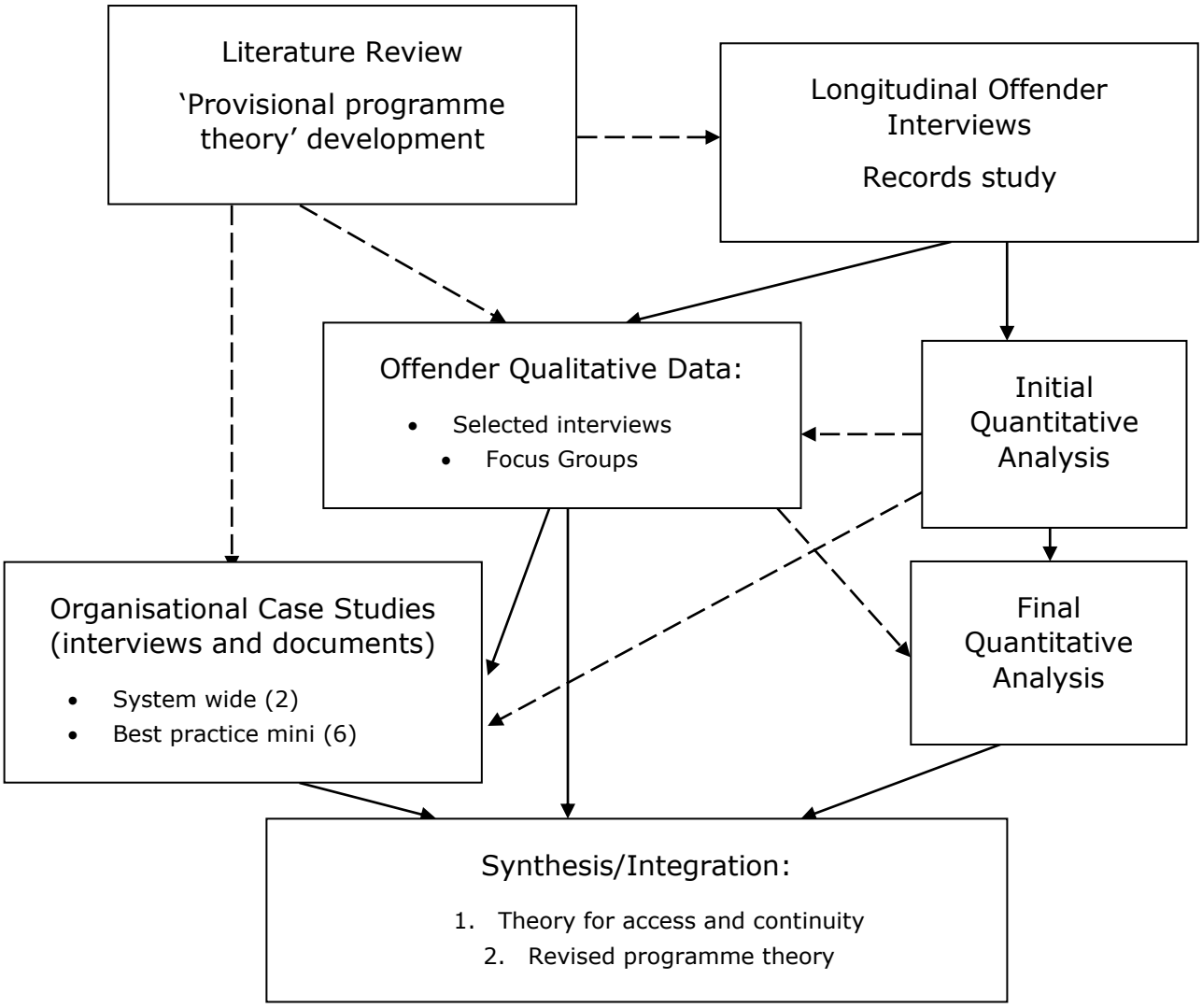


Figure 6. Relationship between data sets

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These six sets of data were utilised and integrated to carry out analyses. The method section describes data collection and analyses separately. Figure 6 shows how the various data sets are: treated alone (e.g. mini case studies); examined in two ways (open ended interviews were used for the main quantitative analysis and contributed to the qualitative analysis study); and brought together for analysis (offender interviews and focus groups). In addition data from the health records study was analysed against offender interview data to test the reliability of the latter. Figure 6 also shows how the provisional programme theory informed data collection, and how early qualitative and quantitative analysis informed final qualitative and quantitative analysis respectively.

Ethical approval for the study was obtained from the Cardiff Multi-Centre Research Ethics Committee (MREC). Governance approval was obtained from PCTs, Her Majesty's Prison Service (HMPS), National Offender Management Service (NOMS) and their Research Quality Assurance (RQA) process.

4.1.1 Changes to protocol

Several significant changes to the original bid were made and agreed with the SDO:

- The survey of organisations was omitted due to rapidly changing policy and operational context
- The intended inner London site was moved to a provincial South East site (London Probation Service refused permission)
- The total number of offenders recruited was agreed at 200 (from the original possible maximum of 300)
- Recruitment of women from prison was abandoned due to practical and governance problems, leaving only 22 women in the study
- A validity study assessing offender report of health contact against healthcare records was carried out.

In addition it is recognised that our original intention to develop peer researchers in the prison environment was not possible, and that some of the peer researchers worked more as individuals than as a group.

4.2 Offender Level Data Collection

This section reports methods for collecting the following data:

- Initial and follow up interviews with offenders (Section 4.2.1)
- Focus groups (Section 4.2.2)

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- Extraction of information from health records (Section 4.2.3)

Method for analysis is described in Section 4.3

4.2.1 Individual Offender Interview (data collection)

Overall Sampling Strategy

The longitudinal interview study of offenders took place within the two main case study sites in the South East (SE) of England and the South West (SW).

The study examined and compared continuity and access to healthcare for groups of offenders prior to, during and after their contact with CJAs. Offenders were recruited at one of three time points: (a) start of prison sentences (including remand); (b) end of prison sentences; or (c) start of probation supervision. The primary aim was to collect quantitative data, however significant parts of the interview were narrative and exploratory in order to yield data for qualitative analysis.

The sample included 200 offenders who were serving a community or prison sentence in one of the two main case study sites. Table 3 below shows the composition of the sample. Women were not included in the prison recruitment sample due to geographical and access difficulties.

Table 3. Composition of initial study sample

		CASE STUDY SITE		
SENTENCE TYPE	OFFENDER GROUP	**South West** *n*	**South East** *n*	*Total*
Start of prison	Males	50	0	**50**
End of prison	Males	50	0	**50**
	Females	0	0	
Start of probation*	Males	39	40	**79**
	Females	12	9	**21**
	Totals	**151**	**49**	**200**

**At start of community sentence monitored by probation service*

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Procedure for Recruitment of Participants

The research team worked closely with each prison and offender management team to agree local procedures for offender recruitment which minimised the effort required from prison and probation service staff yet maximised the likelihood of reaching the above recruitment targets. Table 4 shows the inclusion and exclusion criteria.

In prisons everyone who was admitted from, or was being released to, the related local authority study area, and who was still in the prison at the time of recruitment, was invited to join the study. Potential participants were identified with the support of prison staff, usually through the prisons' database. This required permission from each individual institution. The invitation included a reader friendly invite letter (Appendix A) and information sheet. Where possible a member of the research team delivered this in person. Personal contact is particularly important for this group with high levels of illiteracy and distrust. Potential participants had the opportunity to ask the research team questions before deciding whether they wished to take part or not. Stamped addressed envelopes were also available, to allow people to write to the chief investigator for an independent opinion on whether they should participate. Those who wished to participate then discussed when the interview would take place with the member of the research team, taking into consideration the requirements and limitations of the prison environment.

In the community everyone starting a community sentence, who met the inclusion criteria, was invited to join the study by their probation officer within the first month of supervision commencing, or at weekly induction sessions; where possible a member of the research team, or a network support officer was present. Purposive sampling was used to ensure representation of women, those on unpaid work requirements and those on licence having been released from prison.

The researcher made contact with offenders who had received an invitation to join the study, unless they had already indicated they did not want to take part. A mutually convenient date and time to meet, in the probation team office or prison interview room was arranged. Written consent was obtained after ensuring the participant understood the voluntary and confidential nature of the study.

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Table 4. Inclusion and exclusion criteria for the study

Inclusion criteria	Exclusion criteria
° Aged 18 years and over	° Unable to give informed written consent – e.g. because of severe learning disability or current psychosis
° At the beginning* of their prison or community sentence *or* ° Coming towards the end of their prison sentence*	° Current mental or physical health means they are unable to participate in the research or likely to become distressed by it
° Previously living in SW or SE case study area, (or planning to live there after leaving prison)	° History of violence or other threatening behaviour which is likely to pose a risk to the researcher in the prison or probation environment.

**Within a month of coming into prison and 4-6 weeks prior to anticipated release*

Follow Up Interviews

In keeping with other studies in healthcare settings, approximately 50% of the cross-sectional study sample was followed up in order to examine the impact of moving in and out of the CJAs (and between different CJAs) over a longer period of time on continuity of care. In order to keep numbers balanced we 'capped' follow up of those under probation supervision and pursued a higher proportion of those released from prison, and therefore less likely to be in contact with the CJS, and so more difficult to follow up.

All participants who met the inclusion criteria, particularly those not being judged to be a threat to the researcher, were given the opportunity to participate in the longitudinal study and were provided with an information sheet. Multiple details of how to contact them in three months' time, including mobile telephone numbers and details of services that they might be in contact with, along with consent to contact them were taken. This was

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particularly important for offenders about to leave prison and return to the community. Health and criminal justice staff were involved in reviewing threats to researcher safety at all stages and determined the location of the follow-up interview. Telephone follow-ups were also pragmatically used to ensure researcher safety. At each face-to-face, or telephone, follow up point on-going consent was discussed and renewed in writing; or verbally for telephone interviews.

Offenders who agreed to take part were followed up at three month intervals for up to six months after joining the study.

The researcher asked about changes to social situations and about new and previously reported health problems, and whether the offender had any contact with healthcare services during the previous three months, or since the last interview. If the offender reported using any services during that period, the researcher also asked about the reason for the consultation, its location, and the team and/or health professional consulted for each contact. A shortened version of the questionnaire was also available for pragmatic use when offenders could only be reached by telephone rather than meeting for a face-to-face interview.

The offender longitudinal study questionnaire

The aim of the offender longitudinal study questionnaire (Appendix B) was to collect data about access to and continuity of healthcare and how it related to offenders' health and social exclusion status. The experience needed to avoid alienating highly distrustful and marginalised individuals while retaining validity. Both the perceptions of offenders and an 'objective' measurement of healthcare contact were seen as important.

The offender longitudinal study questionnaire was developed from those used in previous research on continuity of care in the general population, with advice from peer researchers. The questionnaire assessed:

- reported health and social problems
- offenders' experiences of continuity of care in the previous six months
- reported levels of contact with health and social care services
- the reason for contact
- the professionals involved.

In addition, it collected demographic/contextual information, and measured social exclusion.

Prior to its use in the field, the draft questionnaire was piloted and further developed with input from a group of five offenders to ensure its relevance

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and usability for this patient group. On-going input from the peer research consultant was critical during the further revisions after initial field work.

The questionnaire was divided into five sections. Section A included details of demographic status, social exclusion and contact with CJS. Section B elicited perceived health problems, GP registration status, on-going care requirements for different health problems (medication, reviews etc.)

Section C was the core of the interview and involved the use of a pictorial diagram[73], mapping contact with criminal justice agencies and health services over a six month period. Most offenders were found during the pilot to feel able to give a clear account of healthcare receipt oriented around criminal justice contact. For each contact, a service, a time and a quality score was given. Figure 7 shows a completed section C.

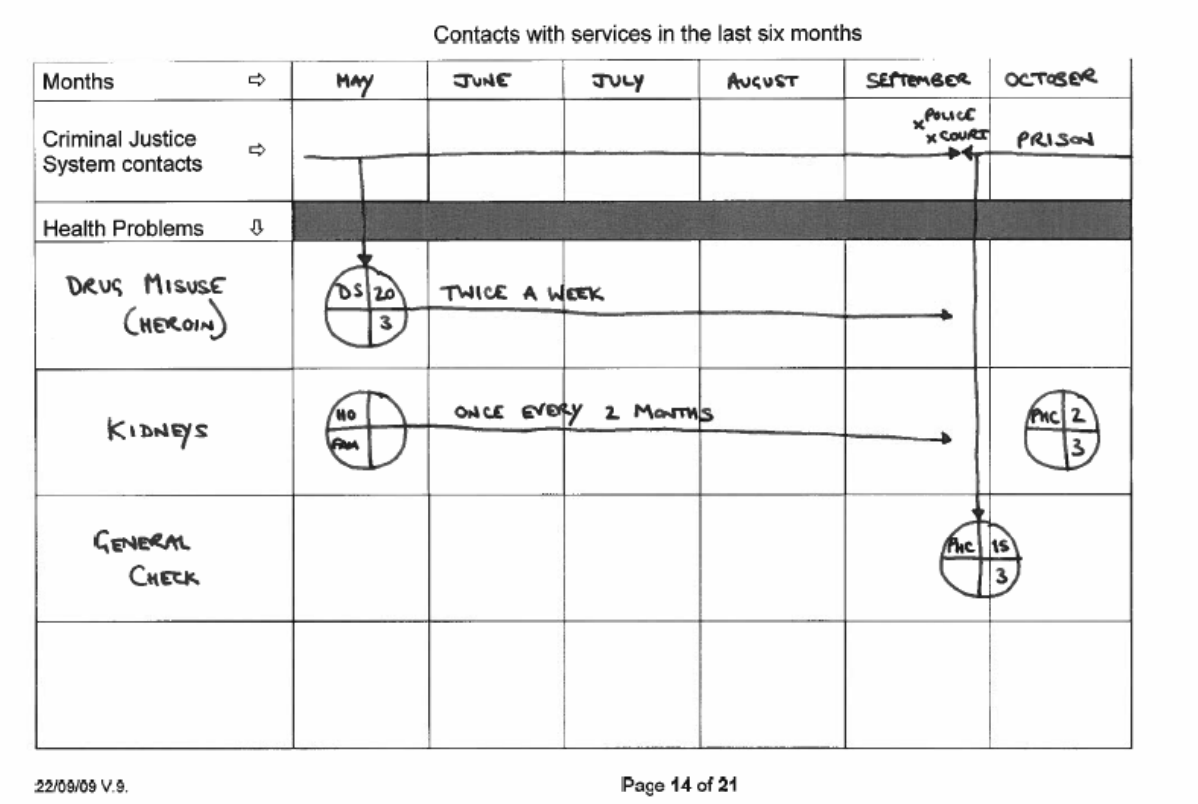


Figure 7. Completed Section C of interview questionnaire

Section D included specific questions relating to elements of continuity such as willingness to agree to information sharing; and other questions related to access such as trust and stigma. Section E discussed avoiding reoffending and healthcare's potential contribution to that.

The questionnaire was designed to be administered via a face-to-face interview which lasted approximately 45 minutes. If the offender felt they needed a short break during the interview, this was possible. The researcher read out the questions verbatim, noting down the offender's

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responses in the appropriate format. Where possible the interview was recorded. Time was given for offenders to think about their responses and ask for explanations and clarifications.

While this structure was used initially, as researchers gained confidence, a much more free form interview technique was used. Offenders were allowed to open up and talk freely around topics brought up by each question, allowing for collection of rich narrative data. The researchers ensured that all the data required for the quantitative analysis was entered onto the structured schedule after negotiating agreement with the participant. Offenders were then asked if they would be willing to take part in the follow up interviews.

Once the study interview was completed, the researcher debriefed the offender, checked that they had not been unduly distressed by participation in the study, and asked if they wished to receive a copy of the research findings. If the participant was distressed the researcher offered appropriate sign posting to support services or offered to talk to staff on their behalf.

4.2.2 Focus Groups (Data collection)

Five focus groups were carried out in the South West case study (SWCS) area. Focus groups were selected on the basis of their potential ability to provide information on continuity, and the potential to address areas of healthcare or sub-types of offenders which the study had not particularly focused on. The following groups were set up:

- a group of prolific offenders.
- a group of long term prisoners
- a group of individuals with long term substance misuse problems.
- a group of women with current community sentences.
- a group of women with current substance misuse problems.

These groups included women to balance the deficit from prison sampling and those with longer term prison sentences which were under-represented based on the sampling strategy for individual interviews.

All individuals were contacted via practitioners working in the five settings and invited to join the focus groups by letter. Five focus groups (4-8 participants) were carried out in environments known to the individuals involved with a researcher and either a second researcher or peer researcher. They were recorded and transcribed orthographically.

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4.2.3 Health records (Data extraction)

Data from health records were extracted in order to:

- Validate offenders' self-reported data on healthcare.
- Assess continuity of communication between prison healthcare and general practice.

A subset of 49 male participants drawn from those recruited at release from a SW prison, who had SWCS addresses and who had given consent for their medical records to be checked were selected. A sample size of 25-30 was aimed for with initial oversampling due to the likely difficulties of accessing community records.

For each participant, their GP records, drug & alcohol service records and prison healthcare records were accessed. The researcher was blinded to the participants' self-reported healthcare contacts. A standardised proforma was used for collecting the data.

Information on which GP or practice the participant was registered with was sought from their interview and from their prison records. A letter was sent to their GP practice, including a copy of their consent form and a study information sheet, asking for permission for a researcher to contact the practice to obtain relevant information from the patient's record. The letter was followed up by a phone call to the practice manager. In most cases, for pragmatic reasons, the information on contacts was collected via a phone-call from the researcher to a member of the practice administrative staff. As the SWCS had a GP walk-in centre which also provided outreach clinics at homeless and probation services, the records of contact with this service were also viewed for each participant.

The electronic records of a substance misuse service for SWCS were reviewed for each participant. The prison healthcare records of each participant were also reviewed.

4.3 Analysis of data from offenders

This section reports the methods used for the analyses:

- Quantitative analysis, including continuity of communication and validation sub-study.
- Qualitative analysis of interview data and focus groups.

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4.3.1 Analysis of quantitative data

The quantitative analysis of the individual offender data included the following, described in the sections below:

- Description of the sample population, and their social and health problems.
- An analysis of access rates for different problems and how these differed across criminal justice settings.
- A description of offenders' views on continuity.
- A validation study, comparing offender self reported service use to that recorded in health records.
- An analysis of communication between prison health and community based teams.

Sample description

Descriptive statistics were used to describe demographic features, social problems and reported health problems. The latter, 'perceived prevalence' was calculated as a simple percentage of the population. Co-morbidity across the major areas of physical, mental and substance misuse was described.

Primary and secondary analyses

The primary outcome, 'continuity of access', was calculated as the number of contacts with health and social care per unit of time. This was derived from both the cross-sectional and follow-up data. Gaps between contacts were also examined and related to imprisonment and CJA contact.

'Continuity of access' was calculated before, during and after contact with various CJS settings. These were also calculated by the type of healthcare provision and the type of problems for which help was being sought.

Multivariate statistical analyses were conducted on 'continuity of access' for the different types of health problems and the different CJA settings to examine if this differed between the different categories.

Secondary outcomes of duration of healthcare contact and the quality rating of healthcare contact were also calculated by the type of healthcare provision and the type of problems for which help was being sought. The values were self-reports by offenders, giving measures of their perception of quality and duration of care.

Multivariate statistical analyses were also conducted on the duration and quality of healthcare contacts for the different types of health problems and different CJA settings.

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Continuity of access rates

Longitudinal continuity of access rates across different CJS settings and transitions were calculated as part of a time series analysis. Transitions were calculated from and to prison from all other CJS settings combined, and between community and probation in both directions.

Analysis for validation of self-reported data

For each participant, data was extracted from the initial and any follow up interviews on:

- Number of months in prison and non-prison setting (any part month was counted as half).
- Number of contacts with a primary care doctor or nurse.
- Number of contacts with the drug service.
- Number of contacts with prison health for a) physical b) mental c) drug or alcohol and d) prison-initiated healthcare.

For each participant information was collected on each contact with a healthcare professional, drug worker or prison healthcare staff during the study period (six months prior to recruitment until last follow up interview). Information was also collected on which health professional the contact was with and on what health problem(s) the contact was for.

Prison-initiated contacts included routine health assessments on entry, prior to court hearings and on release. For prison records, the number of contacts for each of the four categories of problem was counted. Where a contact was for more than one type of problem this was documented.

For GP records, the date the patient was registered with the practice was noted; where there were records for less than the entire study period, the self-report consultations were compared for the available months. Face-to-face consultations with primary care doctors and nurses were counted together. Phone consultations were recorded separately.

For drug service records the number of face-to-face contacts with any professional was counted. Where there were two contacts on one day this was counted once.

The numbers of self-report contacts was compared with the number of contacts documented in the health records for primary care, drug service and prison healthcare. In addition, the prison healthcare contacts were compared separately for each type of health problem.

As neither value could be treated as wholly accurate or reliable, the mean difference was used to estimate the agreement between them. This was

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analysed using a measure of inter-rater reliability (intraclass correlation coefficient). The mean difference was also compared between the three groups (community primary care, community drug service, and prison).

This gives an indication as to whether self-report measures are a valid measure to use in this type of study.

Analysis for communication

For each participant, the prison medical records were assessed for evidence of a letter sent to the patient's GP on release. Where there was a letter, information was collected on the date sent and whether it included details of health problems, medication and future management plan. For each participant, the GP records were assessed for whether a letter had been received from prison healthcare and, if so, the date received and the information it contained.

Continuity of information was estimated from the same sub-sample, based on reports of receipt of notes by practices as a proportion of the total sub-sample.

4.3.2 Qualitative Analysis of Interview Data and Focus Groups:

The original data collection plan involved drawing up a purposive sub-sample, based on the initial interviews, of offenders with relevant experiences relating to access and continuity, and conducting a further 1:1 interview to explore those experiences in more depth. Once we had started collecting interview data we changed the plan, for a number of reasons.

Firstly, many participants had difficulties with concentration and the initial interview schedule took them to the limits of this. To extend the process, even at a later date, we judged what would put an unfair burden upon them. We also realised that conducting a further in-depth interview was unnecessary. Participants' lives, and experiences of healthcare, were interwoven with other issues and experiences of other services and emerged spontaneously, in collaboration with the researcher, during completion of the initial interview schedule. This had a number of advantages over an in-depth interview. It allowed participants to give information in small blocks, which was comfortable for them and avoided them reflecting too deeply upon past traumas and difficulties. If participants felt that they did not have anything to say in answer to a particular question the researcher could move onto the next question.

Allowing participants to give information concerning access and continuity throughout the interview schedule retained the integrated nature of their lives and experiences. We felt that to ask participants to reflect further on abstract concepts of access and continuity would confuse and disempower them. A number of participants, on being approached to participate

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expressed the concern that they would not be able to tell the researchers anything worthwhile. Starting the interview schedule with simple closed questions allowed them to build their confidence and acclimatise to the interview situation, whereas an unstructured approach using open questions may have served to reinforce feelings of low self-worth in this group. We would therefore, recommend conducting research interviews with offenders in this way, using a mixed quantitative and qualitative format.

The focus groups provided additional information on particular points, and for particular groups, within the CJS.

We carried out two separate types of analysis on the individual interview and focus group data. First, we applied an *a priori* coding frame based on the phases of the CJS and known components of continuity. Secondly, we undertook an inductive thematic analysis of offenders' experiences and perceptions of care received, with a particular focus on the ways in which individuals portrayed themselves, their help seeking and the control they had over their lives; this appeared to be important in understanding how offenders engage with, and might continue to engage with, health services.

Defining the Dataset

All five focus groups were included in the data set for analysis. From the 200 offender interviews, a purposive sampling strategy was used to select transcripts for qualitative analysis. The aim was to include individuals who had experienced high levels of healthcare contact for substance misuse, mental health and physical health problems, and also a smaller number of those who had lesser use of services.

A short list of 41 individuals was drawn up by going through the paper based interview schedules, identifying those with the most substantial free-form comments about aspects of access, continuity and healthcare. From this list a sample was derived, selecting all those with contacts for: drug and/or alcohol use (20 contacts or more); mental health contacts (10 or more); physical health contacts (8 or more); low levels of contact overall (6 contacts or less). The sample was checked to ensure that it adequately represented the different recruitment points, interviewers and research sites. If follow-up interviews had been conducted for these participants they were included in the data set. The final data set contained interviews for 22 individuals, four of whom had given follow-up interviews. The interviews and focus groups were transcribed orthographically and two analyses carried out as below.

Access and Continuity Analysis

An *a priori* coding frame was applied, using the NVivo 8 data management tool, based on the components of continuity (longitudinal, relational,

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flexible, organisational and communication) and the wider area of access as defined in the study protocol. Additional codes were generated where the narrative described something particularly important relating to access and on-going receipt of healthcare. The analysis aggregated coded text on a cross-case basis and examined for sub-themes. This allowed us to examine individual experiences of each component of continuity and access, or lack of, and what the participants valued or regarded as important for these aspects of healthcare, based on their experiences. Following analysis of the individual interview data, the focus groups were then coded, using the same coding frame. The findings of the interview analysis were then compared with the focus group data in order to identify agreement, deviant cases and the emergence of additional themes. The analysis was then written up according to the components of continuity and the wider theme of access, and additional aspects of organisational care which had emerged, paying particular attention to how the subthemes related to both the phase of the CJS and the type of health problem.

Depth analysis of offenders' experiences

An inductive thematic analysis of the selected offender interviews was also carried out. Themes were initially generated from five transcripts (one single interview and two sets of initial and follow-up interviews). Two researchers (CQ and IP) immersed themselves in the transcripts and identified themes independently, before comparing with each other, agreeing on a set of five core themes and validating these with a third researcher (RB). During coding of remaining transcripts, the themes were further developed through regular consultation and discussion between researchers.

After coding, a one-sheet summary was produced for each interview, depicting the salient information and issues; these were colour-coded according to theme and interactions between themes were depicted with arrows. From this, a written summary of each interview was then produced, describing the individual's experiences, points relating to each of the themes and any interactions between themes, together with interpretive comments on the way in which the individual portrayed him/herself in the narrative. The summaries were produced by two researchers (CQ and IP), who discussed and agreed them with one another. This within-case analysis allowed the integrity of each individual's narrative to be preserved.

Subsequently, a cross-case analysis was conducted on a theme-by-theme basis, comparing and synthesising material from all the cases.

The focus groups were analysed in a similar way, treating each focus group (rather than each individual) as a unit of analysis, and attending to group interactional issues as well as to the themes.

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Finally a cross-case and cross-group analysis was carried out (involving a fourth researcher CO) with all the data together looking at:

- the individual themes
- the interactions between themes at individual level
- the presentation of self in the narratives.

4.4 Peer research contributions

Involvement through the project as a whole

Peer researcher involvement was seen as integral to the project from the outset, both to shape the project as a whole and to contribute to answering the research question in their own right. Inspired by Canadian peer researchers[74] the term 'peer researcher' was adopted to denote that when they met around the table the academic researchers brought their academic experience, and the peer researchers brought their experience of the CJS, and in this way they were each other's peers. A lead peer researcher (DH) was employed to bring together the group, co-ordinate the work and contribute throughout the life of the project. All peer researchers were paid for their involvement; alternative forms of remuneration were offered for those who would find it difficult to accept payment. Initial discussions with one of the proposed prison sites indicated that they would be willing to include the Offender Research Group as an option in their work placement scheme but this was not pursued due to pressures within the prison system.

A peer research group was developed; COCOA RICH (Research Into Change Highlighted). The following aims were agreed:

1. To access people and topics that the research team may not reach.
2. To make data gathering materials understandable to participants.
3. To ensure that the findings were disseminated in appropriate formats.

Peer researchers were offered a variety of ways of being involved in the project these included supporting the academic research processes and carrying out research in their own right.

Those who supported the academic research process were involved in: shaping the language, content and style of the offender study; interviewing candidates for research staff appointments; co-facilitating focus groups with academic staff; and commenting on focus group analyses.

Those who carried out their own focus groups undertook the following with the support of the academic researchers:

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- Wrote down the story of their own experiences.
- Shared these with other members of the group and jointly identified the key access and continuity issues.
- Developed their own semi-structured interview schedule based on these discussions.
- Carried out an initial focus group with members of the third sector organisation of which they were a part.
- Reviewed this focus group, critiqued their interviewing skills and revised the interview schedule.
- Carried out further focus groups (n=3) with offenders in the community.
- Listened to these focus groups and wrote their own summaries of what was said.
- The above material was then collated and summarised by the lead peer researcher and is presented as the peer researcher results in this report.
- The lead peer researcher (DH) and an academic researcher (CQ) also produced a critique of the process of peer research involvement in the process.

4.5 System Wide Organisational case studies

The system wide organisational case studies were designed to provide an account of current continuity of care across health and criminal justice agencies. They were carried out in two primary sites centred around and PCTs in the SE and SW and their associated CJAs (courts, offender management service and local associated prisons) and described current systems, gaps in care, organisational changes, implementation of guidance and perceived barriers to continuity of care.

They were based on interviews with key staff and documentary analysis, as well as interviews with offenders in prisons and focus groups with offenders in the community (see Section 4.5.1 below).

The data collection and analysis was based around the framework used for developing the provisional programme theory:

- The phases (prison, probation, no CJA contact) and the transition nodes (prison entry and exit; courts; police contact).
- The element of continuity (longitudinal, relational etc.).

Documents and participants were selected with the aim of covering the whole CJA and the associated health services likely to be contacted by offenders.

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Interviews with staff

Staff from a range of professional backgrounds and a range of CJAs and healthcare teams based in the two PCT areas were invited to take part in face-to-face interviews.

Relevant agencies and teams were identified through local groups and advisors. In addition agencies and services identified through the offender cross sectional interviews as well as publicly available information about local organisations and services were used.

Informants received an invitation letter. They were encouraged to read the study information, to decide whether they wished to participate.

Interviews were held at their convenience. In some cases, it was necessary to arrange brief telephone interviews. Up to 20 participants were interviewed per setting.

The interview followed a topic guide that was adapted for staff from different agencies, professional groups and settings, and was piloted before use. The interview asked about the participant's views on how care for offenders is configured, barriers, innovations and potential improvements.

Documentary analysis

The case studies also included the analysis of any relevant reports and papers that were identified by interview participants and were available to the research team.

Data from the interview studies

Data from the interview studies was also used. Quantitative analyses were re-run including data from individuals in each site to indicate approximate prevalence of reported illness, contact rates and quality scores etc. Narrative extracts from interviews from the sites were utilised either when they helped demonstrate an additional finding or to illustrate points made by managers and practitioners.

4.5.1 Analysis of whole system case studies

The two local case studies described in-depth the types of organisational structures, partnership arrangements, the implementation of guidance and the facilitators and barriers (at the organisational and practitioner levels) for improving access and continuity of healthcare for offenders. Patterns of co-operation and perceived continuity found in these two main sites were also contrasted. The case studies were primarily descriptive and exploratory rather than explanatory[75]. They were contributory to answering the

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research questions by describing the current state of continuity at the system and organisational level.

A framework analysis (tabulation) was used to describe the two case study sites in terms of:

- Healthcare resources available within and outside the CJA.
- Intended outcomes in terms of access and continuity and the extent to which they have been achieved or not.
- Linkage mechanisms among CJA and healthcare organisations, especially referral and clinical information flows between care providers.
- How these interact with other managerial processes (e.g. service contracting and cost control), focusing on any dis/continuities of care that they either produce or overlook.
- Facilitators and obstacles to improving access and continuity and implementing guidance on continuity.

Following extraction of data relevant to continuity we constructed a narrative case study to show how, why and when continuity was achieved, the barriers and facilitators, and the communication interactions between health and criminal justice practitioners.

4.6 Best practice mini-case studies

The focus of the mini-case studies was to examine innovative organisational models of care and to assess their impact on the continuity of access to healthcare for offenders. The studies highlight areas of best practice, examine what has been done and assess the positive impact this may have on the provision of care. This best practice was also assessed against the relevant policy presumptions from the 'provisional programme theory'.

4.6.1 Selection and data collection

Six mini-case studies were selected from organisations, services or projects across the UK that have been reported as having incorporated initiatives into their working practices that potentially promote improved continuity of access to healthcare for offenders. They were selected from candidate sites reported in a variety of official, academic or scientific papers or reports. The sites were chosen to represent a range of problems and CJS settings.

Five of the mini-case studies were carried out using a combination of documentary analysis and interviews with up to ten key staff members. A sixth case study was based on documentary analysis only. The interviewees were located through official reports, press, journals, websites or official

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guidance followed by the use of a snowballing strategy. The staff interviewed were selected to reflect different aspects of knowledge of the service and different perspectives of the service. The telephone interviews lasted approximately 15 minutes and included a brief overview of the service, the interviewee's role within it, their perception of the strengths of the service in relation to continuity of access to care, what has changed and what has been learned. If possible, individual examples of good access and good outcomes were asked for. Views on what the service has not been able to achieve and what barriers may exist to prevent progress were also sought.

4.6.2 Analysis

For the analysis, a 'programme logic' was extracted for each service from both the documentary data and the interview data. This comprised of both higher level aims and visions and specific objectives and rationales for activities. What was actually being done or had been introduced and implemented, for example initiation of new training or provision of new services, was examined against both this programme logic and the policy presumptions. Conclusions were reached about the possibility of achieving specific components of continuity in each case setting. These conclusions were then used to develop the 'programme theory' as described in Section 0.

4.7 Integration and mixed methods synthesis

Each of the sections above describes the analysis of individual components of the study. The results of these stand in their own right and contribute to research questions according to Table 1. The final phase of analysis brings together the results of each component in order to answer the following research questions:

- Which elements of continuity of care are most important for improving health and recidivism and most important to offenders?
- Does the relative importance of these elements vary for different criminal justice agencies and different offender groups?
- What are the key facilitators required to increase continuity?
- What models of care are likely to improve health and reduce recidivism, and what are the resource implications?

The first two questions encompass the aim of identifying the essential elements of continuity of care for offenders. The second two help develop hypotheses about effective models of delivery.

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4.7.1 Theoretical issues for mixing methods

Over the last ten years there has been an increased interest in defining both types of mixed methods research and also providing guidance as to how to deliver high quality mixed methods research[76]. This has been driven by a desire to be able to combine the advantages of different methodological techniques allowing them to complement and inform one another, while also addressing the shortcomings inherent in any individual approach. This study was explicit from the outset that different viewpoints and different types of evidence have a role. This has allowed the research questions to be examined from both an individual and organisational level, as well as considering individual and group experiences. Within this study the division between qualitative and quantitative aspects is complex. The methodological components of the study aim to be equally weighted and have informed each other throughout the research process.

The offender questionnaire provides rich narrative data which has been used in three very different ways. Firstly, the perceptions of offenders about their socio-economic status, their health problems and their access to care has been categorised and aggregated and used to provide an approximate 'objective' estimate of rate of disease (perceived prevalence) and rates of access in different situations. Secondly, it has also been used to identify offenders' perceptions about the care they received and reactions to continuity and discontinuity. Finally, it has been interpreted by the research team to draw conclusions about offenders' agency and motivations.

While the offender interviews were used in three different epistemological ways, the case studies brought together a number of different data sources to create a 'subtle realist' view[5] on how services are provided within a whole system.

Mixed methods studies can be defined according to the balance of qualitative and quantitative data and whether they are carried out sequentially or in parallel. Figure 6 showed the relationship between different components of the study and the influence of one on the other throughout the study.

This 'following a thread'[77] was facilitated by having a consistent framework (phases of CJS and components of continuity) as well as the fact that the core members of the research team were working on all components of the study. The initial analysis of the quantitative data informed the emphasis within the qualitative enquiry, within both the case studies and the later individual offender interviews. Similarly the results of the case studies and qualitative analysis informed the detailed exploratory analysis of the quantitative data (e.g. examination of co-morbidity and contact for those of different co-morbidity).

Mixed methods synthesis within this project therefore started in the case studies with the combined use of documents and interviews that later incorporated the quantitative data and qualitative interviews with offenders.

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Figure 8 shows how the different components of the study have been used firstly within the whole system case studies and secondly to develop theories about continuity and the mid-range theories of a revised 'provisional programme theory'.

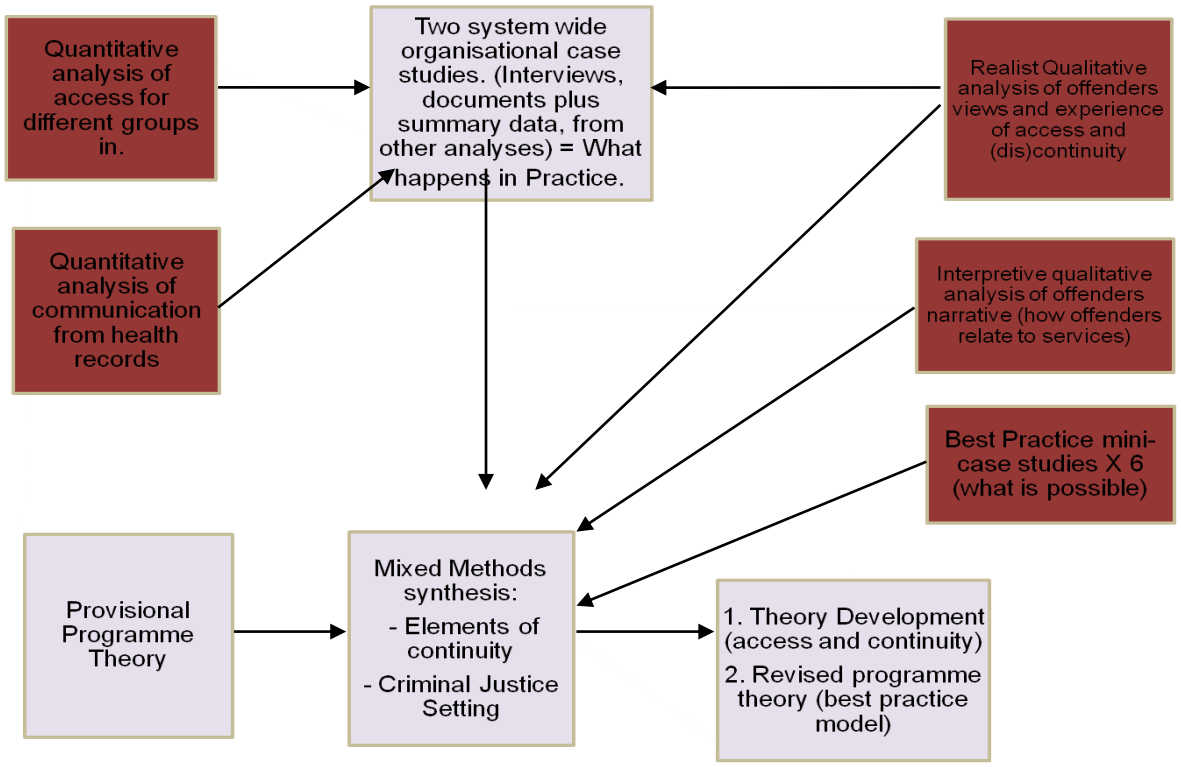


Figure 8. Individual analyses and integration of findings.

4.7.2 Developing theoretical perspectives on continuity and access

This process included the following stages:

- The results from the continuity analysis were used to map out typical pathways of care and potential new elements of continuity.
- Data from all the sub-studies were used to look for consistency, contradictions, silences with respect to the original and proposed new elements of continuity.

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- Data was also examined for evidence about the relationship between the different types of continuity. A diagram was developed to depict this.

4.7.3 Revising 'Programme Theory' for continuity of care for offenders

The final stage of analysis within the project involved taking the abstract theoretical conclusions about access and continuity and developing a 'revised programme theory'.

Having used our results to theorise about continuity, the next step involved developing conjectured theories about how the key mechanisms would be implemented across the criminal justice setting. During the course of the project two important policy documents were released[78 79]. Our original plan had been to revise the packages and components underlying the policy presumptions developed in the first stage of the study. However, this new policy context and our findings led us to an alternative strategy of synthesis: first testing the new policies against our findings, then using our key findings (the mechanisms for creating continuity), along with wider evidence related to health services delivery to develop an outline 'programme theory'.

We examined the implicit and explicit policy assumptions and key mechanisms within these two key documents against our original 'programme theory' and the empirically derived mechanisms for continuity.

We then identified which elements or mechanisms for delivering continuity were applicable to each stage in criminal justice proceedings. We then examined our findings to identify any further context dependence (health problems, coping style) for each key mechanism. Lastly we looked at how the elements of continuity might work synergistically and sequentially.

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5 Results

5.1 Overview of results

The aim of the project was both to describe and to develop relevant theory. The results include a description, both quantitative and qualitative, of care provided (organisational, team, practitioner and offender levels); then they go on to theorise both abstractly, in the form of a development of ideas about continuity of care, and more concretely in the tradition of Merton's middle range theories [7] by developing a 'programme theory' about how continuity of care for offenders can be achieved. Figure 9 shows the relationship between the different sections of the results.

Section 5.1.1 presents the quantitative analysis of the longitudinal offender questionnaire study. This examines access, continuity and the relationship between health receipt and criminal justice contact. Sections 5.2.1 and 5.3 present the qualitative analysis of focus groups and in-depth narrative sections of the offender interviews.

Section 6.1 describes the whole system case study for the South West; with an analysis of key differences in the South East.

Sections 6.3 to 6.8 consist of six mini case studies where the examples of best practice are examined.

The penultimate section (Section 7) of the results utilises the results from the mini case studies and the whole system case studies as well as components of the offender study to develop theory about continuity for offenders.

Section 7.2 details the results of the revised programme theory. This includes high level 'policy requirements' and the packages needed to achieve their aims.

5.1.1 Quantitative offender longitudinal interview study

Offenders were recruited to the study soon after entering prison, before leaving, and at start of community sentences. The numbers of participants at each stage of the study are shown in Figure 10. Of the 286 potential participants invited to join the study 21% (59/286) declined to take part and 12% (27/227) did not attend the interview (by choice or due to logistical reasons). This gives an overall recruitment rate of 70% of those eligible to take part (200/286).

The targeted number of 100 offenders for follow up was split across the three recruitment points in order to include sufficient numbers of those leaving prison (the more difficult group to target). Follow ups on prison entry and probation were 'capped', and Figure 10 shows that overall '3 month' follow up was successful in 70% of offenders (84/120).

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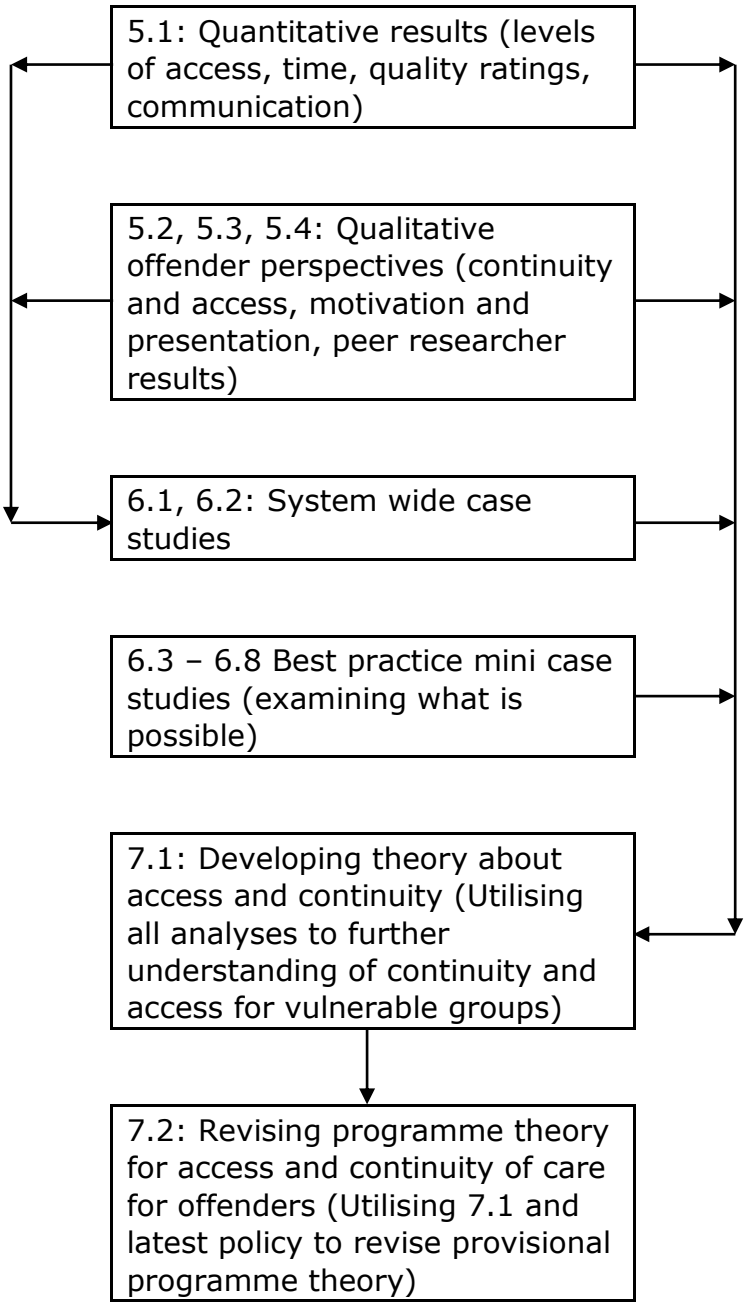


Figure 9. Relationship between the different sections of the results

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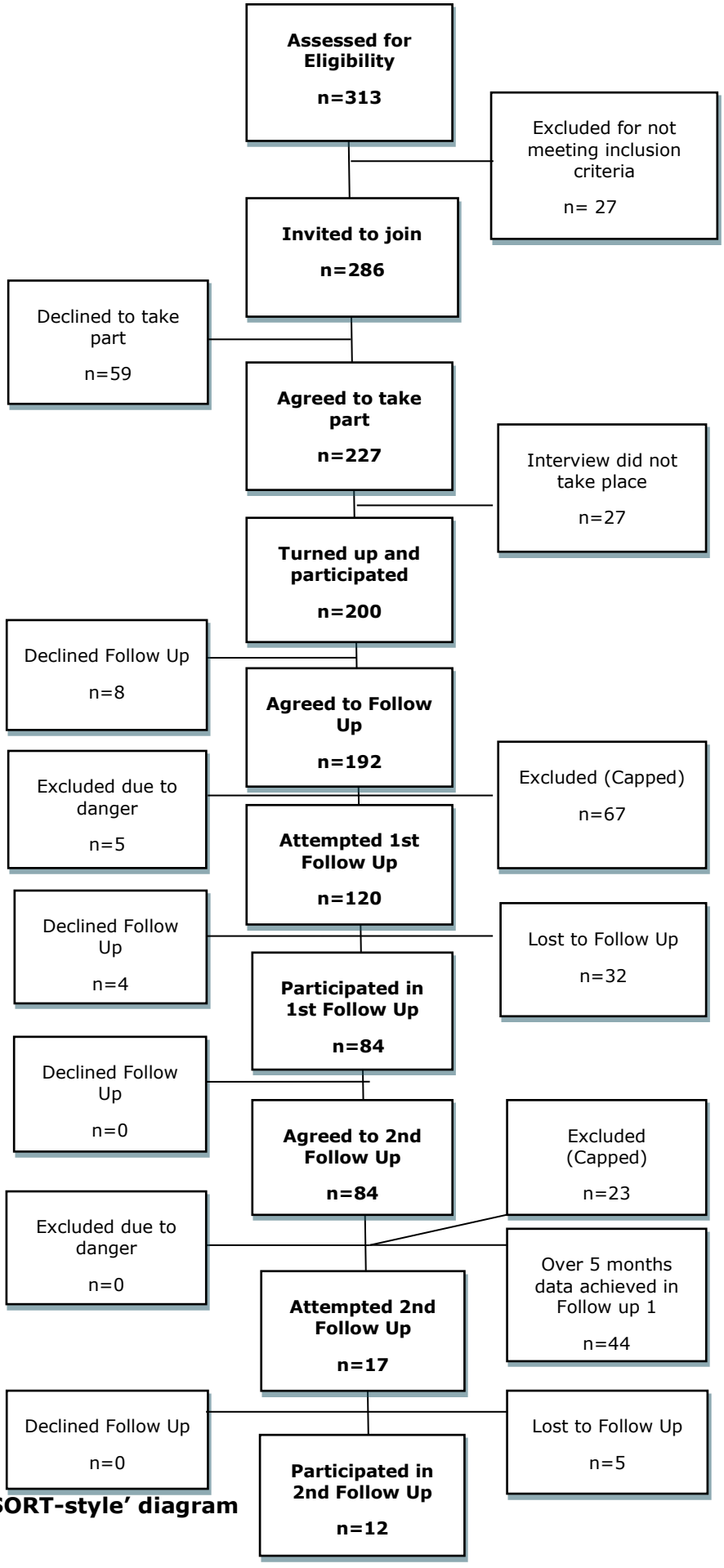


Figure 10.'CONSORT-style' diagram

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5.1.2 Description of the sample

What is the make up of the study population?

Predominantly male, white, skewed to 18-25 age range. Many had partners (47%) and children (52%). Twenty three percent were employed and 20% homeless. Twenty seven percent had been in prison more than five times

The sample consisted of 200 participants: 178 males and 22 females. The average age of the sample was 31.7 (standard deviation (SD) = 10.5) years, and the mode was 24 (modal group 22 to 25). Ninety two percent were White (English, Scottish, Welsh or Irish) with 2% Black, 3% from the Indian subcontinent and 3% mixed or other. The breakdown by age band is shown in Table 25 of Appendix D.

Table 5 shows the socio-demographic descriptors. Out of the 200 participants, 94 (47%) reported they lived with a partner. Additionally, 103 (52%) reported having one or more children under the age of 18, and over one-third of the sample (73/200; 37%) reported that they had problems with their family relationships.

Living arrangements and accommodation

Most participants lived on their own or with their partner (58%). Just over half lived in a house or flat rented from a housing association, local authority, or private landlord (55%) (Table 5).

Over one in three (77/200; 39%) reported that they currently have or may have (on release) problems with accommodation, 48/200 (24%) did not feel settled in their current accommodation (or before prison), and 42/200 (21%) did not feel part of the area they live(d) in.

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Table 5. Socio-Demographic descriptors

Characteristic	Frequency (%)	
Living arrangements[a] (n=200)		
Normally living with:		
Partner	47 (24%)	
Child/Children under 18	12 (6%)	
Parents	34 (17%)	
Other family/friends	33 (17%)	
Alone	68 (34%)	
Type of accommodation (n= 200)[b]		
House or flat owned by you	8 (4%)	
House or flat rented from HA/LA[1]	65 (33%)	
House or flat rented from private landlord	44 (22%)	
Residential home or sheltered housing	4 (2%)	
Staying with friend/family with own room	35 (18%)	
Hostel*	15 (8%)	
Living on the street*	3 (2%)	
'Sofa surfing' (staying with friends/family with no room)	11 (6%)	
Other[2]	8 (4%)	
Current / previous employment (n=200)	In community[c]	Before prison[d]
Paid/self-employed	16 (16%)	28 (28%)
Unemployed	21 (21%)	34 (34%)
Unemployed and looking for work	27 (27%)	15 (15%)
Unable to work (long-term sickness/disability)	22 (22%)	15 (15%)
Retired	1 (0%)	0 (0%)
Looking after family or home	6 (6%)	1 (1%)
In full-time education	2 (2%)	3 (3%)
Doing something else	4 (4%)	1 (1%)
Highest level of education (n=200)[e]		
Degree or equivalent	3(2%)	
Higher education or equivalent (below degree)	15 (8%)	
GCE/GCSE A-levels or equivalent	9 (5%)	
GCE/GCSE O-levels or equivalent	71 (36%)	
Other qualifications at NVQ level 1 or below	51 (26%)	
No formal qualifications	31 (16%)	

The above characteristics were self-reported. [a] 6/200 (3%) no clear response. [b] 7/200 (4%) not answered [c] 2/100 (2%) no response. [d] 3/100 (3%) missing. [e] 20/200 (10%) unanswered.*part of broad homeless definition.

Employment and Education

[1] HA – Housing Association; LA – Local Authority
[2] Other includes homeless; on street; shared; don't know; don't know or sofa surfing; to be deported so no accommodation

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The majority of respondents were unemployed or on long term sickness benefit (70% of those in probation and 65% of those in prison). Details of employment status can be seen in Table 5.

Just over one third (71/200;(36%) of the sample were educated to GCSE or equivalent level, with 51 having qualifications at the NVQ 1 level (26%). The remainder had mixed levels of education as represented by Table 5.

When asked if they felt they had any problems, or pending problems on release, with employment, education or training, 112/200 (56%) participants reported that they currently did not have, or would not have any concerns.

Participants were also asked if they felt they had any problems, or pending problems on release, with finance, benefit or debt and 85/200 (43%) participants reported that they currently have, or anticipate experiencing these problems.

5.1.3 Contact with criminal justice system

Details of sentence type and duration are shown in Table 6 (below) and Table 25 (Appendix D). Three-quarters of the sample were serving community or prison sentences, the remainder were on licence or on remand. The majority of the sentences were below 12 months. Approximately one-quarter of the participants (26%) reported having on-going legal or criminal justice issues.

Table 6. Sentences and duration

Sentence being served (n = 200)	
Community sentence	78 (39%)
On licence	20 (10%)
Prison sentence	75 (38%)
Remand	27 (14%)
Duration of sentence (n = 176)	
Less than 1 month	9 (5%)
1-3 months	27 (15%)
4-6 months	39 (22%)
7-12 months	47 (27%)
Over 12 months	54 (31%)

Appendix D displays the frequencies of community and prison sentences across the group. The majority had served between one and five prison sentences (38%) and between one and five community sentences (51%).

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Demographic data and access rate

Analyses[3] that used the demographic data collected to examine the rate of access showed that where offenders stated they would live on release affected their access for mental health problems ($F_{(8, 171)} = 3.13$, $p = 0.003$, $\eta_p^2 = 0.13$). Specifically, pairwise comparisons showed that those who stated they would be living in residential or sheltered accommodation had higher rates of access for mental health problems (1.5) than those who stated they would be living with their friends or family (0.2), renting from a housing association (0.3), renting privately (0.1) or sofa-surfing (0.2) (all p's < 0.05).

Regressions showed that age was weakly but significantly related to the access rate for physical health problems, with increasing age related to increased access ($F_{(1, 186)} = 4.72$, $p = 0.031$, with an adjusted $R^2 = 2\%$). An increase in age of one year was associated with a 0.04 increase in access rate for physical health problems.

Feeling part of where they lived was also significantly related to access for mental health problems ($F_{(1, 195)} = 12.61$, $p \leq 0.001$, with an adjusted $R^2 = 6\%$), with increased agreement with the statement ('do you feel part of the area where you live/d') related to increased access (an increase of 1 point of agreement with the statement was associated with an increase of 0.13 in access rate).

Age was associated with an increase in overall access rate ($F_{(1, 187)} = 4.72$, $p \leq 0.031$, with an adjusted R^2 of 2%), with an increase in access rate of 0.04 associated with an increase in age of one year.

Qualifications, problems with education and type of sentence did not have an effect on access rate for any health problems ($p > 0.13$)[4]. Pairwise comparisons showed that those reporting themselves as 'sick or disabled' had a higher rate of access for mental health problems (0.6) than those who were employed (0.1) (main effect of $F_{(3, 172)} = 3.01$, $p = 0.032$, $\eta_p^2 = 0.05$).

5.1.4 Perceived health problems

What health problems did offenders report?

Thirty seven percent rated their health as poor. Fifty three percent reported (current) drug misuse, 36% alcohol misuse, 15% had severe and 59% more moderate mental health problems. Only 4% believed they had no physical problems. Co-morbidity was the norm.

[3] MANOVA; $p = 0.05$
[4] MANOVA; $p = 0.05$

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Of the sample, 37% (74/200) of participants believed their health to be quite poor over the past six months, while 25% (50/200) of participants rated their health over the past six months positively.

Health problems were recorded in detail and then categorised. A complete summary of the reported health problems is shown in Table 7 together with the numbers of contacts for each health problem and the percentage of individuals reporting each health problem.

The health problems were specified (left hand columns), and then a frequency for each diagnostic group was calculated, grouped at a mid-level. The high level grouping (right hand columns) was used for comparing contact rates and termed broad care group(s).

Just over half of the participants (106/200; 53%) reported drug misuse as being one of their health problems, and this was mostly related to heroin (56/106; 53%) . The vast majority of substance misuse contacts were associated with heroin use (1112/1328; 84%), which made up 40% of all healthcare contacts. Just over one-third (36%) reported alcohol misuse, with 211 associated contacts. Disabilities were commonly reported (34% reported disability related health problems) though the number of contacts for these problems was low.

Fifteen percent reported themselves as having bipolar, personality disorders, psychosis or schizophrenia (severe mental illness). More than half of the participants (59%) reported themselves as having less severe mental health problems (e.g. stress, depression). Depression was associated with a total of 327 (13%) healthcare contacts, reported by 98 (49%) participants.

Physical health problems were most frequent overall (reported by 184 (92%) of participants) with large numbers of offenders reporting chest problems (56/200 (28%)) or musculo-skeletal problems (92 /200 (46%)).

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Table 7. Health problems by number of contacts and percentage of participants

Specific Health problem (% of participants reporting problem)	N of contacts	Mid level health problem category (% of participants reporting problems)	N of contacts	Broad care group (% of participants reporting group)	N of contacts
Alcohol Misuse (36%)	211	Alcohol Misuse (36%)	211	Dependency (71%)	1539
Benzodiazepines (13%)	52	Drug Misuse (53%)	1328		
Cannabis (25%)	31				
Cocaine (13%)	71				
Crack (10%)	14				
Heroin (28%)	1112				
Methamphetamine (10%)	46				
Other (4%)	2				
Blind / Deaf (14%)	3	Blind / Deaf (14%)	3	Disability (34%)	44
Learning Disability (21%)	22	Learning Disability (21%)	22		
Physical disability / limitation	19	Physical disability / limitation (8%)	19		
Bi-polar disorder (4%)	11	Severe Mental Health problem (15%)	99	Mental Health (61%)	455
Personality Disorder (5%)	22				
Psychosis (7%)	39				
Schizophrenia (6%)	27				
Anxiety (30%)	22	Stress[5] / Mental Health problem (59%)	356		
Depression (49%)	327				
Panic attacks (13%)	6				
Post Traumatic Stress Disorder (4%)	1				
Obsessive Compulsive Disorder (4%)	0				
Eating Disorders (4%)	0				

[5] Stress was not categorised as a sub-set

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Table 7 (continued). Health problems by number of contacts and percentage of participants

Specific Health problem (% of participants reporting problem)	N of contacts	Mid level health problem category (% of participants reporting problems)	N of contacts	Broad care group (% of participants reporting group)	N of contacts
Heart Attack (1%)	0	Cardiovascular (15%)	64	Physical health problem (92%)	762
DVT (deep vein thrombosis) (2%)	5				
Heart problems (4%)	15				
Hypertension (high blood pressure) (6%)	9				
Other (3%)	10				
PE (pulmonary embolism) (1%)	25				
Hepatitis (8%)	21	Infections (10%)	22		
HIV (1%)	0				
Sexually Transmitted Diseases (3%)	1				
Emphysema (1%)	0	Lung / Chest (28%)	60		
Asthma (24%)	46				
Chronic Bronchitis (4%)	8				
Chronic Obstructed Pulmonary Disorder (1%)	6				
Cancer (1%)	8	Miscellaneous (60%)	392		
Diabetes (2%)	7				
Contraception	0				
Gastro (2%)	6				
Other (57%)	371				
Arthritis (6%)	23	Muscular Skeletal (46%)	100		
Back (28%)	55				
Joint (14%)	20				
Pain (6%)	2				
Epilepsy (4%)	8	Neurological (20%)	45		
Fits (4%)	6				
Headaches (16%)	31				
Problems under investigation (11%)	44	Problems under investigation (11%)	44		
Eczema (11%)	18	Skin / Rash (18%)	35		
Injection Site Problems (1%)	1				
Psoriasis (7%)	16				

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Co-morbidity:

Participants with self-reported dependency, mental and physical problems were grouped into seven co-morbidity categories, depending on the number of problems reported. All participants reported having at least one health problem.

The pie charts below show the proportions in each category for the overall sample (Figure 11), for those recruited in prison (Figure 12) and for those recruited in probation (Figure 13).

Dep. – Dependency

Mental – Mental health problem

Phy. – Physical health problem

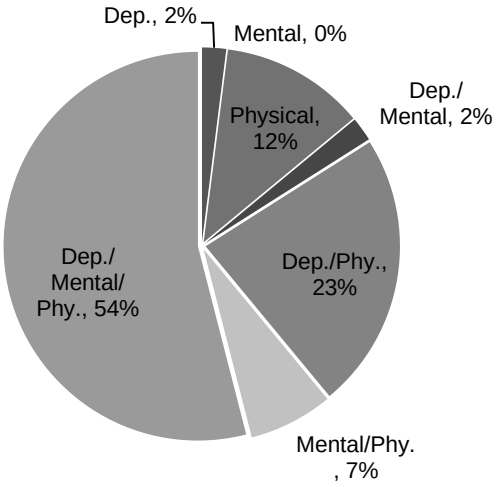


Figure 11. Co-morbidity in overall sample

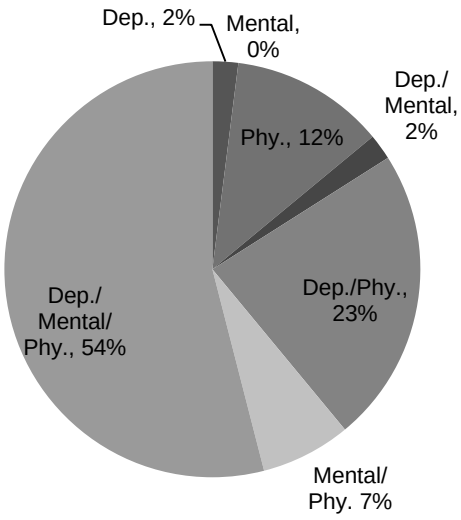


Figure 12. Co-morbidity in prison

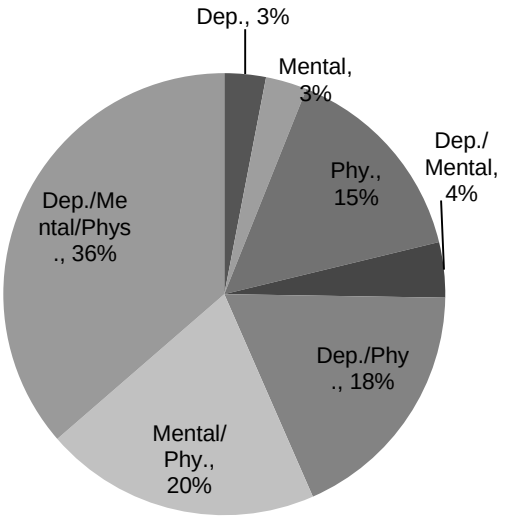


Figure 13. Co-morbidity in probation

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Overall, seven percent of participants reported mental health problems without any associated dependency issues. The proportion of participants reporting this type of problem was higher in probation (23%) than in prison (7%).

A greater proportion of offenders in prison (54%) reported triple co-morbidity (dependency, mental health and physical health problems) than those on probation (36%).

Co-morbidity contact rates:

Does having multiple dependency and mental health problems affect contact rates for health problems?

There were no significant differences between co-morbidity groups in health problem contact rate, though triple co-morbidity appeared to increase contact rate for severe mental health problems.

Heroin use increased mental health access for those who reported mental health problems.

An exploratory analysis was conducted to see how often participant health problems were addressed for people with different levels of substance misuse and mental health co-morbidity. This was achieved by grouping participants into the categories of co-morbidity shown in Table 8 . Contact rates (per month, adjusted) were then calculated for the categories shown in Table 8.

There were no statistically significant differences in contact rates for any of the health problems (all $p > 0.05$). The pattern of contact rates suggested that an additional drug or alcohol problem did not affect the chances of contact for common mental health problems, though triple co-morbidity may have increased the likelihood of contact for severe mental health problems. Contact rates for physical health and disability health issues were only minimally affected by substance misuse and mental health morbidity. Care for both alcohol use and heroin use suggested a trend towards increased care in the absence of co-morbidity. Table 8 shows the contact rates for each problem for each category of co-morbidity.

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SDO Project 08/1713/210

Table 8. Health problem contact rate by co-morbidity group

Co-morbidity category	Alcohol Misuse	Heroin	Other Drug Misuse	Disability	Major Mental Health	Common Mental Health	Physical
Alcohol Substance misuse Mental Health	2.61	8.43	0.34	0.27	3.35	3.89	6.29
Alcohol Substance misuse	4.06	7.18	0.51	1.09	-	-	3.44
Alcohol Mental Health	3.60	0	-	0.00	0.59	4.55	5.35
Alcohol only	10.08	0	-	0.00	-	-	4.05
Substance misuse Mental Health	-	18.08	0.43	0.33	0.80	4.34	5.09
Substance misuse only	-	27.98	0.76	0.39	-	-	5.61
Mental Health only	-	0	-	0.49	1.00	4.23	6.30
None	-	0	-	0.08	-	-	8.17

Effect of drug use on mental health access rate

A further exploratory univariate analysis[6] compared drug co-morbidity groups (no drug use reported; heroin use reported; heroin and other drug use reported; other drug use reported) on access rate for mental health problems (moderate and severe combined).

There was a main effect of drug co-morbidity group ($F_{(3, 118)} = 10.65$, $p \leq 0.001$, $\eta_p^2 = 0.21$). Pairwise comparisons showed that the access rate for mental health problems for those who reported heroin use (3.6) and heroin and other drug use (2.5) was significantly higher than for those who reported other drug use (1.2) or no drug use (0.5). Those who reported mental health problems and heroin use gained more access for mental health problems than those who reported only mental health problems.

[6] ANOVA; $p = 0.05$

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SDO Project 08/1713/210

5.1.5 Views on healthcare provision and continuity of care

What are respondents' opinions on health services?

The majority (71%) of offenders reported that they found it easy to see someone about their health. The treatments suggested by healthcare services were received for the majority of dependency related (74%) and physical health problems (71%), but for only half of the mental health (50%) and disability problems (53%) reported.

The majority of offenders (79%) were happy for health services to know about their contact with the CJS, and for health services to share their medical information (82%). The majority also preferred to have one professional with a general overview of all their health needs (81%).

GP registration was associated with lower hospital access rates.

Multivariate[7] analyses[8] were used to compare total healthcare contacts across the major healthcare categories. The analysis was adjusted for CJS setting. The number of contacts for dependency related problems was used as the reference category. The rate of healthcare contacts was significantly lower for disability (1:0.05, 95% confidence interval (CI)[9] 0.04 to 0.08, $p < 0.001$), mental health (1:0.35, CI 0.31 to 0.39, $p < 0.001$) and physical health (1:0.35, CI 0.32 to 0.39, $p < 0.001$) broad care groups compared to dependency related problems. This inference did not change when adjusting for participant demographics, recruitment site or follow-up status.

Most participants (142/200; 71%) agreed that it was easy to see someone about their healthcare. However, 49/200(25%) participants reported they did not find it easy to see someone.

The majority of participants (176/200; 88%) reported that they were currently registered with a GP practice, with only 21 (11%) participants not being registered. Of those currently registered with a GP, 40 (20%) had been registered for less than one year, 39 (20%) had been registered for between one and five years, 94 (47%) for five years or more and 1 (<1%) could not recall how long they had been registered with their GP.

[7] Poisson regression, with alpha set at 0.05, after statistical assumptions were met. The sample size of 200 was calculated based on a two-sample comparison of proportions, detection of a difference of 5% versus 20%, $\alpha = 0.05$ (two-sided), power = 0.8: n = 88.for each group

[8] Participant was included as a random effect, and month of data collection adjusted for, in all multivariate analyses

[9] Confidence intervals at 95%

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SDO Project 08/1713/210

GP registration and effect on access rate

The majority of those reporting contacts with healthcare providers were registered with GPs (168/187; 90%). In the community, those not registered with GPs had no contacts with GPs. Those registered with GPs had, on average, an access rate of three contacts per year. In contrast, those not registered had a mean access rate of three to hospitals (in and outpatient) compared to a mean access rate of one for those who were registered. The access rates for other services were similar for both groups.

For those offenders who reported multiple health problems, accessing GP service or prison healthcare was associated with being seen for multiple health problems. This is shown in Figure 14. Main effects of healthcare provider ($F_{(7, 1295)} = 9.01$, $p \leq 0.001$, $\eta_p^2 = 0.05$) and number of health problems reported ($F_{(3, 185)} = 2.90$, $p = 0.036$, $\eta_p^2 = 0.05$) were found, as well as an interaction between them ($F_{(21, 1295)} = 1.64$, $p = 0.035$, $\eta_p^2 = 0.03$).

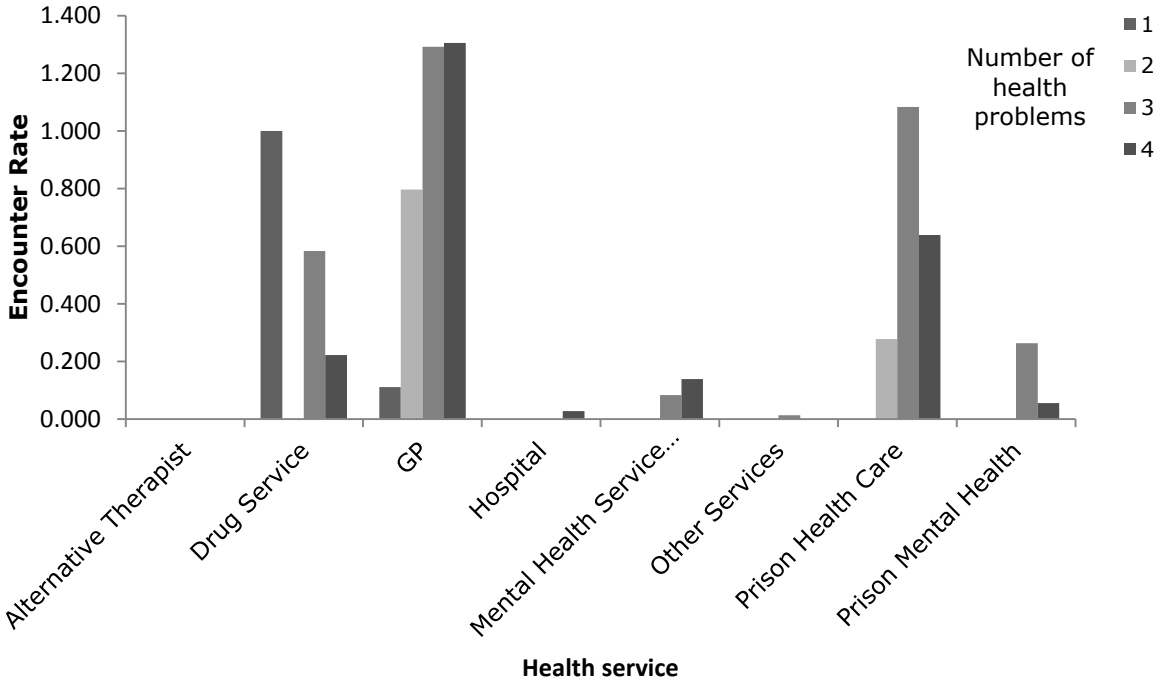


Figure 14. Encounter rate by number of health problems reported and healthcare provider seen

For those who reported two health problems, the encounter rate did not differ statistically between providers due to low numbers. For those who reported three health problems, drug services and prison mental health services did not differ from the other providers in encounter rate.

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SDO Project 08/1713/210

There was a marginally significant difference in encounter rate for GPs for different number of health problems (p = 0.098), with an increasing encounter rate for one (0.11), two (0.80), three (1.29) and four (1.31) health problems. Similar results were found for prison healthcare.

When asked if anyone in the CJS had ever tried to help them register with a GP, only 23 participants (12%) reported that they had received such help, while most (161/200; 81%) reported they had received no help at all. This supports reports that CJS staff facilitate access (Table 9).

Participants' healthcare (categorised as dependency, disability, mental health and physical health) was enquired about in respect of healthcare utilisation over the six months prior to the interview. Participants were asked whether they had received the treatments suggested by healthcare services, and the results showed that there was significant unmet need. The details are seen in Table 27 (Appendix D).

Table 27 (Appendix D) also shows that additional healthcare (to that offered) was perceived as being needed for 27% of existing problems and that only 10% (of this 27%) were receiving that care.

While the majority of offenders with physical and dependency problems received the care they required, 50% (14/28) admitted that they did not gain follow up for substance misuse, even though 88% (45/51) said they had received medication. This pattern was similar for physical health problems. For mental health problems, only 61% said they had received the medication needed and 32% the therapy needed (although only 19 of the 122 with mental health problems saw themselves as needing treatment).

Views on continuity

Participants were asked about healthcare appointments and the sharing of information between healthcare services and the CJS. Most participants were happy for healthcare professionals to know about their contact with the CJS (79%). Most (164/200; 82%) were happy for different healthcare services to share their medical information across services but reported that they would prefer just one person to have a general overview of all their health needs (81%). Participants were happy for members of the CJS to be made aware of their healthcare treatment (70%). This information is shown in more detail in Table 9.

In the past six months, 48 (24%) participants reported that there were issues that they did not wish to discuss with healthcare staff. Of those who gave a reason, 12 (24%) reported it was because of trust issues, 11 (22%) reported it was because of the stigma of being labelled, eight (16%) reported it was because of not wanting to face health issues.

Twenty seven participants (14%) were worried about the potential consequences of using healthcare services. Of those who gave a reason,

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two (7%) reported this was due to concerns regarding employment, five (19%) due to potential problems with access to their children, two (7%) due to a fear of mental health labelling, three (11%) due to stigma, two (7%) due to potential impact on criminal justice.

Table 9. Co-ordination of care and sharing of information

	Yes [N (%)]	**No [N (%)]**	**No response [N (%)]**
Are you happy for anyone from healthcare who is treating you to know about your contact with the CJS?	158 (79%)	23 (12%)	18 (9%)
Are you happy for different health services treating you to share medical information about you with each other?	164 (82%)	17 (9%)	18 (9%)
Do you want one person to have an overview of all your health needs? (*e.g. GP or key worker)*	161 (81%)	16 (8%)	22 (11%)
Are you happy for anyone from CJS to know about healthcare treatment you are receiving?	139 (70%)	40 (20%)	20 (10%)
Would you like more information about what health services there are that you can use locally (*when you are released)*?	80 (40%)	68 (34%)	51 (26%)
(Where appropriate) Are you happy for a/your GP to be sent a summary/record of the healthcare you received while in prison?	122 (61%)	15 (8%)	62 (31%)
(Where appropriate) When being released from prison do you want the prison staff to have already made health appointments in the community for you?	66 (33%)	64 (32%)	69 (35%)
(Where appropriate) When being released from prison do you want to be given a prescription for the next lot of medication that you may need?	94 (47%)	32 (16%)	73 (37%)

Seventy nine (40%) indicated that being in contact with the CJS had helped them to access healthcare services. When asked about desired healthcare, 53 (27%) indicated that they felt being in contact with the CJS had prevented them from getting the healthcare they wanted.

Out of the 2,800 reported health contacts, 583 of these were reported as being directly influenced by the CJS contact (20.8%) and 2217 as not.

The proportion of healthcare contact influenced by CJS contact (eg police, probation or prison officer facilitating access) remains consistent across healthcare categories (15 to 22%) (Table 10).

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SDO Project 08/1713/210

Table 10. Proportions of healthcare problems influenced by CJS contact

Broad care group	Influenced by CJS contact	Not influenced by CJS contact
Dependency	342 (22%)	1197 (78%)
Disability	8 (18%)	36 (82%)
Mental	67 (15%)	388 (86%)
Physical	166 (22%)	596 (78%)

Table 11 on the other hand shows that the prison setting was reported as most likely to influence healthcare contact.

Table 11. Proportion of healthcare contacts influenced by CJS contact by CJS setting

CJS setting	Number (%) contacts influenced by CJS contact	Number (%) contacts not influenced by CJS contact
Prison	247 (42%)	343 (58%)
Probation	165 (14%)	997 (86%)
Police / Courts	33 (22%)	116 (78%)
No CJS contact	41 (8%)	445 (92%)

For each type of health provider, the proportion of healthcare contacts influenced by CJS was calculated. The biggest influence was noted at prison healthcare (61.5%). A more detailed breakdown can be seen in Table 12.

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Table 12. Proportion of contacts influenced by the CJS by healthcare provider

Health service type	Proportion of healthcare contacts influenced by CJS contact (%)
Alternative Therapies / Practitioners	1 (25%)
Substance misuse service	222 (17%)
Primary Care	33 (5%)
Hospital (in- and out-patients)	16 (12%)
Mental Health Services (Community or in-patient)	15 (16%)
Prison Healthcare	281 (62%)
Prison Mental Health, In-reach, addiction	8 (8%)
Other services	1 (25%)
Unknown	222 (17%)

Continuity of communication:

In 8/50 (16%) cases where the prison notes were accessed, a record of a letter having been sent to the offender's registered GP was found. Five of the letters (63%) contained information about medication only and three letters (37%) also contained information about health problems or future management plans.

In 2/25 cases (8%) where full GP records were accessed, there was documentation of a letter received from prison healthcare. Of these, one contained information only about medications and one contained information about health problems or future management plans.

In 14 /25 cases (56%) where drug and alcohol service records were accessed, there was documentation of communication from prison healthcare (either via phone call, fax, letter or a referral).

These findings suggest that there was often a lack of communication from prison to general practice, despite the fact that details of the registered community GP were present in 39/49 (80%) of prison records. It is unclear why the proportion of GP records indicating a letter had been received was so much smaller than the proportion of prison records that documented that a letter was sent.

Communication from prison to drug and alcohol services seemed to be more frequent.

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SDO Project 08/1713/210

5.1.6 Continuity of access

Does the healthcare contact rate differ between CJS settings and between the broad care groups?

There were significantly more healthcare contacts in probation than in the other CJS settings. These were predominantly for heroin dependence.

There were more healthcare contacts for dependency compared to the other major healthcare categories.

The number of healthcare contacts for dependency related problems was significantly lower for prison compared to the other CJS settings. The number of healthcare contacts for physical health was significantly higher for prison compared to the other CJS settings.

Contact rates for mental health problems were low compared to substance misuse, and more of these occurred in primary care (prison and community) than in specialist services.

Access by CJS setting:

The number of healthcare contacts was calculated for each CJS setting. As the time spent in the different CJS settings varied between participants, the number of months (per year, adjusted) in each setting was also calculated in order to give an overall contact rate for a participant in each setting[10].

Table 13 shows that the healthcare contact rate was higher in probation than in the other CJS settings. A multivariate analysis accounting for different 'case-mix' in each CJS setting confirmed a rate ratio of 1:1.77 (prison:probation); see details below.

Table 13. Number of healthcare contacts, person-months and contact rate for each CJS setting

CJS setting	Total	Person-months	Contact rate (by person-year[11])
Prison	590	490	14
Probation	1162	579	24
Police / Courts	149	141	13
(Community) No CJS contact	486	443	13

[10] Person-month is defined as the (single) CJS setting a participant is in for each individual month during the study. As participants may be in more than one CJS setting in a given month, priority is given to prison > probation > police/courts > no CJS contact. For example, if in a given month a participant spends time in prison and probation, the person-month was designated as prison.
[11] Person-months divided by 12

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Multivariate analyses

The multivariate analysis was adjusted for broad care group. The rate of healthcare contacts was significantly higher for participants in probation than for those in prison (rate ratio: 1:1.77, CI 1.58 to 1.98, $p < 0.001$). Participants in police and/or courts had a higher contact rate (1:1.21, CI 0.99 to 1.48, $p = 0.056$) than those in prison. There was no significant difference in rate of healthcare contact for participants with no CJS contact compared to those in prison (1:1.11, CI 0.97 to 1.26, $p = 0.121$). This inference was not affected by adjusting for follow-up status, participant demographics, or for recruitment site (comparing SW and SE probation recruitment sites only).

A further analysis was completed with the reference as healthcare contacts made in the community (with no CJS contact). It showed that rate of healthcare contacts was significantly higher for those participants in probation than for participants with no CJS contact (rate ratio: 1:1.60, CI 1.42 to 1.81, $p < 0.001$). There was no significant difference in healthcare contact rate for participants with no CJS contact compared to those in prison (rate ratio: 1:0.90, CI 0.80 to 1.03, $p = 0.140$) and in police/courts (rate ratio: 1:1.09, CI 0.90 to 1.32, $p = 0.360$). Adjusting for participant demographics and recruitment site did not affect this pattern. Adjusting for follow-up status (excluding those who were not followed up) shows that the rate of healthcare contacts in those participants in prison was significantly lower than for those with no CJS contact (rate ratio: 1:0.87, CI 0.76 to 0.99, $p = 0.036$). Multivariate analyses were used to compare total healthcare contacts across the major recruitment sites. SE probation service was used as the reference category, to which SW prison and the SW probation service were compared.

The analysis showed that the number of healthcare contacts for those participants in contact with the SE probation service was significantly higher when compared with those in contact with the SW probation service (rate ratio: 1:0.57, (SE probation: SW probation, CI 0.36 to 0.86, $p = 0.008$) but not when compared to those in the SW prison (rate ratio: 1:0.84, CI 0.54 to 1.25, $p > 0.352$). This inference does not change when participant demographics and follow-up status were adjusted for.

Healthcare service type

The categories of healthcare service that the participants were in contact with across setting are shown in Table 14. Across all CJS settings the highest proportion of contacts was with the substance misuse service (50%), with some in primary care (19%) and others in prison healthcare (14%).

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Table 14. Number of contacts for different categories of providers

	Substance misuse service	Primary Care (Community)	Mental Health (Community)	Prison Substance misuse service	Prison Healthcare	Prison Mental Health	Hospital	Other	Alternative	Blank
Total CJS / % of total	1177 / 50%	451 / 19%	84 / 4%	19 / 1%	339 / 14%	76 / 3%	134 / 6%	79 / 3%	4 / 0%	14 / 1%
Prison	103 +	35 +	9 +	19	327	62	14	18	0	1
Probation	802	215	37	0	1	12	44	39	4	3
Police / Courts	58	49	14	0	11	0	12	4	0	0
Community/ No CJS	214	152	24	0	0	2	64	18	0	10

+ Priority coding for CJS exposure caused these apparent anomalies (i.e. each month was allocated a CJS exposure, with transition months prioritising prison>probation> police/courts).

*Healthcare contact rates: health service, health problem and CJS setting**.***

For each type of health service, the frequency of contact for each category of health problem was calculated. This shows that common (stress/mental health) mental health problems were seen mainly in primary care (community and prison), rather than by specialist mental health teams, such as the new IAPT services. Primary care also saw people for severe mental illness and substance misuse. Specialist substance misuse services appeared to focus their activities on alcohol and drug misuse, rather than on wider mental health problems. This can be seen in Table 15.

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Table 15. Frequency of contacts for each category of health problem for each type of health service

Health service type	Alcohol Misuse	Drug Misuse	Severe Mental Health	Stress / Mental Health	Blind / Deaf	Learning Disability	Physical disability / limitation	Physical problems*
Blank								11
Alternative therapies / practitioners		2				3		2
Substance misuse service	140	1109	5	16				6
Primary care	29	66	20	190		1	9	321
Hospital (in and out patients)	3	6		5		2	4	117
Mental health	2	2	40	43				5
Other services	19		1	5		3	4	44
Prison healthcare centre	18	121	15	58	3	7	1	235
Prison mental health		22	18	39		6		18

*Similar proportions were seen in different health services for all physical problems.

Contact rate by problem across criminal justice settings:

The number of contacts in each CJS setting for each broad care group is shown in Table 16. The number of contacts for dependency related problems was higher in probation than the other CJS settings, and the number of contacts for physical health was higher for prison than the other CJS settings. There were no large differences between the other major healthcare categories, and the number of contacts in police/courts was lower than for other settings. This pattern was confirmed in the multivariate analysis below.

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SDO Project 08/1713/210

Table 16. Number of contacts across CJS setting by broad care group

CJS setting	Total	Dependency	Disability	Mental	Physical
Prison	719	280 (39%)	14 (2%)	131 (18%)	294 (41%)
Probation	1311	899 (69%)	10 (1%)	187 (14%)	215 (16%)
Police / Courts	171	83 (49%)	2 (1%)	28 (16%)	58 (34%)
No CJS contact	599	277 (46%)	18 (3%)	109 (18%)	195 (33%)

Multivariate analyses were used to compare total healthcare contacts for each broad care group for each CJS setting[12]. For dependency related problems, the rate of healthcare contacts was significantly higher for participants in probation (1:3.54, 3.02 to 4.15, $p < 0.001$), with no CJS contact (1:1.83, 1.38 to 2.44, $p < 0.001$) and in contact with police and/or courts (1:1.58, 1.31 to 1.90, $p < 0.001$) than for those in prison. There was no difference between the rates of healthcare contacts for disability or for mental health problems in the different CJS settings. For physical health problems, the rate of healthcare contacts was significantly lower for those in probation (1:0.55, 0.45 to 0.68, $p < 0.001$), with no CJS contact (1:0.58, 0.42 to 0.81, $p = 0.001$) and in contact with the police and /or courts (1:0.65, 0.52 to 0.80, $p < 0.001$) than for those in prison.

5.1.7 Duration of healthcare contact[13]

Does the total duration of contacts differ between CJS settings and between the broad care groups?

The total duration of contacts was significantly longer in probation than in the other CJS settings. The total duration of contacts was significantly longer for dependency related problems than for other healthcare categories.

For dependency related problems, the duration of contacts was significantly higher than disability, mental healthcare and physical healthcare across CJS settings. These results are consistent with results for contact rates.

[12] An overall analysis to compare healthcare contacts in each broad care group by CJS setting could not be done due to co-linearity of broad care group.
[13] Full results are in Appendix D

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SDO Project 08/1713/210

5.1.8 Quality ratings

Does the quality rating of contacts differ between CJS settings for different providers and across the major healthcare categories?

The mean quality rating of healthcare contacts was significantly lower in Prison than in the other CJS settings. Quality ratings were higher for drug services and mental health services.

Quality rating of contacts by CJS setting:

In each CJS setting, the quality rating of contacts was calculated for each major healthcare category. Table 17 shows that the quality rating was higher for participants in contact with probation services than for the other CJS settings. Multivariate analyses showed that services in prison generally were rated lower.

Table 17. Quality assessment of healthcare contacts in each CJ setting[14]

CJS setting	Good	Average	Bad	Missing data
Prison	349 (59%)	109 (18%)	93 (16%)	39 (7%)
Probation	928 (80%)	124 (11%)	64 6%)	46 (4%)
Police / Courts	110 (74%)	10 (7%)	24 (16%)	5 (3%)
No CJS contact	324 (67%)	68 (14%)	59 (12%)	35 (7%)

In the multivariate analysis used to compare the quality rating of healthcare contacts across the different CJS settings the analysis was adjusted for broad care group. The quality rating was significantly lower for contacts made in prison than for those made in probation (p <0.001), when in contact with the police and/or courts (p = 0.038) and with no CJS contact (p = 0.001).

When demographics and recruitment site were included in the model, the quality rating remained significantly lower for contacts in prison than for those in probation (p < 0.01), in police and/or courts (p = 0.040) and with no CJS contact (p = 0.002). When adjustments were made to the model for

[14] 'Good' is a summation of those contacts assessed as 'Very good' and 'Good', and Bad a summation of those assessed as 'Bad' or 'Very bad'

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SDO Project 08/1713/210

demographics and those with no follow up were excluded, the quality rating remained significantly lower for those contacts in prison than in probation ($p < 0.01$), in police and/or courts ($p < 0.033$) but not between prison and community ($p = 0.177$).

When those in probation with those who have no CJS contact were compared, the total quality rating was significantly lower for those with no CJS contact than for those in probation ($p = 0.036$), higher than for those in prison ($p = 0.002$) but not different to those contacts in the police and/or courts ($p = 0.992$). Adjustment for participant demographics, recruitment site and follow up status did not affect this pattern. Multivariate analyses were used to compare the total quality rating of contacts across the major recruitment sites. SE probation was used as the reference category, to which SW prison and SW probation were compared.

The analysis shows that the overall quality rating of contacts made in the SE probation was no different to those made in SW probation ($p = 0.820$) or SW prison ($p > 0.292$). This inference does not change when participant demographics, recruitment site or follow-up status were adjusted for.

Quality rating by health service:

For each type of health service contact, a quality score was reported. Generally, positive feedback was given for all health services, being particularly positive in the substance misuse service (78%), the hospital (82%) and the mental health service (89%). A more detailed account can be seen in Table 18. Multivariate analyses were not performed given the large number of categories.

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SDO Project 08/1713/210

Table 18. Quality assessment of healthcare contacts for each type of health service

Health service type	Good	Average	Bad	Blank
Alternative therapies / practitioners	2 (50%)	0 (0%)	2 (50%)	2 (50%)
Substance misuse service	933 (78%)	152 (13%)	50 (4%)	65 (5%)
Primary care	296 (66%)	54 (12%)	80 (18%)	21 (5%)
Hospital (in and out patients)	110 (82%)	12 (9%)	7 (5%)	5 (4%)
Mental health services	75 (89%)	6 (7%)	2 (2%)	1 (1%)
Prison healthcare	172 (50%)	67 (20%)	86 (25%)	16 (5%)
Prison mental health	59 (78%)	4 (5%)	1 (1%)	12 (16%)
Other services	49 (62%)	16 (20%)	11 (14%)	3 (4%)
Missing data	14 (88%)	0 (0%)	0 (0%)	2 (12%)

Quality rating by broad care group:

The total quality score of contacts for each broad care group was calculated, as was the number of participants with problems in each category. As participants could have multiple health problems the total number of participants in Table 19 is more than the total number of participants in the study sample. As Table 19 shows, the majority identified the quality of encounter as good across all healthcare problems. The multivariate analyses showed no differences across groups.

Table 19. Quality scores of healthcare contacts by type of encounter

Broad care group	Good	Average	Bad	Missing data
Dependency	1143 (75%)	182 (12%)	140 (9%)	66 (4%)
Disability	37 (88%)	3 (7%)	2 (5%)	0 (0%)
Mental	324 (72%)	54 (12%)	65 (14%)	8 (2%)
Physical	492 (68%)	108 (15%)	94 (13%)	32 (4%)

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SDO Project 08/1713/210

In the multivariate analyses used to compare total quality of contacts across the major healthcare categories the analysis was adjusted for CJS setting. Dependency related problems were used as the reference category. The analysis showed no significant difference of quality ratings between contacts for dependency related problems and disability (p = 0.891), for mental health problems (p = 0.977) or for physical health problems (p = 0.160). This inference did not change when adjusting for participant demographics, recruitment site or follow-up status.

Changes in illness reporting over time:

The health problems reported by participants were re-analysed at follow-up. Four offenders (5%) and two offenders (6%) reported new alcohol and drug misuse problems respectively. Five offenders (19%) reported new mental health problems, three (13%) reported lung problems, five (14%) reported musculoskeletal and 23 offenders (29%) reported miscellaneous problems. In contrast only 2% (1) reported new severe mental illness and 6% (3) new neurological problems.

5.1.9 Continuity of access rates

Do transitions between CJS settings affect access rates?

Entering prison did not affect access rates for dependency related problems, but increased access rates for physical health problems, and for physical health, mental health and disability problems combined.

Leaving prison increased access rates for dependency related problems, but did not affect access rates for physical health problems.

Entering probation from the community increased access rate for dependency related problems, and leaving probation to the community setting decreased that rate.

The effect of CJS setting and transitions through different settings on access rates for the broad care groups[15] was analysed using time series analysis. The majority of offenders made one or two transitions between CJS settings in the six month period recorded. Table 28 in Appendix D gives the results in detail.

[15] The model did not converge for disability problems, as the number of contacts was low

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SDO Project 08/1713/210

Dependency related contacts

The number of contacts for an individual significantly increased upon transition from prison (to any other CJS setting) (rate ratio: 1:1.8, p <0.001) but did not change upon entry into prison (rate ratio: 1:1, p = 0.99). The access rate therefore increased when leaving prison, but does not decrease upon entry to prison.

The number of contacts increased on transition into probation from community (rate ratio: 1:1.94, $p < 0.001$), and reduced for the opposite transition (rate ratio: 1:0.26, $p < 0.001$), showing greater access for dependency related problems in probation.

Physical health contacts

Upon leaving prison into any other CJS setting, there was no change in the contact rate for physical health problems (rate ratio: 1:1, $p = 0.99$), though contact rate increased upon entry to prison (rate ratio: 1:1.77, $p <$ 0.001). No other changes in contact rate were seen in the other transitions calculated.

Mental health contacts

Transitions between CJS settings were associated with no difference in the access rates for mental health contacts.

Physical health, mental health and disability related contacts

The number of contacts increased upon transition into prison from other CJS settings (rate ratio: 1:1.65, $p < 0.001$). No other transitions changed contact rate.

5.1.10 Validation study

How does offenders' self report of healthcare receipt compare with that recorded in medical records?

Ratios of reported to recorded contacts overall was 7:8. Mean differences were low and reliability was good. This demonstrates that using offender accounts has validity, although recall of substance misuse care was better than other services.

In order to assess the reliability of offenders' self-reported use of health services during the study period, their reported contact with community primary care services, community drug services and prison services were

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SDO Project 08/1713/210

compared against the contacts recorded by each organisation. While records are not necessarily a 'gold standard', similar results would provide some evidence for the reliability of offender accounts.

GP records were accessed for 25/49 (51%) participants in the validation sub-study. Details of the offender's registered GP were missing for 10/49 (20%) offenders; two offenders (4%) were not registered with a GP in the SW area; three offenders (6%) were not recognised as being registered at the recorded practice; and the researcher was unable to make arrangements to access GP records for nine (18%) offenders .Twenty-five offenders had been in contact with the substance misuse service within the study period and notes were accessed.

Table 20 shows the agreement values for all of contact categories analysed. Ratios varied for 1:2 to 3:2. Scatter plots of self-reported contacts against the recorded contacts are shown in Figure 17, Figure 18, Figure 19 and Figure 20 in Appendix D.

Table 20. Agreement values for self-report and records by category of contact[16]

	Community primary care	**Community substance misuse service**	**Prison-initiated**	**Physical**	**Mental health**	**Drug**	**Overall prison**
Ratio	8:7	3:2	5:8	5:6	1:2	5:6	5:7
Average difference	2.64	4.84	1.43	0.94	0.24	1.04	2.96
SD	4.27	6.20	1.73	1.41	0.72	1.29	2.72
N	25	25	49	49	49	49	49
Intraclass Correlation Coefficient	0.339	0.394	0.141 (ns)	0.446	0.101 (ns)	0.271	0.336

Community primary care contacts

There was a very small difference between the number of contacts with community primary care services reported by the offenders and that recorded in their GP records. There was moderate agreement between the number of contacts reported by offenders and reported in their GP notes (indicated by the interclass correlation (ICC) value in Table 20). The ratio suggests that offenders may have overestimated the number of contacts.

[16] For ICC coefficient, $p < 0.05$ unless reported ns (not significant).

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SDO Project 08/1713/210

Community substance misuse service contacts

From a sample of twenty five offenders, there was a larger average difference between offender's self-reported contacts with community substance misuse services and their substance misuse service records. There was moderate agreement between the number of contacts recorded in offenders' reports and GP records. The ratio suggests that offenders may have overestimated the number of contacts with substance misuse services.

Prison contacts (overall[17])

From a sample of 49 offenders, there was a small average difference between offenders' self-reported contacts with prison services and those recorded in the prison records. There was moderate agreement between the number of contacts recorded in offenders' reports and prison records. The overall ratio suggests that offenders slightly underestimated the number of contacts they had with prison services.

The ratios for all the types of prison contact recorded indicate that prisoners tended to underestimate the number of contacts. The intra-class correlation coefficient was significant for physical and drug contacts, indicating a reasonable level of agreement between the self-reported contacts and recorded contacts for these categories. Prison-initiated and mental health contacts did not have a high level of agreement between self-reports and records.

Comparison between community primary care, community substance misuse and prison contacts

The dependent variable was calculated as the difference between self-report and GP, substance misuse service or prison records divided by the number of self-report records. This was done in order to take into account variance of self-report. The analysis showed that there was no effect of setting ($F_{(2, 28)} = 3.321$, $p = 0.051$, $\eta_p^2 = 0.192$, observed power = 0.581), though the pattern was that community substance misuse contacts had the smallest adjusted mean difference between self-report and records.

[17] Prison-initiated contacts included the initial screening contacts upon entering prison, which offenders may not have counted as actual healthcare contacts. Because of this, the overall prison analysis was calculated without these contacts.

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SDO Project 08/1713/210

5.2 Offender perspectives

Three related analyses are presented:

- The peer researcher focus group results. This sets the scene, with views from offenders in groups facilitated by and analysed by peer researchers.
- A depth analysis of offenders' agency and motivations (Section 5.3).
- A qualitative analysis of offenders talk related to access and continuity (Section 5.4).

This first section describes how the complexity of offenders' lives affects their access to, and continuity of, healthcare. These findings come from focus groups with offenders.

5.2.1 Peer researcher focus group findings

A total of three focus groups with approximately fifteen participants in total were held as part of the peer researcher project. These groups helped to establish the nature of the problem of access to and continuity of healthcare for offenders and suggested potential solutions. Appendix E highlights quotes that the peer researchers believe give a sense of the contents of the focus groups.

5.2.2 Access



- Longer waits and access for people living in rural areas.
- Access to services often through word of mouth, rather than referral by professionals.
- Access to services and the range of services while in prison is better than services available in the community.
- Charitable service providers seemed to have better and easier access than statutory services.
- National signposting to relevant information would be beneficial. Currently awareness of services tends to be gradual and left to the individual.

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SDO Project 08/1713/210

5.2.3 Longitudinal continuity (following patients over an extended period of time)



- Sometimes action plans were never updated, to take into account improvements or declines.
- Bonds built between workers and clients were challenged by staff sickness, changes in staff, caseloads and changes in service provider.
- Prisons could be in danger of relying too much on mental health services in the voluntary sector to carry out specialist treatment.
- Notes can take a long time to reach voluntary services; sometimes getting lost in transit.
- Statutory mental health services provided good levels of permanency among key workers, appointments and case notes, developing trusting working relationships with their clients.

5.2.4 Relational continuity



- Treatment could be more difficult to obtain if families were not involved from the beginning.
- Families had problems getting involved with their loved ones' treatment plans.
- On the whole clients had a good relationship with their worker but share less trust with other members of the same team.
- Clients reported having a good level of trust and faith in their workers within the mental health services.
- Many of the clients, especially with drug and alcohol, and mental health issues, or both, were estranged from their families.
- On occasion families had been contacted without prior consent from the client.
- Clients reported not necessarily having the skills to rebuild relationships with family members.

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SDO Project 08/1713/210

5.2.5 Flexible continuity



- Clients thought that sometimes services did not take into account their perceived needs when constructing a care plan.
- Re-assessments were irregular and not always carried out.
- Mental health services were difficult to access outside of office hours.
- Generally agreed that services are not for life. Many clients thought they would like to have an exit strategy in place for when they move on from the service. They believed that they were not getting enough support to leave services.
- Mental health services came out strongest in light of home visits, changes in appointments, travel costs refunded, and time spent with clients. Clients often found it difficult to cover travel expenses before being reimbursed, especially for those living in rural areas.

5.2.6 Communication



- Appointment time changes, staff sickness and service provider changes were not always made clear to clients.
- Confirmation of appointments was not always made in writing.
- Flow of reports between services would often breakdown resulting in services not having the paper work in time for appointments.
- Services are hesitant in sharing information between clients, and use policy, data protection or confidentiality as reasons for not doing so.
- Charitable trusts seemed better at sharing information, making good clear referrals, and keeping clients informed.
- Client's information was not always kept up to date and sometimes misreported which led to clients having to repeat details and personal circumstances.
- On leaving prisons clients often had no action plan in place and paperwork was slow to arrive at the receiving service.

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SDO Project 08/1713/210

5.2.7 Recommendations



- Clients being allowed to keep their information/reports with them in hardcopy, CDS or USB sticks. (They could pass them on to someone to take care of the info if they felt unable.)
- All services advice teams under one roof. A friendly and informal setting that would be manned by staff and volunteers with similar experiences.
- More volunteering opportunities to be made available to people who have had similar difficulties.
- More clients embedded on decision-making groups and panels.
- Self-referral made more commonly available rather than having to rely on GP referral.
- Family workers to help in the rebuilding of family relationships.
- Mentoring, Befriending and Peer Support programmes to be promoted and made available.
- Prison staff to have more training in mental health needs.

5.3 Depth analysis of interview and focus group data

Summary

Offenders reported a range of health needs, particularly drug, alcohol and mental health problems. Although they saw these issues as causing them difficulties, they did not perceive healthcare as being part of the solution. Offenders prioritised other needs and ambitions, such as employment, accommodation, family and relationships, over healthcare; although they did value 'care' when it was shown. The interconnected nature of these, often chaotic and complex, lives meant that health and other needs could, and did, exacerbate or support one another. Conflicts with medical practitioners were framed in terms of offenders' self knowledge being superior, due to their greater understanding of the difficulties they faced. The interviews highlighted the importance of control and participants presented themselves polarised towards either end of a 'spectrum of control'. Those who talked about themselves as self-reliant were at one end, even if the experiences they described did not support this, and those who were highly dependent on services were at the other.

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SDO Project 08/1713/210

An in-depth qualitative analysis, using an inductive thematic analysis, was used to analyse selected transcripts and focus group data, as described in Section 4.3.2. The themes, the interactions between themes at an individual level and the presentation of self in the narratives have been interwoven into Sections 5.3.1-3 below. They provide a broad context for interpreting the results in all other sections. The theme of control was very strong throughout the analysis process. Participants presented themselves along a spectrum ranging from self-reliance to an abdication of responsibility for their own actions and care. Some participants oriented themselves towards an extreme and others gave multiple, sometimes conflicting, presentations within one interview: Participants who sought to portray themselves as self-reliant described experiences that showed they had difficulty in coping and those who portrayed an abdication of responsibility gave examples of having achieved access to care.

5.3.1 The link between health and criminal justice involvement

Interactions between criminal justice involvement and health services were not uniformly experienced as positive or negative by participants; some experienced these interactions in different ways, at different times. Some participants regarded addressing health problems, including mental health, as key to breaking the reoffending cycle. One 19-year-old-male, with a history of mental health issues (depression and paranoia), drew an explicit link to his offending behaviour: "*As soon as I've got that cracked I reckon that will be it, the end of my offending really*" (1158a). Another participant reported that getting something to help with his anger would be the thing most likely to keep him out of prison in the future: "*If they can sort out my anger… just give me something to calm me down*" (1036a).

Other participants, particularly those who listed problems with drugs or alcohol, did not see healthcare as the solution for their difficulties. One participant articulated how he did not think they were connected: "*You'll reoffend whether the healthcare is there or not. It's nothing to do with that; it's to do with the situation with drugs and things like that… I don't think it's anything to do with healthcare, reoffending*" (1173a).

The opportunity to more easily access healthcare, facilitated by prison or community sentences, gave some participants the chance to address their healthcare needs. One heroin user described prison as an opportunity to "*just to sort my head out and get clean.*" Periods in prison were presented as having a positive health effect: "*it's probably what's saving me*" (1027a) however, this can sometimes be ambiguous. One 24-year-old-male described himself as having '*chosen'* to come back into prison rather than finish his sentence in the community on an electronic tag (1016a). When reporting how he had stopped using drugs, he said "*I done it meself*", although it was clear that he had received high levels of support from the prolific offenders team, while serving a community sentence, to achieve

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SDO Project 08/1713/210

this. In his follow-up interview he repeated that it was his 'choice' to be back in prison for this subsequent sentence: "*I handed myself in*". He described prison substance misuse services as helpful, "*they do help a lot... if you work with them*", while repeating that he did not see himself as needing that help (1016b).

Others were less inclined to regard prison entry as a positive choice, but recognised the benefits to their health while they were there (1174a). One participant described how, although reluctant to go to prison initially, he was glad that he did, as it enabled him to stop using heroin, and he was adamant that he "*won't be touching that again"* (1146a). Contrastingly another participant, with kidney problems, experienced prison as having a negative effect on his healthcare. In the community he had taken care of himself, and experienced a considerable lack of control on entering prison. He became focused on the ways in which he was no longer able to support his health. Consequently he became very fearful and convinced that it was only due to '*luck'* that his health hadn't deteriorated (1173a).

Although healthcare was not always considered a solution to the problems of offenders' lives, the care demonstrated by healthcare staff was valued highly. Caring was repeatedly valued over treatment outcomes (1184a). One participant epitomised this as follows: "*she's a brilliant doctor, she's the best doctor I've ever had. She actually cares like, you know*" (1135a). Another young man stated that, if a member of healthcare staff gave the impression that they cared, it had a motivating effect (1117b).

5.3.2 Reducing reoffending: aspirations, motivators and other priorities

Participants did not appear to prioritise healthcare needs, but emphasised a range of other needs and ambitions that they believed would improve their lives and reduce their reoffending including, employment, families and relationships and accommodation. One participant regarded finding work as the main thing that would stop him returning to prison. Another participant also thought employment was crucial, but was pessimistic this would happen and was resigned to returning to prison (1061a).

Other participants saw family and relationships as providing the major motivation to successful resettlement, valuing this over and above any practical support they could receive from services or the CJS. One participant, describing himself as a full time carer for his partner was adamant that he would never return to prison as he was anxious to resume his caring role (1099a). A 23-year-old with a history of alcohol misuse, and five children aged under five, also prioritised plans to see his children and his intention to stop misusing alcohol. Throughout his interview, however, he listed occasions on which he was offered help and repeatedly failed to access it when faced with small obstacles: he missed appointments, stopped taking tablets for depression, turned down the opportunity for a

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SDO Project 08/1713/210

drug/alcohol worker and didn't attend a GP appointment for support with giving up alcohol when he was told he would have to wait for a week (1015a).

Many participants regarded stable accommodation as the key both to good health and to reducing offending in the future. One offender expressed the belief that having somewhere to live would solve his drug use and criminal justice problems (2029a). He said that if you didn't have your own place you would be unable to take care of yourself and cook healthily.

Throughout the interviews healthcare needs and practical ambitions were seen as interacting with and exacerbating one another. One participant explained that he drank to cope with the pressures of poor living conditions and not seeing his children, but that drinking also contributed to his problems, leading to missed appointments that may have helped him regain access to his children (1004a).

5.3.3 Conflicts with healthcare practitioners

The interviews contained numerous accounts of participants disagreeing with medical staff about: i) diagnoses, ii) access to drug substitutes, iii) appropriate medication. Within these conflicts offenders presented themselves as more authoritative than medical staff, because they had a greater understanding of the realities of their lives.

Disagreements with diagnoses

Many offenders disagreed with medical diagnoses, especially for non-physical conditions, including personality disorder. "*I have been written up as having a personality disorder, but I don't see me as having a personality disorder*" (1014a). This participant expanded in the follow-up interview: "*I think everyone has got a personality disorder in one way or another… "Everyone has their own characteristics and their own ways… It's just traits*" (1014b).

One man expressed extreme annoyance after a prison nurse assessed him as an alcoholic: "*I don't think I'm an alcoholic… I don't get the shakes or nothing... I can give it up… They give me Librium up here for the first 4 or 5 days, but yeah, I didn't really need it anyway. Don't know why they give it to me. I told them like I'm not an alcoholic, no way*" (1135b).

In some cases disagreements reflected negative experiences of healthcare early in life, or early abuse severely reducing people's capacity to trust healthcare, and increasing conflicts. This seemed to strengthen a sense of independence. As such, one 26-year-old, repeatedly emphasised different examples of how he could take care of himself, legitimised by a first aid certificate he held. "*In my opinion everyone's useless… If I get ill I will deal with it myself*" (1026a). He both denied having an alcohol problem and

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SDO Project 08/1713/210

stated that he had addressed it due to his own efforts. "*The only one who can help is myself, because no one can help me*."

Some cases highlighted a noticeable conflict between self-diagnosis and medical opinion, particularly around whether symptoms had physical or mental aetiology. One participant reported an incident on his first night in prison when he thought he was having a heart attack, whereas the healthcare professionals told him it was a panic attack. He was adamant that he was in a calm state at the time and that it was heart trouble, relating a history of heart problems in his family (1099a).

Finally, there were conflicts around the use of illegal drugs as a form of self-medication to cope with existing health problems, particularly mental health problems, even though healthcare professionals had told them that these could be exacerbated by drug use.

Prescribing of illegal drug substitutes as a right

A number of participants attempted to legally access methadone. One 39-year-old participant saw his access to methadone as a right and any criminal consequence of him not receiving it as the responsibility of services, rather than himself (1014a). He believed that he had a right to methadone in the community, even if he was still using street drugs as well. He described a disagreement with his prescribing GP: "*she was saying to me if you don't stop the drugs you are taking at the moment I will stop your script, and I said well if you stop my script then you are going to make me turn back my crime to feed my habit to take drugs*" (1014b). Another participant, who was being prescribed methadone in prison, believed that he should have the right to choose his withdrawal drug substitute on release (1016b).

For some participants this 'right to access' covered a range of services. Those who had abdicated responsibility for their own problems and healthcare, tended to be heavily critical on the services on which they had become dependent. One 34-year-old participant was heavily dependent on services and expected them to improve his life including sorting out his alcohol use, ensuring his access to methadone and accommodating him. He stopped engaging with services when facing small obstacles, such as a drug worker taking a whole week to respond to him (1135b).

Methadone was described as being helpful in reducing offending, but as not completely unproblematic. A prolific offender and long term drug user saw both pros and cons of being on a methadone script: "*It's keeping me off street drugs and it's keeping me off illegal drugs so yeah, it's a benefit in that way... [but] it's not the thing I want. I do actually want to be clean*", meaning not needing street or prescribed drugs (1173a).

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SDO Project 08/1713/210

Appropriate medication: A 'chemical solution'?

Participants expressed strong views both for and against medication. One offender was adamant that his mental problems required a chemical solution, in the form of prescribed or street drugs (1036a). He was convinced that valium was the best solution, while in prison, and was highly sceptical of talking treatments: "*at the end of the day I know that talking ain't going to do nothing*" (1036a).

By contrast, another participant (2020a, Vignette C, Appendix E) had complained that the care he received was "*only medication. I have medication, story of my life, medication, medication*" (2020a). He saw doctors as overly keen to prescribe antidepressants and benzodiazepines: "*all they do is numb the pain so you can cope with it*" (2020a). Individual participants also revealed contradictory views, within a single interview, about the role of medication in their lives. One participant, who took methadone as a substitute for heroin, refused paracetamol because "*I don't believe in medicines*" (1014a).

5.4 Analysis of access and continuity

Pre-defined codes relating to aspects of access and continuity were applied to selected transcripts and focus group data, as described in Section 4.3.2.

To experience continuity of healthcare, individuals must first access services. Access must then be maintained in order to ensure continuity. Offenders have high levels of healthcare need and correspondingly low levels of access. We examined access as a pre-requisite for continuity. This included 'initial access' and continuing to maintain that access (continuity of access); both are considered, in turn, below. Longitudinal continuity is defined as on-going contact with the same practitioner and has been considered in its own right. We considered both the contributions of services and of offenders to achieving access to a wide range of care, including self care.

5.4.1 Initial access

Summary

Access for the general population is defined as initial and on-going access. The barriers to initial access were such, for this group, that initial access has been examined in its own right. Different people within the offender healthcare group chose to access healthcare at different times, depending on competing priorities in their lives. Many accessed healthcare through associated criminal justice services. Ease of access varies across different health needs with substance misuse services, particularly drug services, proving easy to access and mental health services being much more difficult.

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SDO Project 08/1713/210

Access issues pre-dominated over subsequent components of continuity. These included how offenders themselves had contributed to, or worked against, achieving access to healthcare.

Offenders' perceptions of barriers to initial access

Waiting was perceived as a barrier, and disincentive, to accessing healthcare services (1004a, 1036a, 1173a). One participant, even when he had done everything that was required of him, still hadn't achieved access to a substance misuse service. "*So I thought oh, well I've done all that running about for nothing then, really, haven't I? I know it's not for nothing, but it's still waiting innit?*" (1004a).

Two offenders struggled to access healthcare due to their homelessness because of difficulties with receiving appointments (1015a) or registering with a GP (2029a). Other participants reported that they were reluctant to use healthcare services, or expected to receive a poorer quality of service, because of practitioners' negative perceptions of offenders and street drug users (1015a, 1027a). "*I get the feeling that I'm a junkie. Some doctors won't even take on heroin users*" (1027a).

Low expectations of what services could provide also acted as a disincentive (1027a, 2029a, 1117b). One participant felt that a doctor would be unable to give him anything to help with the stress that he was experiencing (1027a) and another explained that he would not be bothering to put in an application to see the prison doctor because "*They've never done anything really for me in the past, not really*" (1117b).

Offenders blocking initial access

Some participants had failed to access healthcare services because they had turned down support, e.g. with GP registration (1184a). More commonly, participants failed to attend healthcare appointments due to their own omissions or decisions not to attend (1004a, 1014b, 1015a, 1016b, 1026a, 1027a, 1174a). One participant failed to attend an appointment for his liver because he forgot, and missed an appointment with his GP because he had been drinking alcohol the night before (1004a).

Three participants chose not to take medication that had been prescribed, one knew it was dangerous to take tablets for his liver on top of drinking alcohol (1004a), another felt that medication made him worse (1015a), and a third just didn't want to take it (1117a).

Some respondents were reluctant to tell healthcare staff about their needs. One young man was concerned about a tremor (1014a). At his follow up interview this condition had worsened but he still hadn't talked to anyone about this, despite having seen prison healthcare (1014b). Others rejected support because they didn't want to have to talk about mental health issues (1027a).

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SDO Project 08/1713/210

Two participants did reach healthcare services, but then left before being treated or assessed. One, to avoid having a camera "*inserted into his throat*" for a suspected cancer (2003a). Another having been released to the care of the ambulance service, by the police, after having a seizure while highly intoxicated with alcohol (1027a).

Offenders promoting initial access

The interviews included accounts of individuals who had secured access to healthcare services including one man who had registered himself with a GP every time he moved (1004a), and another who had gone to a drug and alcohol treatment centre on his own initiative (1027a). Emergency services were often used for initial access to healthcare and a wide range of expectations were given as to what healthcare A&E departments could provide including registering you with a GP (1016b) and providing inhalers (2003a).

Healthcare and criminal justice services also contributed to promoting, and blocking, initial access. This included i) variations across different types of services in the community ii) CJS involvement in access in the community and iii) the role of the prison in healthcare access.

Community healthcare services; access by problem type

Some offenders felt that the way in which community healthcare operated blocked access. Difficulties varied according to type of service, most notably drugs, alcohol and mental health services. Access to drugs was generally reported as easily accessed if not always of the sort that individuals would prefer.

Alcohol misuse support services were reported to have longer waiting times, of up to six months, particularly if you did not have any criminal justice convictions (3001). One participant had received an appointment simultaneously with his prison sentence, and was concerned that his incarceration would mean him having to restart the waiting process when released from the prison (1178a). Other participants reported that a certain threshold, determined by the services, had to be reached before someone could receive support with alcohol problems (1135b).

Availability of mental health services was talked about the most and reported as the hardest to obtain. Some participants had obtained initial access to support when seeking help for other things. One man ended up talking about depression when discussing his alcohol consumption with his GP "*I didn't know it was depression at the time*" (1004a). Others received support when accessing treatment for drug addiction. The interaction between addiction and mental health problems proved more problematic for other participants whose addictive behaviours acted as barrier to obtaining support with mental health issues (1036a).

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SDO Project 08/1713/210

CJS involvement in initial access in community

Offenders made numerous references to accessing healthcare through support from criminal justice staff. Some participants commented on the irony of having received greater access to healthcare as a result of increased offending; particularly with drug addictions. One participant explained that to receive a methadone prescription, "*I gotta go out and commit crime… mad it is*" (1027a). Another participant, who had received a methadone prescription and access to support with his illegal drug use when he was put on the prolific offenders scheme, explained that previously he "*couldn't get the strength*" to deal with his addiction (1016a). He explained that he had committed crime to get help.

Police officers had offered appointments with drug and alcohol services while people were in the cells (1004a). For one man, although both the police and courts offered him help with his drug use he reported that this never happened "*Yes officer I would like to see help. Oh we will sort it out for you straight away. Oh thank you. Wasting my breath, wasting my breath*" (1016b). Some participants reported being more willing to accept help from some parts of the CJS than others; one man had previously accepted substance misuse appointments from the courts and probation service, but he would not accept them from the police (1027a).

The most commonly reported incidents of CJS staff supporting and facilitating access to healthcare concerned probation officers. This included: basing services in probation offices, making access easier and more likely (1004a, 1174a); probation officers making appointments with substance misuse services (1014a, 1015a, 1027a, 1173a); making an appointment with a mental health worker (1015a); and encouraging and supporting offenders to register with and visit GPs (1135a, 1174a).

Access to healthcare services in prison

On prison entry everyone receives health checks. Some of those with particularly chaotic lifestyles, who didn't access healthcare in the community, employed a conscious strategy of using prison to address health needs. One participant had received an eye injury in a fight, but failed to attend appointments made in the community for him "*So I'm gunna get it looked at in here*" (1027a). Others reported purposefully using incarceration as a break from illegal drug use, allowing their bodies to recover; "*Sometimes I ask to go to jail just to sort me head out and get clean but then I go back see*" (1027a).

A variety of healthcare services were accessed while participants were in prison including physical healthcare services (e.g. investigative blood tests (1014b); and an external hospital appointment to treat broken nose cartilage (1135b)). Difficulties reported in accessing healthcare services within the prison included: understanding the system for new prisoners "*I thought the doctor would come over you know*" (1099a); planning the need

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SDO Project 08/1713/210

of painkillers in advance and arranging set medication times (1016a); and long waiting times for healthcare related services, such as dentists and opticians (1014b, 2048a).

Easier access to healthcare in prison was facilitated by higher staffing levels than in the community. One man found it easier to see someone about his healthcare in prison "*they are pretty good for that*" (1061a), another explained that in prison you have nurses 24 hours, a doctor on call and a psychiatrist on call "*it's just got a lot more help regularly available*" (2020a).

5.4.2 Continuity of access

Summary

Offenders reported experiences of discontinuity at all stages of the CJS. In the community, offenders faced particular barriers to continuity of access over and above those faced by the general population, including reluctance to discuss potentially stigmatising issues and chaotic lifestyle factors. Entry into prison could produce delays and changes in medication. In prison the needs of the CJS could break continuity of access, including release from court. Participants were most vocal about continuity of access being maintained when they left prison, particularly for support they may not have previously been receiving in the community, such as treatment for drug and mental health problems. As in initial access, the importance of the individual's contribution to achieving continuity of access was clear. This highlights a two directional definition whereby individuals sometimes break their own continuity.

Offenders described experiences of services holding together well or breaking down at different points in the CJS: i) within the community; ii) coming from the community into prison; iii) within prison; iv) release from prison back into the community.

Within the community

Participants experienced inconsistency in services, for example when waiting for appointments and results, when locations of appointments were changed, or when staff were on sick leave (1027a, 1135b, 1178a and 2003a). Inconsistency led to some individuals breaking their own

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SDO Project 08/1713/210

continuity (1135b, 2003a): " *I've just given up on everything cos… it's just not there anymore*" (1135b).

Specific conditions set out by the best practice guidelines for taking medication concerned offenders (1004a, 1016b, 1027a, 2003a and 1036a). Two individuals experienced being taken off medication because they were drinking too much: "*yeah but they stopped it 10 days before I came in because I was drinking too much*" (1027a).

Bureaucracy of healthcare in the community was seen as breaking continuity:

> "*You have to phone up for these appointments and now there's this different system, the doctor sends me, and then I get a letter from the doctor telling me to phone this one and get an appointment, and they said we've got no appointments for you next month, we'll wait until the month after and then we'll let you know when your appointment is*" (2048a)

One young man, who had established a really good relationship with his community GP, and could talk about anxiety and depression with him, still found himself unable to discuss his self-harm (2003a). This highlighted that even when there is continuity of access with a particular practitioner, an individual may not be receiving continuity of access for all their health problems.

Lifestyle factors challenge some offenders ability to maintain access to standard services (1004a, 1015a, 1135b, 2029a). For example one offender expressed frustration as being late for an appointment had meant not seeing anyone (1135b).

Experiencing discontinuity of on-going access had led some participants to practice self care, including self-medicating with heroin (1036a). One participant reduced his monthly emergency admissions for asthma by 'self-prescribing' steroids (2029a). Other participants claimed that they had grown used to long-term conditions and could manage better alone. These included personality disorder (1174a) and post-traumatic stress disorder (PTSD): "*I've got used to it, used to feeling that way so I've sort of, adapted to it like and overcome it*" (1117b).

From community to prison

There were many suggestions that admission into prison led to a break in treatments (1016b, 1026a, 1099a, 1117b, 1173a, 1178a and 2048a). Individuals experienced being put on a different type of medication in prison (1016b and 1099a). Others experienced a break in the opportunity to have mental health tests or receive test results (1026a and 1099a) or to have a test repeated (1099a). The most common experience of admission to prison breaking continuity was a break in access to medication, whether

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this was due to it being stopped or awaiting community GP confirmation (1117b, 1173a, 2048a):

> "*It took me like two weeks to get my medication for my kidneys because they have to be prescribed by a doctor and the doctor has to go and check up with the hospital and this, that and the other and he has to speak to people in the hospital and it takes as long as it takes*" (1173a)

This participant went on to describe what he saw as the main differences between community and prison healthcare:

> "*If you're outside and you made an appointment for a doctor, it wouldn't take you a week or two weeks to see a doctor... [In prison] you have to fill out a form, post it in a box, then you have to wait for them to collect it and then somebody to read it, then somebody to check the doctor's books to see if they've got enough space to put you on it to see them, and it could take ages... being able to get the treatment that you need, when you need it*" (1173a).

Within prison

Occasionally CJS requirements impacted on people's access to healthcare within prison and on release, such as a man who was released directly from court and so didn't receive a discharge health check (1014b). Another participant had to rebook a prison doctor's appointment to attend a video link appearance to a court (1117b).

Release from prison into the community

A number of offenders expressed their desire for continuity of access, and more help, on release (1019a, 2029a and 2048a).

> "*Um ideally like to go on a detox and rehab and get completely clean then have help afterwards when I get out like I did before when I was in prison. I did detox, come out there wasn't any help afterwards so I relapsed and got back on it.... it happens all the time cos I've seen it happen to so many people before. They've come out and they're clean and then they haven't got anywhere to live, they're on the streets and the next thing you know they're back on the drugs again*" (2029a).

One participant had previously received good support giving up heroin when in prison, but this support was not available in the community and he began to use heroin again (2020a).

One man had had twice weekly appointments with the prison psychiatrist in the three months before he was released. He was told that on leaving

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SDO Project 08/1713/210

prison he would need to see a community GP for referral to a community psychiatrist, which could take three months. Eventually the prison governor became involved. A referral was made and three days before he was released he knew who he would be seeing in the community. He would have liked to have had this certainty much earlier (2020a).

5.4.3 Longitudinal continuity

Summary

There was limited evidence that offenders valued being able to see one person over time simply because that practitioner would know them; they prioritised instead being able to see someone when they needed to, and the relationship with that person.

Longitudinal continuity has been defined as the provision of care over time from as few professionals as possible. It can be measured by the proportion of contacts with the same practitioner or assessed subjectively. It is not, necessarily, predicated on a 'good' relationship. There was very little evidence, in the interviews, of this form of continuity being important to offenders. For offenders continuity is broken on release from prison and care from new practitioners must be sought. Some deliberately chose to wait until their release because they wanted to carry on seeing the community based doctor that they saw originally (1014b) or because they were generally distrustful of prison staff (1117b).

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SDO Project 08/1713/210

5.4.4 Relational continuity

Summary

Good relationships with practitioners have been indicated to be important for these individuals but not in the way we would expect. Previous definitions have emphasised the importance of maintaining a relationship with the same practitioner over time, longitudinal continuity, in order to build and develop relational continuity. In these interviews the participants highlighted the importance of healthcare practitioners providing a good experience and skills on individual occasions. This contradicts the previous definition and literature for the importance of relational continuity overtime. There is also an awareness that relationships are two directional and requires contributions from both sides, the practitioner and the offender.

Relational continuity has been defined as the personal or therapeutic relationship achieved during contact with a professional and the importance of establishing and maintaining this relationship. This has been linked to the importance of being able to see the same practitioner.

Offenders' experiences of building relationships with healthcare practitioners, and what they thought was important about relationships within healthcare, included three main elements: i) practitioner contributions to relationship, ii) offender contributions to relationship and iii) limits to relationships.

Practitioner contributions to relationship

This aspect of offenders' experiences focuses on what the practitioner contributes to the relationship and whether this promoted positive or negative experiences for the offender.

Multiple references were made to positive relational experiences by discussing practitioner's skills (1004a, 1117a, 1135b, 2003a). These included the feeling of being listened to "*I just have a talk to him like because I never wanted to speak to anyone really so I always used to speak to my doctor and he was pretty good*" (1117a) and trusting the practitioner enough to then confide in them.

> "*I went to my doctor about it because I couldn't handle it and he was pretty good with me.....The advice and that he give me, and knowing that he said if ever I need him, I can just go up there and speak to him or anything like that" (2003a).*

These two aspects of positive practitioner experience are interlinked, "*he's listening to me and I was telling him sort of a lot of things*" (1004a).

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SDO Project 08/1713/210

Therefore when the individual felt listened to this led the offender to feel they could confide in the GP.

Individuals highlighted the importance of practitioners being non-judgemental (1027a, 1019a). One described a positive interaction with an ambulance crew "*They seemed to care miss yeah cos when you do heroin all your life, you look at yourself in a different way you don't look at yourself as a nice person yeah and they seemed very polite, caring*" (1027a). Participants also appreciated proactive healthcare follow up from practitioners (1027a, 1174a, 2048a), as previously discussed in 'access'.

This 'going the extra mile' to provide continuity of access appeared to the offender to demonstrate caring. However, elsewhere experience of the professional going the extra mile to follow up on healthcare didn't work suggesting although practitioners can show relationship building behaviour, if it's not reciprocated, it doesn't work,

Participant	"*No but he did he did ring up the chemist yeah and I believe he sent me a letter if I remember rightly to um make an appointment to see him.*
Researcher	***But you didn't go.***
Participant	*No I don't like doctors miss if I'm being honest*" (1027a).

There were multiple references among offenders of a feeling of healthcare practitioners not understanding them and therefore leading to poorer relationships (1014a,1099a, 1135b, 1158a, 1174a, 2003a, 2020a, 2029a and 2048a) "*I don't like him one bit....you just go in there, nothing wrong with you … go home, you'll be all right*" (2003a).

Others have suggested an experience of both the practitioner and the individual not understanding each other leading to a poorer relationship (1014a, 2048a). Multiple references were made by offenders of feeling treated 'like a child' (1014a, 1036a, 1117a and 1117b) suggesting they felt patronised by healthcare staff. This indicates a tension between a desire for caring relationships and not wanting to be patronised.

Participants revealed fragility in their relationships, where faith in the practitioner was easily lost or never achieved; they suggested that previous bad experiences with healthcare professionals harmed trust for future relationships (1014a, 1015a, 1026a pg8, 1027a, 1117b, 1135b, 2003a, 2048a).

A feeling of prejudice from healthcare practitioners also created bad experiences of healthcare (1027a, 1117b, 1015a).

> "*When I went to the hospital they just, didn't care. They did, they thought, oh well, they obviously thought, oh look at him he's a, he's a prisoner, who cares about him like....that's what I felt like anyway*" (1117b).

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SDO Project 08/1713/210

The importance and fragility of continuing relationships was shown where one bad incident led to an individual severing his access to services, "*I had an argument with my worker because I had something important to tell her on the phone and she didn't get back to me for like a week, so I didn't bother*" (1135b). A decline in relationships with healthcare staff could lead to severance of healthcare in some individuals.

Offender contributions to relationships

A couple of participants felt caught out by criminal or dishonest behaviour which damaged their relationship with practitioners (1027a, 1014a)

> "*No I don't like doctors miss if I'm being honest, It's not the people...Yeah cos of my cos they were getting concerned about the amount I was drinking on top of my methadone he found out that I OD'd from my drug worker and that so*" (1027a).

As shown, distrust in healthcare practitioners can build from previous bad experiences, however offenders also indicated a generic distrust for everyone therefore having an indirect effect on trusting healthcare staff (1026a, 1061a, 1117b, 2029a) "*I don't want to speak to no-one about nothing. Do you know what I mean? If I'm honest.....Yeah, I don't trust no-one*" (1061a).

There were some examples where offenders indicated an awareness of their role in building on relationships with healthcare staff (1004a, 1016b, 1174a, 2020a). Some participants began to open up over time and to present themselves as listening and receptive to advice. One participant (1174a) reflected that his attitude used to be that he "*didn't care*" but now realised "*it's not just me it affects*." He explained that his attitude had now changed and that he was "*very honest and open*", he talked to people and took advice on board, "*if I think someone seems alright or trustworthy, I'll speak to them*" (1174a). Hence some participants seemed aware that relationships are bidirectional, requiring input from themselves as well as the practitioner.

Limits to relationships

One offender suggested limits to trusting healthcare staff (2003a). The individual was happy to confide in his GP about his girlfriend's accusation of rape but was then reluctant to confide in his GP about his self-harm "*I just felt I didn't want to tell him, I thought I'd keep it from him*" (2003a).

Limits to relationships were also suggested in terms of breaking of relationships from community healthcare staff when coming into prison (2020a) and limits to trust (2003a). This has been discussed in regard to continuity of access.

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SDO Project 08/1713/210

5.4.5 Flexible/Holistic continuity

Summary

Much of the perceived inflexibility outside of prison is not specific to the offender population but may be more common for those misusing drugs, being homeless or having cognitive impairment, depression or personality difficulties.

Practitioners may not only see themselves as following guidance but may also believe they are practicing within an integrated bio-psycho-social model by not providing immediate relief and feeling that is in the individual's overall best interest.

There is potentially a conflict of beliefs about what would constitute flexible and holistic care and a problem arises when the individual's concept of flexibility is in tension with the best medical practice guidelines.

Flexible continuity has been defined as the ability of healthcare services to adjust to changes in a person's life over time. This includes the need to ensure that a system of care can meet a broad range of needs at any one time and included the importance of practitioners viewing an individual as a whole person. Therefore flexible continuity also includes the concept of 'holistic' or integrated continuity. This has two levels, firstly, integrating with other health needs and secondly, integrating with other socio-economic needs. Flexibility is about how the service fits around the individual to achieve initial, and then continuity of, access.

Offenders' experiences and beliefs about the flexibility, or otherwise, are examined in terms of: i) Structural limitations of services for individuals, ii) limitations of prescription guidelines and iii) structural limitations of prison.

Structural limitations and enablers of services

Some offenders reported that their problems and reasons for seeking help often precluded them from meeting the access criteria for healthcare services. One offender experienced this whilst trying to access housing support:

> "*They said you have to prove yourself, do you know what I mean, you have to stay off the drink and the drugs for like three or four weeks – well I can't sleep on the streets for three or four weeks*" (1135b).

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SDO Project 08/1713/210

Potentially, an holistic approach to care and an awareness of the socio-economic problems these individuals experience, on top of their health problems is important here.

Another offender suggested having a key worker for their healthcare needs would improve integration of care.

> "*That would be better....Because then it ain't, well I've got to get in touch with so and so, let me ring up so and so, d'you know what I mean if you only spoke to someone that knew everything, about you....that would be ideal wouldn't it?*" (1036a)

In the community some offenders felt that the way in which healthcare systems operated had blocked their initial and on-going access to services. This included not receiving appointments because of being homeless (1015a), stopping on-going medication without explanation (1117b), failure to pass on to another drugs worker when his allocated one became sick (1027a) and not responding when initial attempts to gain access were made (2003a). All of these complaints have been considered in more detail elsewhere, what links them together is the interview participant's perceptions that access to services is configured around the needs of the service, rather than themselves. Some participants felt that the responsibility for initial and on-going access lay with services rather than themselves. One participant articulated this as the need for services to make an effort to reach out to him and initiate access. "*If they actually show some, show some initiative to act, to like having an understanding of things that make ... so they actually look like they care*" (1117b). When healthcare services were located at places that the participants were already visiting they reported themselves as more likely to use these services, such as a GP clinic which took place in a homeless shelter (1036a). This highlighted flexible continuity as an underlying mechanism to initial and on-going access.

Limitations of prescription guidelines

The most frequent reports of healthcare being inflexible were when practitioners wouldn't give individuals the medication or street drug substitutes that they wanted, even if what they wanted went against medical guidelines (1014a, 1016b, 1027a, 1135a, 1036a, 1158a, and 1173a). This included threatening practitioners that their offending behaviour would get worse if they didn't get what they wanted (1014a, 1036a).

> "*She was saying to me if you don't stop the drugs that you are taking at the moment I can stop your script and I said well if you stop my script then you are going to make me go back to crime to earn money to treat my habit to take drugs*" (1014a).

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SDO Project 08/1713/210

There were multiple mentions of how individuals felt the system was not working for them.

Some offenders wanted more flexibility in the range of treatments (2020a). Unlike many participants, one individual wanted talking therapies rather than medication for his mental health needs:

> "*I have medication, story of my life, medication, medication but I don't like medication because it doesn't stop...sorts of like the benzos and benzodiazepines and all those sorts of things, doctors seem to love just throwing them at you....*" (2020a).

Structural limitations in prison

Practical and structural limitations in prison reduced flexibility of how and when medication was available to people (1019a, 1026a, 1036a, 1117b, 1135a, 1173a, 2048a). There were a number of references to the inflexibility of the hatch system in prison for medication, where medication is issued at set times of day for immediate, observed consumption. One offender discussed the inflexibility of the time medication was administered out of the hatch and how taking his sleeping tablets too early meant he was tired too early and not being able to sleep later on rendering the medication useless "*so when you take it out the hatch well, by sort of like, six o'clock, you're **** knocked out*" (1117b).

Part of the structural limitations of prison life was limiting access to the holistic view of health rather than to treatment and medication (3004). For some, this included diet and exercise (1026a, 1135a, 1173a) and the inflexibility of the regiment, having set meals every day (1173a).

5.4.6 Communication

Summary

There are references to information transfer problems between healthcare and criminal justice agencies. However, the importance of communication being two directional, between services and offenders, received much greater weight. This included formal communication, such as receiving appointments, and feeling they are being communicated with, not 'left in the dark'. Some offenders showed they could contribute to continuity of communication by being proactive, and not reliant on others to make appointments for them.

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SDO Project 08/1713/210

The protocol defines 'continuity of communication' as requiring excellence in both transfer of information and working relationships between different professions within and across teams and statutory boundaries.

Results of offenders' experiences of communication are reported in terms of i) individuals contributions, ii) healthcare system and staff contributions and iii) CJS and staff contributions.

Individual contributions

Communication from the individual was seen as either pro-actively communicating their needs to healthcare staff or blocking communication from healthcare staff.

Some individuals suggested a need for playing a pro-active role in communicating with healthcare (1135b and 1178a). This included chasing up healthcare (1135b and 1178a) and communicating with their GP when on certain medication (1178a). Participants had also signed forms to allow communication flow between professionals (1004a and 1178a).

A number of individuals suggested they had blocked communication from healthcare because they didn't want communication between prison and healthcare (1015a, 1026a, 1027a, 1135b and 1174a).

A recurring theme was a reliance on others to communicate to each other about their healthcare without their input (1014a, 1036a and 1146a). One offender felt he didn't need to tell his doctor about his healthcare as he relied on his information having already been communicated. "*They just said see the doctor about it but I never got around to saying it to the doctor, but I think they have got something on my files about my tremor, because I told them years ago about it*" (1014a).

Healthcare system and staff contributions

There were multiple references that indicated individuals were feeling 'left in the dark' by healthcare (1019a, 1027a, 1099a, 1117a, 1135a, 1135b, 1158a and 1174a). These were examples of times when healthcare were not communicating with the individual about their healthcare. The offender was frequently left wondering what was happening "*Had a CPN (Community Psychiatric Nurse) done. And they said, to get, they was going to get in touch with me, and they <u>didn't</u>*" (1174a).

Continuity of communication was sometimes achieved by the proactive actions of practitioners who had found the best way to communicate with individuals (1174a).

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SDO Project 08/1713/210

Criminal justice system and staff contributions

A number of references were made to offenders feeling that police and probation officers can communicate more easily with services (1004a, 1019a, 1061a and 1178a). Communication from criminal justice staff seemed to assist in getting quicker healthcare appointments for these individuals. However another offender indicated his lack of willingness to communicate with criminal justice staff when asking for help to access a drug service.

> "*Yeah I wouldn't ask (anything from the) police innit....I mean where I had to see probation and they put me in touch with (name of SW substance misuse centre)...I don't want no help from the police miss I won't take their appointment*" (1027a).

Offenders expressed their frustrations of waiting for healthcare staff in prison to communicate with healthcare in the community to receive their prescriptions (1016a, 1135b, 1173a and 1178a). Therefore structural factors or communication barriers in prison led to difficulty in offenders getting immediate access to the medication they are prescribed in the community.

It was also suggested that prison admission can sever communication with community healthcare staff (1099a, 1135a and 1178a). For one offender this meant a severance in communication of healthcare test results and a referral for specialist treatments:

> "*Er I saw him, I started seeing him again a couple of months before I came in here um and he referred me again and about week before I came in I had a phone call from um.....and they said that they were passing all my information on to (name of large SW hospital) and sent me an appointment again and obviously.....since I've come in here..... I dunno whether they'll be aware if I'm in here or no*" (1099a).

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SDO Project 08/1713/210

6 Organisational case studies

The organisational case studies were designed to provide a system wide picture of how the criminal justice and health systems interact to provide healthcare and continuity. They contributed to answering the following research questions:

What is the current situation concerning continuity of care for offenders during their contact with CJAs, both in custody and in the community?

To what extent does contact with CJAs promote offenders' access to and continuity of care?

To what extent have prison service guidelines on continuity been adopted and what are the barriers to achieving this?

The SWCS was developed from interviews (15) and documentary analysis (20) with additional illustrations from the qualitative and quantitative results. To avoid repetition about systems which operate nationally, the SECS is reported in summary form with key differences highlighted.

Six mini best practice case studies are then reported in order to examine what is possible in a receptive context.

6.1 South West whole system case study

This case study: i) describes the context; ii) outlines the provision of relevant services; iii) goes through each element of the CJS examining how, in turn, care is provided from within or interacts with the wider healthcare system; iv) concludes with an analysis of how far the system goes in achieving the aims of the policy presumptions within the provisional programme theory.

6.1.1 Case study context

The case study is set in an urban local authority area in the predominantly rural south west and its associated prisons, population 200,000+. The previously dominant manufacturing sector is in decline; the city has areas of high deprivation and poverty. There are two police stations, one with a custody suite, a crown and magistrates' court and a probation service building in the city centre. There are no prisons within the immediate area. The nearest local, remand male prison is approximately 50 miles away. There are two other male category C prisons in the county. The nearest female prison is considerably further away. Currently the county mental health trust (MHT) and an independent provider, deliver mental health and primary care within the three prisons. The Prison Counselling, Assessment,

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SDO Project 08/1713/210

Referral, Advice and Throughcare (CARATs) service for substance misuse is provided by the prison service.

The Drug and Alcohol Action Team (DAAT) is responsible for delivering the national drug strategy; the PCT is responsible through different commissioning managers for mental healthcare, specialist physical healthcare and for primary care.

6.1.2 Healthcare in the case study site

Summary

Most community based services that provide for the healthcare needs of offenders are not directly allied to the CJS. There are no offender specific pathways for these services and offenders access them by luck, default or as a result of crisis. Some services and new initiatives, such as the forensic team, a criminal justice drug treatment service, the learning disability sex offence service and the GP outreach are designed with offenders in mind.

The organisation of healthcare in the community in the case study site is similar to other areas.

The accident and emergency (A&E) department may be attended when people have not been able to access other services. Many of these people are said to be 'in social rather than medical crisis' (4004). The A&E team have developed systems with the probation service to identify individuals who present a particular risk. People with alcohol problems can be connected with the city's substance misuse team or the hospital's hepatology department; people who self-harm are referred to the hospital psychiatric liaison team.

Primary care is provided by independently contracted NHS GPs and one PCT provider practice. This surgery had been running the 8am-8pm GP health centre and included outreach clinics in homeless shelters, hostels and probation, giving greater access to care for vulnerable groups. A walk in, women only clinic, is being trialled (4002). The normal range of community and inpatient mental health facilities include two early intervention teams, for psychosis and personality disorder, based in a youth health centre; these are considered less stigmatising. The new Improving Access to Psychological Therapy (IAPT) service for people with depression and anxiety is not commissioned to provide therapy to those receiving services for substance misuse or personality disorder (4016). In the current study sample, 95 (63%) reported less severe mental health problems, and 25 (17%) reported severe mental health problems, most with substance misuse, reinforcing the need for these services. The case study area has a

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SDO Project 08/1713/210

Community Forensic Mental Health Team (CFMHT). The majority of the people passing through the courts with a mental health need are not highly dangerous and so are ineligible for the service.

A city centre located drug and alcohol service treats addictions, along with residential and day facilities located across the city. There are limited dual-diagnosis services for those with mental health and substance misuse issues (4016). The majority of offenders (131 (87%)) in the current sample reported both substance misuse and mental health problems. The substance misuse practitioners receive training in a number of modalities but are not fully trained therapists (4016).

Alcohol services are not centrally funded; government expectation is that finance will come from PCTs. A small team of four have cleared a waiting list that was 6 months long and offer programmes of 6 and 12 weeks, depending on need. Those needing higher levels of support present a resource challenge (4016).

A successful sex offender treatment programme for people with learning disabilities treats a small high risk group (P16). Multiple third sector providers operate in the health community providing: a drop in day centre, and meals (4003 & P11) and a mental health advocacy service. Many offenders seen to lack the skills to access them (4006).

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SDO Project 08/1713/210

6.1.3 Police

Summary

The police provide a frontline contact for people in crisis with drug, alcohol, mental health, or a combination of these, problems:

- *Immediate access to healthcare treatment for urgent needs. Forensic Medical Examiners (FME) and assessments from psychologists can be called, but may be delayed. A&E can also be used for physical health assessments and mental health assessments, if a Section 136 Place of Safety assessment isn't being made.*
- *Referral into mental health system through Place of Safety Scheme.*
- *Access to urgent medication is facilitated while in police custody, when possible. This 'facilitation' includes going to people's houses to pick it up.*
- *There is good access to previous healthcare information from previous police, but not from medical records.*
- *There is very little mandatory mental health training*

Some people come into contact with the police because of a lack of services to treat their addiction and mental health needs. When the police try to appropriately process those people the same gaps remain.

The custody suite has one fulltime Healthcare Professional (HCP), who is employed by a private provider. A FME can be called and usually arrives within a couple of hours. Psychiatric consultants can be called on; they may also be subject to delays, 'arriving within one hour, or eighteen'.

The police are often called when someone with mental health and or substance misuse issues is causing a disturbance in the community, but receive very little mandatory training in mental health (1-2 days in initial training). A local mental health charity has, however, been offering the opportunity for police students to visit their drop in facility to engage with people with mental health problems (4003). Police officers were reported to be proactive into getting people into treatment for substance misuse problems, before they reached the court stage (4016).

Police officers can take people to the custody suite. The presence of a HCP sometimes leads them to have unrealistic expectations of the healthcare that can be provided there (4014). It is the custody sergeant's role, with

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SDO Project 08/1713/210

medical information provided by the HCP, to decide if someone is fit to be detained. Everyone who asks to, and everyone who the custody sergeant considers needs to, sees the HCP (4014). HCPs keep their own records and enter a summary on the custody record which may omit information that the individual wishes to be kept private. Medical information on custody forms can be easily re-accessed and is usually quite comprehensive (4014).

For those with more serious health needs there are a variety of other options. A designated 'Place of Safety', as per the Mental Health Act 1983 (Section 136), was established in the period of the case study. This allows the police to move people who are believed to be more suitably cared for in a psychiatric setting to the 'Place of Safety' situated in a psychiatric hospital. The introduction of the facility initially required learning on both sides. The police needed to appreciate that they could only take people with psychiatric needs, and not use it as a solution for detoxifying alcoholics, and hospital staff needed to see the person as primarily ill, rather than a criminal threat. After a settling in period, the facility now appears to be functioning appropriately (4011)[18]. Community police can also take people straight there, without going through a custody suite assessment (4014). Before this provision there were people who came into the custody suite on repeated occasions, such as self-harmers, for whom there was nothing they could do (4014). If someone is mentally disturbed, but does not meet the service threshold, they will probably be released. The custody sergeant will put a release plan in place to try and keep them safe, which may include a referral being made to the out of hours team. The person may go on to cause further disturbances in the community; sometimes there is nowhere to send people with mental health issues (4014).

The custody suite can be used to monitor those at risk of suicide; except from overdose. Other serious conditions may require sending people to the city's main hospital; particularly pre-existing health conditions such as diabetes, deep vein thrombosis (DVT) and broken bones. Officers will take people straight to A&E; particularly if they have arrested them primarily to calm them down. The custody sergeant bears the ultimate responsibility for deaths in custody and, if the HCP considers someone needs to go to hospital, they will err on the side of caution (4014). Sending someone to A&E under police guard is expensive and the decision of the duty inspector. A&E staff felt that their facilities are used inappropriately by other services (4004).

The police service is involved in a variety of other healthcare functions, for example collecting long-term medication from homes and methadone from chemists (4014). These medications are then stored in a different place from someone's other belongings, the transport services will not accept methadone, however, because it is a controlled substance (4014). Patrol and custody officers also become involved in referring people to services,

[18] Over the 12 months immediately prior to publication 199 offenders went into custody on Section 136, and 190 into a Place of Safety provision.

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SDO Project 08/1713/210

who sometimes return to custody before receiving these appointments (4014). The DAAT service praised the police's active involvement in encouraging people to enter treatment (4016). The time people spent in custody cells, withdrawing from substance misuse, was regarded as a pragmatic opportunity to address addiction (4014). The custody suite was also reported to serve the social function of a bed for the night, particularly for those banned from the hostels, or when hostels were full.

Custody sergeants received training in health related issues from briefings, leaflets and once a year in first aid. One interviewee regarded keeping up with this information as something you have to take personal responsibility for, as part of on-going training. They cautioned that they would not want to receive too much training; they required just enough to be able to do their job (4014). The main tension between custody sergeants and healthcare staff was emphasised: In a coroner's court a nurse can be questioned, but it is the custody sergeant who is ultimately responsible (4014).

There are, however, gaps in catering for the health and social needs of the offender population. When these individuals reach crisis point, or impinge on the lives of others, they often come into contact with the police. The police are then faced with the problem that there are no suitable services to refer these people to. One example of this in the case study area is a lack of facilities for homeless alcoholics, because there are no wet hostels in the city (P3).

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SDO Project 08/1713/210

6.1.4 Court facilities in the South West

The court facilitates access to some mandated treatment options for drugs, alcohol and severe mental health needs. There are no healthcare services or routine assessments of healthcare needs available in the court. Appearing at court facilitates limited access to healthcare:

- *There is mandated access to drug and alcohol treatment for those with high level needs, but not for those who do not met thresholds or receive a custodial or community sentence.*
- *Assessments, and mandated treatment, for those with severe mental health needs is infrequently used.*
- *Advice and support from other services, including substance misuse, is limited to community court days.*
- *The public advice and support service facilitates access, and re-engagement with, services. They achieve this by building up relationships and trust over time.*
- *There are no healthcare systems within the court to ensure that people's medication or healthcare information follows them through the CJS.*

There is nowhere for people with multiple, below threshold, needs to be directed and less support if a custodial or community sentence is not received.

People arrive at court from the community or from police custody. Some, particularly those with on-going health needs who expect to be sent to prison, may bring medication and medical notes with them. Homeless offenders interviewed were often in the habit of carrying their medical records with them, to ensure their on-going care (1003a & 3005E).

Those coming from police custody are held in the court cells. There is currently no trained health person working in the cells, or mental health professional working in the court (4015). Everyone who goes on to the crown court will have initially appeared at the magistrate's court, on which this case study focuses. There are 150-160 magistrates in the case study area, who sit a minimum of 26 sessions a year, although many do much more. Magistrates receive training and information from a variety of sources. These include ad hoc training days, training attached to meetings such as the Annual General Meeting (AGM), information contained in a twice yearly newsletter, and information distributed by the court legal advisors. Significant changes in the law are the main emphasis in the

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SDO Project 08/1713/210

information they receive, however the DAAT do provide an annual training opportunity (4016).

Health related information is rarely presented in the court room (4015). Legal teams sometimes allude to health issues in an unsubstantiated manner. Legal teams can only tell magistrates what they have gleaned in what may have been limited contact. If magistrates are considering a community penalty or custodial sentence they can order a PSR to be carried out by the probation service, in which they can direct them to examine certain issues. These are not possible for people receiving fines, conditional discharges or found not guilty, who may have an equal level of need. Sentence options include DRR or alcohol treatment requirements (ATR) which require thresholds of need to be reached, particularly for residential treatment; otherwise the magistrate can only recommend that they seek help.

The MHTR also has a need threshold. The magistrate interviewed had not, personally, used this very often; this is in line with national trends (4015). They reported that the psychiatrist and courts were often working to different timeframes. Another interviewee, with experience of mental health services in courts, reported that the case study court struggled to get psychiatric reports, so only requested them if someone was very obviously and seriously mentally disturbed or hospitalised due to their mental health (4010). The courts have access to a full time probation officer who does some of the non-professional mental health work within the courts (4010).

Additional advice given to individuals depends on the 'court' they attend. Community courts operate two days a week and some support services are available including: volunteer substance misuse advisors, a public support and advice desk, police and probation representatives. On other days, people may be appearing at youth, family, custody, trials, motoring offences, domestic violence and TV licence courts. They may have a similar level of need, but the same services are not available to them. The magistrate interviewed said that this was *"…very, very frustrating…"* (4015).

The majority of the people in the case study area passing through the courts with mental health problems are not highly dangerous as a result of their mental health problem and so are not eligible for the CFMHT service. Prior to the case study a senior member of the CFMHT team, through individual initiative, ability and interest had undertaken very successful work with some of the offender population. After the loss of his very popular leadership the team has been undergoing restructuring. Currently their main focus is on redirecting resources from funding out of area beds in secondary care facilities, to being able to offer a wider service within the locality (4011). In the magistrate's court there is a public support and advice desk run by a mental health charity. The staff join police and probation officers in 'problem solving sessions' held briefly during the court proceedings to assess psycho-social needs and willingness to address these. Sentencers take this into account, and individuals can meet with the

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SDO Project 08/1713/210

staff after their court appearance. The service can help individuals to join up services around their needs, rather than the other way around (P18a.). Many of their clients have previously been part of mental health services and have often 'fallen out' of those services (P18a). Many have multiple low level needs, but do not meet the threshold for any particular service. The support and advice service is able to see them on an unlimited number of occasions, this allows them to build up relationships with the individuals and overcome some of their barriers have that caused them difficulty in accessing other services. The staff and volunteers, however, are not trained to assess mental health needs and lack services to direct people towards.

6.1.5 Probation

Probation sentences provide the opportunity for offenders to access healthcare services with the support of a probation officer who may also be helping them address their other needs such as accommodation and finance.

- *Offender managers help people access services including through sentence planning, risk assessment and management plans. They do this by making phone calls and appointments. Staff receive some mental health training and some staff receive further training. Much of their knowledge is experience based.*
- *Location of healthcare services in probation building (blood borne virus nurse, drug and alcohol workers, GP clinic), and other places offenders visit (homeless hostel), encourages access. Additionally there is a visiting dentist.*
- *GP clinic is facilitating wider GP access and partly addressing a need for mental health service access. Establishing GP contact allows offenders to access other healthcare services. Positive relationships are built with a positive attitude and an understanding of their other needs*[20 21]*.*

There are three types of probation supervision i) Prison leavers who had received sentences longer than 12 months ii) Community sentences, which may include requirements such as drug, alcohol or anger management courses aimed at reducing reoffending; iii)Unpaid work for a specified number of hours.

Probation officers complete an Offender Assessment System (OASys) form for all offenders, containing sections on illegal drug and alcohol use,

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SDO Project 08/1713/210

designed to assess risk not need. The final section of OASys, Section 13, is a free form box, with no prompts, for any relevant information about healthcare needs. This box is often poorly completed as it appears at the end of a very long process, conducted in a pressured first appointment with a probation officer.

Healthcare service information is provided on notice boards and in the waiting room of the probation offices (P8). The offender study has shown that offenders are less likely to access services when information is given in this passive way. The offender study has shown that probation officers help increases the likelihood of successfully engaging offenders in services. Officers help engagement through their knowledge of local services and by making telephone calls and writing letters to local services. This knowledge is gained by experience and there are no, up to date, directories of local services. Particularly problematic are third sector services which may change frequently due to the time limited nature of their funding (4007).

The services available vary for different types of need. Alcohol services include: the local drug and alcohol service; recommending seeing or registering with a GP; Alcoholics Anonymous (AA); or seeing a GP at one of the homeless hostel clinics. Offenders on probation sentences in the offender study reported making good use of these clinics (1135b) and regional leads described the city as having *"…excellent GP access…"* for offenders due to these services (4010). Drug services include: Narcotics Anonymous; their GP or registering with a GP; the drug and alcohol service in the city; the drop in day centre or residential detoxification services based in the city.

There are no direct links between the Community Mental Health Team (CMHT) and the probation service. Mental health services were reported by probation officers to be the most difficult to access for their clients (4007). Services for different problems work separately and there are no specific services to address co-morbidity. Personality Disorder (PD) is also reported as a barrier to being able to access services for clients (4007). The main opportunity, currently, for different services to work together is at meetings for people under the 'prolific offenders' scheme. Substance misuse services have prioritised this opportunity in recent years and a multi-disciplinary team, including police and probation representatives, operates from their facilities (4016). From the probation service perspective the CMHT are the least likely to attend these meetings (4007), and from the CMHT perspective they are only called to these meetings when they are being asked to pay for something and not to work in partnership in planning for an individual's needs (4011).

There are some healthcare services based within the probation service building. The offender study showed this made offenders more likely to use them. There are two workers on secondment from the drug and alcohol service and a blood-borne viruses nurse (4007). A local mental health commissioner described the Probation service as doing the closest, within the CJS, to what CMHTs do: providing support not just at the point of crisis,

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SDO Project 08/1713/210

but helping people with the on-going stresses and temptations of everyday life (4011). An additional service was introduced, during the period of the case study, partly to try and meet the identified need of a lack of mental health support. This service is a clinic, one afternoon a week, staffed alternately by two local GPs; one male and one female. Offenders can be referred by, or book themselves through, their probation officer. Attendees have reported that they choose to access the service because of convenience or perceived lack of stigma (4008). If a patient already has a GP they are encouraged to re-establish a relationship with them; the probation GPs do not generally make non-urgent referrals, give more than a few days medication or provide a sick note if someone already has their own GP. If seeing their own GP is not possible or appropriate, they can register with the outreach GPs' practice. For those who live outside of the city support and advice is offered to register with a GP nearer home.

The GP interviewed believed that a sympathetic approach was more important than specialist knowledge or experience, in terms of providing a service that offenders would engage with (4008). The GP described a good working relationship with the referring probation officers and valued the work they were doing in supporting the individual's other needs, such as housing. Conversations often took place between the GP and probation staff before consultations and, with the patient's permission, feedback was given afterwards. Data sharing protocols appear to be working well and Probation staff seemed motivated by health, rather than criminal justice, concerns (4008).

Although all of the appointments slots are usually booked, up to half of the people can fail to attend. To continue to develop the service the GP interviewed would like to address this, to improve the efficiency of the record keeping system and to be able to provide access to therapy for common mental health problems (4008).

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SDO Project 08/1713/210

6.1.6 Prison

Prison provides an opportunity to continue healthcare received in the community, identify unmet needs and pass care back to the community.

- *A wide range of healthcare provision is available in the prison, usually more and more easily accessible, than that in the community.*
- *Prison is sometimes the first opportunity for people to deal with underlying problems, when they no longer have access to the substances they have been masking them with.*
- *The secondary health check is an opportunity to identify and address on-going healthcare needs. If the delivery of this check is compromised then this opportunity is lost.*
- *Prison healthcare teams (substance misuse, primary care and mental health) are starting to work together. Starting to attend each other's meetings is helping communication. Sharing information about individuals and shared record keeping would help this to develop.*
- *Continuity of access to medication, particularly methadone, is a challenge, particularly out of hours.*
- *Unplanned releases from court stretch and challenge healthcare systems.*
- *Discharge planning works well for those with identified high level mental health, substance misuse and physical conditions. These people are already receiving a relatively high level of support.*

Prisoners from the case study area, sentenced or on remand, are initially sent to a local, category B, prison approximately 50 miles from the case study area. At the time of this report the prison had an integrated primary care and mental health team, recently merged, an Integrated Drug Treatment System (IDTS) team, a CARATS and an in-patient 24 hour hospital bed. The associated local category C prisons have also recently integrated primary care and mental health teams, CARATS and IDTS, but don't have 24 hour hospital facilities.

6.1.7 Healthcare on entry

When prisoners arrive they receive a very brief healthcare check that identifies their immediate/life threatening healthcare needs, and does not

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SDO Project 08/1713/210

include a mental health assessment. These medical checks take place as part of their induction into the prison, in a newly built specialist area; approximately 10-20 arrive each day. The prison building is a city based, brick, Victorian building with many structural limitations. The newly built 'arrival suite' facility overcomes some of these; the medical team have their own dedicated space. There is an issue when large numbers arrive at one time, particularly at evenings and weekends when less experienced staff may be working (4012). Ideally a primary care health worker would be paired with a mental health worker, for the induction process, but resources are not available for this (4009).

The first reception health screen form takes information on current physical and mental health, GP registration, any treatment or medication being received in the community, including drugs and alcohol treatment, and if they will need support withdrawing from alcohol and/or street drugs. There are questions about the likelihood of self-harm. There is a dedicated section for health information that may have accompanied the individual from the community or through the criminal justice process.

The prison healthcare team frequently need information from the community. They report that the necessary on-going medication and healthcare notes rarely make it as far as the prison with individuals, this includes illegal drug-maintenance medication, mental health medication (anti-depressants and anti-psychotics) and medication for on-going physical conditions such as asthma, diabetes and high blood pressure (4013). Approximately half a nurse day is spent contacting community GPs, drug and alcohol teams and pharmacists. They report that 95% of requests result in the information requested being supplied; the other 5% usually comes when the faxes of consent forms are supplied. Permission to obtain medical information from the community, and other prisons in the cluster, is routinely requested on admission. It is much more difficult to obtain community based healthcare information quickly for people who arrive at the prison late on a Friday, or on a Saturday morning. For those who have been within the prison cluster before their previous prison healthcare records can be consulted. When the necessary information cannot be obtained quickly, and someone is in immediate need, such as withdrawing from heroin, the prison doctor makes an informed clinical decision.

6.1.8 Medication and substance misuse prescribing

There are difficulties concerning medication on admission. The main reason that participants in the offender study complained about prison healthcare was the prison medical team being unable to provide the type or level of substitute for illegal drugs they desired, or believed they were entitled to. The doctors explained it is safer to give someone a lower dose and to increase this if they show withdrawal symptoms. Forty one (41%) of the

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SDO Project 08/1713/210

sample recruited from the SW prison reported alcohol misuse problems, and 63 (63%) reported drug misuse problems.

Doctors in the prison explained that they were following the most recent guidelines for prescribing illegal drug substitutes, but that based on previous prison detoxifications, or community prescribing patterns, some offenders firmly believed that what they were demanding was better for them (4001). A community GP reported that the case study area had also been associated with high levels of prescribed benzodiazepines, being made available as street drugs. They are highly addictive and long term use compromises people's ability to cope with anxiety and can cause disinhibitation (4002). This disparity in prescribing regimes led to some offenders being very dissatisfied with the healthcare they received on entry to prison.

Offenders who had used street drugs for many years reported that the introduction of the IDTS scheme into prison had greatly improved the experience of detoxification on prison entry. The introduction of improved detoxification facilities in the prison, even for those who had not previously been prescribed methadone in the community, was generally welcomed; although it caused pressure on other parts of the system. One of the requirements of the IDTS scheme is that the individual is released to an area where a service will agree to go on providing a methadone prescription. Some local services could not, initially, cope with the increase in demand. This was not the case in the case study area, and most areas are now able to support this (4012). The IDTS team lead the medical components of withdrawal and treatment, while the CARATS team co-ordinate the on-going care plan and deliver short based interventions. Prisoners are now able to access support from CARATS for alcohol dependency, as well as drug dependency.

IDTS and CARATS do not have joined up record keeping systems. IDTS use healthcare note keeping systems (System 1), which are IT based, while CARATS use a paper based system. This means that information coming into the prison from the community does not always reach all the staff for whom it may be useful. Joint meetings between IDTS, CARATS and healthcare have begun in all 3 of the prisons associated with the case study area, but this way of working is in its very early stages. All teams reported that communication between them was improving, but expressed a desire for more regular and systematised contact and information sharing. The main barrier to this was reported by CJS and healthcare interviewees as healthcare having different understandings about patient confidentiality (4009, 4012, 4013). The IDTS team are not part of the primary care team in the prison and both they and the CARATS team have stated that they would like stronger links with, and greater visibility of, the mental healthcare team (4012).

When a prisoner receiving this support is released to the case study area the CARATS team will ensure that they are put in touch with the local drug and alcohol service, which will have agreed to prescribe methadone for

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SDO Project 08/1713/210

them. Departing prisoners will also be given advice on harm minimisation and avoiding overdoses. If someone receiving this support is released from prison through the courts, unexpectedly, the custody worker should inform the IDTS and CARATS team who will try to put the appropriate support and prescriptions in place.

6.1.9 On-going healthcare in prison

A more thorough secondary health screen is carried out within 72 hours of prisoners arriving at the local prison. This provides an opportunity for a thorough assessment of an individual's needs and forward planning for their time in prison and post-release (P1). Unlike the initial health screen there are no dedicated facilities for this. Nursing staff have to carry all the equipment required with them, including blood pressure monitors and scales, and then find a space to conduct the assessment. Compromises in the location and atmosphere of the assessment can also make it hard for the practitioner to build up trust and confidentiality with patient (4013).

The secondary health assessment is also the opportunity to provide patients with information about health protection and improvement. They receive a 'Well Man' assessment including information about checking for testicular cancer and the opportunity for immunisations (P1). Information is also given about smoking and alcohol. The opportunity is given for HIV and hepatitis B testing and support from the Terrence Higgins Trust is offered (4009).

The three prisons associated with the case study area are served by one healthcare organisation which has recently moved to integrated primary and mental healthcare teams. The introduction of provision of both primary and mental healthcare, a few years ago, by a community mental health trust, has had a number of advantages for the prison based staff, these include: training; education; voluntary interchange with the community; and nurses having the chance to refresh and develop their skills (4009). Primary care and mental health nurses work together and learn from each other promoting awareness of mental health needs (4009). In one of the prisons concerns have been raised at the prisoner forum, however, that the integration could be detrimental because it removes dedicated mental health staff time (4013). Records are now shared with the introduction of System 1 which is reported to have improved record keeping and sharing of information.

As people settle into the prison, they no longer have easy access to the drugs and alcohol that they may have been using to cope with other issues and symptoms in their lives. This may be the first chance that they have had to address these (4009). Having a prison health team, including mental health staff, nearby and in the local prison available 24 hours a day, is a much more comprehensive service that people could expect in the community.

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SDO Project 08/1713/210

Other associated services are also available in the prisons to support people to address health related and resettlement needs. These include: A service developed to support the unmet health and social care needs of older offenders through 1:1 mentoring and supported by Age Concern (P15); A 1:1 counselling service to discuss mental health concerns, particularly concerning release for those approaching the end of longer sentences being released to the case study area, supported by MIND (P5). Contact is offered with the Samaritans and AA, inside and outside the prison (P6).

6.1.10 Care during release period

The prisons run a discharge clinic 1-2 weeks before prisoners are due to leave, which the IDTS team attend. All prisoners see a GP 24 hours before they leave prison, to check that they are fit to be released to the community. The discharge clinics generally target those with identified physical, mental health and drugs needs. Those with high level and/or on-going physical needs will have their initial medication provided on release. They will be asked if they are registered with a GP and, if not will be provided with information of local GPs, NHS Direct and any walk in services, and will also be given details of any future community appointments.

The continuity sub-study that was conducted as part of this report, suggested that communication between prison and community GPs is very bad (no records that were recorded as sent by the prison were found in the GP records). The communication audit showed that faxes and telephone conversations between local drug teams and the prison were commonplace. Prisoners leaving to other areas are given the option of keeping local hospital appointments (made while they were in prison) or returning to the start of the waiting list and booking themselves a new appointment in the area they return to.

The CARATS worker is the key worker for those on IDTS, and takes the lead on pre-release communication and information with community drug teams. The community drug team in the case study area have made sure that they have a prescriber available on Fridays in response to the IDTS scheme (4016). For prisoners on CPA for mental health needs, pre-release meetings are held with community workers, the patient and the prison Registered Mental Nurse (RMN). If a prisoner is not on the CPA scheme, but does need community mental health team support, the RMN will liaise with them before release. The patient will also be given their care information, GP details, letters for services and seven days of medication.

The day before release everyone is assessed to see if they are 'fit for release'. The discharge process can be a good opportunity to plan a meaningful path forward and pick up those who may have slipped through the net (4009). The mental health nursing lead urges his staff to always think that a patient could leave at any time. Having health records on a centralised electronic systems has meant that staff are able to respond

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SDO Project 08/1713/210

much faster in such circumstances because they are no longer searching different departments for a paper record (4009).

The healthcare system in prisons currently provides services not readily available outside. A staff member interviewed believed it would help offenders utilise community healthcare if services inside were configured in such a way as to encourage them to take more responsibility for themselves, particularly their healthcare; "*Empower them*" (4012).

6.1.11 No contact with Criminal Justice System

Ex-prisoners, and others with recent past contact with elements of the CJS, are often vulnerable and have significant health problems. While prisons, courts, police and probation each have the potential to facilitate or disrupt healthcare as described in the preceding sections, those no longer in contact with the CJS may have significant on-going needs.

Specific measures designed to help this group immediately after contact, i.e. after release from prison and police cells, or when found not guilty in court are described above.

There were no services identified which aimed to enhance access and continuity of care for those who have previously been subject to the CJS specifically. Individuals are subject to finding their way round the system as described in the section on healthcare.

6.1.12 Relationships between criminal justice services and healthcare

Through the analysis of the case study, a theme arose relating to the assumptions health and community criminal justice practitioners have about each other; and also about the assumptions individuals have about their role in supporting healthcare for offenders. While prison health and prison staff were relatively well integrated there were clear contradictions between the beliefs across the health CJS divide in the community. An additional analysis was carried out to examine these differences in relation to their potential impact on liaison and the generation of access and continuity of care. The findings are summarised in a diagrammatic form in Appendix G. Appendix H contains a consideration of the extent to which the policy presumptions had, or had not been implemented in the SWCS area.

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SDO Project 08/1713/210

6.2 South East case study

Summary

The south east case study site has introduced an intervention which seems to offer additional access to, and continuity of, mental healthcare services for those who reach the threshold and are accepted by the panel. The introduction of this scheme has encouraged joint working between some health and CJAs and the stimulus has encouraged the development of other CJS based projects addressing offender's healthcare needs. The panel's efficacy would be enhanced by a data sharing protocol, to address concerns about information sharing. There remain gaps, in the courts, and in community based services for those with common mental health problems, who constitute a much larger group in the offender population, however attempts are underway to address these.

The second case study site was a south east town and borough, with a high density of population (estimated 83,800) and a high volume of migration, leading to a diverse ethnicity and broad mix of cultures. Job density is high and although the economic recession has had an impact, the figures remain above the national average. The banking and hospitality sectors are the largest employers; with large department stores also employing proportionately high numbers of the population.

Within this area there are two police stations, two magistrates' courts and a probation office. As with the SWCS site there is no prison located within the town, however several of the CJAs within this site share resources across the country. This includes a dedicated remand court, which solely processes those remanded following arrest and the crown court, which is located 8 miles away. A male category B prison, provides custodial accommodation for male remand and newly sentenced prisoners from the area. There is also a category C male prison in the vicinity. In common with the SWCS there is no female prison in the area, meaning women from this site serving custodial sentences are located in excess of 80 miles from the area.

The healthcare contact rate for those offenders in contact with the SE probation service was significantly higher than for those in contact with the SW probation service (rate ratio: 1:0.57, 0.36 to 0.86 , p = 0.008).

6.2.1 Innovations beyond standard services

The main innovation described by numerous interviewees was a multi-disciplinary MDO panel where CJS and CMHT staff jointly agree actions. Where appropriate, the panel serves as a diversion scheme, this is primarily

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SDO Project 08/1713/210

when there is a direct causal link between an offender's mental health condition and the offence they have committed. However in the majority of cases put before the panel this is not the case. In such circumstances the panel advises the CPS on a defendant's mental health and appropriate disposals to address both the crime and the individual's needs. For this reason the area has established a solid working relationship with the CMHT which has facilitated a greater number of Mental Health Treatment Requirements being issued than in many other areas of the country. To order advance and coordinate this service a MDO liaison Officer has been seconded from the Probation Service; a role jointly funded by local health and CJAs. She described the strengths of the scheme as offenders having access to the panel from any point of the CJS pathway and the communication between healthcare and the CJS.

> "*The standing panel members are from health, police and probation, probation chairs it, who receive referrals primarily from the police at point of arrest although referrals can be made at any point in person's process with the CJS. We get advice from the persons care notes and mental health records" (6000).*

The panel is also served by a full time MDO Liaison Worker; a community psychiatric nurse, appointed to assess people's mental health needs in police custody and liaise with services on their behalf. He also worked in with the probation service carrying out initial screenings about "*people they had concerns about*" (6002). The MDO panel also supports some who are usually excluded from main stream services, such as those with learning disabilities (LD) who can access support with drawing boundaries and formal behaviour modification help (6000).

A further innovation in the area has been the appointment of a health commissioner within the PCT with specific responsibility for offender health improvement. She also viewed the panel as leading the opportunity for innovation in offender healthcare in the area. In addition she described the two immediate priorities of her role as being the compilation of two offender health need profiles; for those in the local prison this was linked to national requirements, however she explained the second of these would investigate the health needs and perceptions of offenders in the local community and this would be one of the first reviews of this kind:

> "*Health hasn't done these assessments on this cohort [probation], and since we had responsibility for commissioning health in prisons we have been doing health needs assessments in prison....a lot of criminal offenders are offending because of their unmet needs*" (6001).

The health commissioner went on to explain how this premise had led her to recognising an issue with offenders struggling to access GPs. She had addressed this by distributing details to all probation offices in her area, including the case study site, so that offenders could be assisted by

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SDO Project 08/1713/210

probation to register with a GP. The probation senior management had supported this by encouraging staff to check the status with each of their offenders. A probation officer told us how helping offenders to access healthcare had become an increasingly important part of her role, to the stage where offering help with registering with a GP feels as if it is 'mandatory'. "*What we have to do when we get anyone in on an order or coming out of prison is ask them if they've got a GP.... we'll ring them up and we'll say can we send someone down to you?*" (6005).

The health commissioner and MDO liaison worker both reported that the Bradley Report had changed the focus of their jobs. The latter praised the report for highlighting the need for mental health help for offenders that he felt had been ignored for over 20 years, "So I think we're actively actually doing something about it now" (6002). The probation officer attached to the PPO scheme described how this had further enabled joint working between health and CJAs by providing "*innovative and flexible ways of dealing with problems*". For example, through an awareness of the high rates of missed appointments due to chronic unaddressed dentistry needs among long term drug using offenders, the project "*actually set up something with a dentist so that all of their offenders can have help with their teeth*" (6005). This experienced probation officer explained how a primary care walk in centre had also been opened, aimed at the homeless population (6003).

Another innovation in the area was a primary care walk in centre, located within the town, which had been opened by a GP in the area in order to facilitate access to healthcare for the homeless population, in particular those with substance misuse problems. Although this centre was not directly linked to the CJS, the GP recognised that a large proportion of his patients come into contact with the CJS at some stage (6003). In addition a walk in GP-led health centre, open every day of the year, 8am-8pm, to promote flexible access to healthcare services for offenders had also been established in the neighbouring town (6002).

6.2.2 How is access to, and continuity of, healthcare for offenders promoted?

The multi-disciplinary, across CJS settings nature, of the MDO panel provides the opportunity for offenders with mental health problems to be tracked throughout their CJS journey (6000). This can be supported by the MDO liaison officer. For those with drug misuse needs the prison based CARATs teams liaise with the community based drug intervention programme (DIPs) teams to make sure offenders keep their drug appointments on release (6001). The importance of being able to work with someone inside and outside of prison was emphasised by the probation officer who had the flexibility to do that within her role. It's "about having responsibility for them when they're inside and when they're out and so seamless delivery, you know consistency of relationship that kind of thing" (6005). The walk in nature of the GP service aimed at the homeless population allowed ease of access and was recognised as a valuable

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SDO Project 08/1713/210

resource by all of the professionals interviewed for the case study as well as a high number of the offenders interviewed. The GPs' understanding of the needs of this group and the respect shown by all staff to patients helped to promote positive relationships (6003).

The working to common aims of a number of services across the case study area was reported to be having a positive impact by the MDO liaison officer who found, from his personal experience, that the number of people being remanded was decreasing.

> "*Cos they're picked up at an earlier stage whether that's through the panel or througher their GP actively referring them to community health services at an earlier stage or even probation flagging them up at an earlier stage*" (6002).

He went onto explain how they had encouraged the police service to refer people to them:

> "*So for example if midnight or out of hours, weekends they can refer people without having to go through me because they've got the dates of the panels, they've got the referral form....we never refuse referrals we don't knock back referrals we'd rather sit and discuss even if it's an inappropriate one cos that promotes or encourages the officers to continue to make referrals, what you don't want is um people not being referred in the way they should be*" (6002).

There were numerous examples, in the case study interviews, of healthcare and criminal justice workers communicating with one another. GPs, nurses, prison based CARATs workers and mental health in-reach workers all meet to discuss rolling programmes (6004, 6006). The healthcare commissioner had worked to promote "a shared agenda" in these collaborative meetings (6001). She emphasised the importance of understanding both healthcare and CJS cultures and "understanding each other's perspectives" (6001). She also described the ease of communication through formal and informal networking "If I've got a burning issue...I'll just pick up the phone and I spend a lot of time in probation" (6001). The MDO liaison officer explained that networking "makes my job easier and it kind of quickens the process up" (6002).

Other interviewees also emphasised the importance of collaborative working and how this helped everyone to carry out their jobs. In discussing homeless alcoholics, "we all need to be working together...trying to rehabilitate them by probation and another person stitching them up every Saturday night, it's actually working in a partnership" (6001). Another participant emphasised the importance of collaborative working:

> "I think we should work closely with people and try and understand what their roles are because a lot of the times the conflict is because we don't understand what they want from

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SDO Project 08/1713/210

us or why they're not getting back to us with the information" (6005).

Positive personal relationships were also reported to promote shared working and the sharing of information (6005).

6.2.3 Limitations and challenges.

The MDO panel had channelled resources at the police stations, and provided a service to probation, however there remained a lack of provision in the local courts, so that they could have "*routine access to somebody who would be motivated to, who has specific interest in relationship to, forensic psychiatric reports*" (6002).

Although some criminal justice staff had made moves towards embracing the health agenda, as described above, it was reported that "*criminal justice is not the agenda for most people who work in the PCT*" (6001). The GP who set up the walk in primary care clinic aimed at the homeless population faced numerous bureaucratic barriers and resistance from health colleagues (6003). One of the greatest tensions between the two professional groups centred around information sharing, which had not fully been addressed by the MDO panel.

> "*With sharing information from a health point of view...it needs to be anonymised, if you are going to share information, unless it's, if not sharing puts that patient or family or community needlessly at risk.... but it's actually getting the data sharing protocol so that everybody's happy and maintaining that patient focus; whereas I've got a patient focus, the CJS may have a reducing crime focus and catching criminals focus....its understanding each other and working together*" (6001).

Despite earlier reports of the innovative working with the Police service there were some references to resistance by them to the MDO panel (6002). The MDO panel lead also found that there was a lack of community based provision for PD; such as cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) (6000).

The community probation officer discussed her frustrations surrounding referrals for mental health services and suggested that those offenders who are at a lower risk and have milder mental health symptoms are "*sliding through the gaps*". She went on to say "*we can't refer to mental health services um because we're not medically trained all we can do is encourage them to go to their GP*" (6005). She expressed how she felt powerless "there's nothing we can really offer them" (6005). The GP highlighted that when people with mental health issues came to him if they were too complex for counselling, but not severe or long-term enough for psychotherapies there was also very little he could offer (6003).

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SDO Project 08/1713/210

6.3 Mini Case Study: Probation Service – Health Support Service

The Health Support Service within a Midlands Probation Trust appears to be improving access to healthcare through different mechanisms. This service is a Health Support Service from the NHS and is community based with a multi-agency team including clinical NHS staff, health trainers, and probation officers. It operates in the community of Lincolnshire and is accessed through prison discharge services and prison health services. Engagement is encouraged through the option of one-to-one sessions with health trainers. The provision of a non-medical, less formal, approach to health planning can allow flexibility and has the potential for the development of trust. The development of the role of health champions as peer support is an additional mechanism. For health champions, the opportunity to engage with their own health issues, be able to help others and the possibility of future employment is conducive to raising self-esteem and motivation and has the potential to facilitate the resettlement process. Low level mental health issues appear to be addressed through improving offenders understanding of general health issues, exercise and wellbeing. The health courses are presented in a flexible way making adaptations relevant to the clients as a group. The nurse practitioners offer optional, flexible access to all aspects of healthcare and have facilitated the use of gyms in the community.

Context and continuity

In 2003 a Midlands probation service set up a five year healthy living project which was run by a multi-agency board including HMPs, PCTs and the local university. It was broadened in 2008 to become the Health Support Service and was taken over by the NHS. The team includes clinical NHS staff, health trainers, and a probation service officer. This service was chosen as a case study because of its innovative approach to promoting access to healthcare within probation and the cross agency workforce.

Sources

Telephone interviews were conducted with a manager of the Health Support Service, a probation service officer working within the service, a community nurse practitioner and two health trainers.

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SDO Project 08/1713/210

Documentary data was derived from two internal reports and a health trainers programme.

Programme logic

Aims:

- To increase offenders' access to health provision within the probation service and the community in order to reduce social exclusion and reoffending.
- To target a broader set of socially excluded groups beyond offenders.

Specifics:

These aims will be met by:

- Improving offenders' knowledge of and access to mainstream healthcare.
- Reinforcing positive lifestyle choices.
- Developing opportunities for offenders to engage with health issues by becoming health champions.
- Improving clients' engagement, motivation, self-efficacy, concentration and thinking skills.
- Using a broad and holistic approach to health inequalities and working in partnership with other agencies in order to best address the physical, mental, social and economic determinants of health.

Programme Implementation

Interview and documentary evidence suggested that the following had been put in place:

i. Health promotion workshops covering issues such as self-perception, relationship skills, alcohol awareness, conflict management, relaxation, and healthy eating. Although offenders often complained about the enforcement of some of the health programmes, the feedback and evaluation they gave was always good (7101). For the first quarter in 2010, 70% of workshop participants reported an increase in knowledge (M1.2). Flexibility was seen as key; the relationship skills component worked particularly well because 'we change and

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SDO Project 08/1713/210

work around what is relevant' (7101). There was an 'Understanding Health Improvement' programme, with a recognised certificate awarded by the Royal Society of Public Health, (RSPH). This was felt to enhance self-esteem and motivation and enhance opportunities for employment.

ii. Two health trainers gave advice and support on health issues, doing brief health assessments and sign-posting. The service was described as a 'massive benefit' providing access to non-medical health advice and facilitating trust (7101). The one-to-one service could be opted into at any point. There was some continuity as clients could still access the health trainers for up to three months after the probation period. Health trainers set goals in partnership with offender managers.

iii. A new role has been developed in the form of health champions (3 trained), offenders who had undertaken the 'Understanding Health' exam. The health champion had a 'buddy' role (7103), offering support on health issues and sign-posting. This new role was reported as contributing to offender engagement in the health services through peer support (7101, 7103).
The community nurse practitioners offered physical, mental, emotional and sexual healthcare advice. Changes were made from the first stage of the Healthy Living Project, which had focused on targets for signposting, to promoting longer term engagement with individuals (7104). Individuals were seen to require different things at different stages - 'good rapport goes a long way to success' (7104). The inability of the nurses to refer directly to the mental health teams was considered a barrier to continuity (7104). The allocation of gym passes was highlighted as a significant factor in engaging clients with their own health and helping towards integration into the community (7104). Clients had to demonstrate motivation through attending health trainers' sessions prior to receiving gym passes.

iv. Broadening the set of socially excluded groups targeted was achieved by extending the health support work offered by the probation officer to a local organisation for the homeless and to young people on the Princes Trust programme.

v. There were plans to extend the programme to prisons.

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SDO Project 08/1713/210

6.4 Private young offenders institute

This institution appears to offer good access to healthcare and, through links with community services, promotes continuity of care on release or transfer to an adult prison. As it is operated by a private company, within the constraints of contractual and regulatory rules, decisions can be made at the operational level. The local manager has been given greater budgetary flexibility to deliver a service more responsive to needs and as a result it appears that mental health services have been much improved. Each youth is allocated a YOT worker on release which is used by the service to facilitate good links with community services. The data revealed a tension between the benefits and disadvantages of merging the healthcare and the custodial roles with regard to building relationships of trust with offenders. In some instances it was reported that having a dual role was beneficial in developing more individualised care, however, it was also commented that moving between a disciplinary role to a healthcare role may impede the development of trust and openness.

Context and continuity

This was a case study of a privately run young offenders institution (YOI) for males aged between 16 and 19 with a capacity for up to 400 young offenders. It had been highlighted as promoting innovative approaches. It was chosen as a case study because of its apparent flexibility in promoting access and continuity of healthcare, particularly focusing on mental health and LD, from their time in custody and following their return to the community.

Sources

Telephone interviews were conducted with a visiting consultant psychiatrist, a contract manager, a clinical nurse manager, a staff nurse, a CPN, a prison officer in healthcare, an occupational therapist (OT), an OT assistant, a healthcare assistant and a substance misuse worker. A one day observation also took place.

Documentary data was obtained from internal reports, government reports and a journal article.

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SDO Project 08/1713/210

Programme logic

Aims:

- To provide a seamless healthcare pathway from custody to release or to adult prison.
- To create an 'entrepreneurial' and innovative culture promoting better awareness of and access to healthcare.

Specifics:

These aims will be met by:

- Comprehensive initial assessment and continuity of care between prison and release or transfer through the enhancement of links with community and prison services.
- Creating a culture of personal responsibility within the staff for a shared goal of continuous improvement.
- Creating an ethos that is pro-active in trialling new ideas and promoting a 'no-blame' culture.
- Promoting dignity and respect through recognition of the individual and improvement of the physical environment.

Programme implementation

Interview and documentary evidence suggested that the following mechanisms had been put in place:

i. Due to the age and social backgrounds of the young people there was a high demand for particular healthcare services, for example, psychiatry, psychology, substance misuse, sexual health and dentistry. The documentation states that 95 percent of young people in the institution had one or more mental health issues and almost all have used illicit substances (M3.3). Because the institution was privately run it enjoys greater budgetary flexibility and this had allowed the redesign of the healthcare service (M3.3, 7309). The Child and Adolescent Mental Health Service (CAMHS), provided by the local healthcare trust, had been funded to provide an additional CPN and a bi-weekly psychiatry clinic. Special clinics included dentistry, vaccinations, optical services and a genito-urinary clinic in which all young people coming in for more than two weeks were screened (M3.3).

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SDO Project 08/1713/210

ii. Mental and physical health education had become a core part of the service beginning at the entry assessment (M3.3). A system of prison-wide referral to the CPN from custodial and health staff had been set up to ensure access to mental healthcare. Following initial assessment, one-to-one sessions, behaviour therapy and group work were co-ordinated by a multi-disciplinary meeting. Continuity was enhanced by a CPN package on release and a visit by the same CPN within two weeks of release if within the local area. The substance misuse worker reported an additional mentoring service offered for a month post release. It was suggested that time and resources for family therapy would be beneficial. Some problems of co-ordinating aftercare arose due to wide geographical spread.

iii. In-house responsibility for decision making had allowed managers to be flexible in delivering the most appropriate service possible. One interviewee commented on the reduction of red tape and time-wasting because of delegated budgets and authority (7309).

iv. Health responsibilities had been extended beyond the healthcare team with eight custody officers dedicated to supporting the healthcare unit. The OT talked about the importance of making the sessions fun and breaking down the barriers with regard to mental health issues. Another new initiative was the introduction of the care of pet rabbits, ferrets and bantams. Animal nurture may have enhanced self-respect.

v. The institution promoted a culture of 'honouring success' and celebrating achievement both within the staff and the offenders. Certificates were given to the young offenders. The physical environment had been improved.

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SDO Project 08/1713/210

6.5 Whole system drugs project

The service based in East Anglia appears to offer improved continuity of access to healthcare for offenders. The individual can build up trust with the service throughout the whole of the criminal justice system. Familiarity with the team members in different settings together with individualised and flexible plans facilitates personal trust not only with individuals but between the clients and the service as a whole. At the organisational level the communication between all the partners in the criminal justice system and with outside agencies appears to be good. Efficient communication about individual care helps to address issues of confidence and stress reduction at the individual level, for example, reducing the repetition of paperwork and potential for discontinuity.

Context and continuity

This case study offered a substance misuse service across the CJS to individuals with class A substance misuse issues. The aim of the service was to help the client recover from drug dependency and break the cycle of reoffending. This case study was selected to understand the potential for continuity of access to healthcare for drug users across the different organisations of the CJS.

Sources

Telephone interviews were conducted with one senior practitioner, one DRR practitioner, four community practitioners, and one community drug worker.

Documentary data was derived from two internal reports, two journal articles and a professional website.

Programme logic

Aims:

- To break the cycle of drug dependency and reoffending.
- To promote engagement of the client with the services offered.

Specifics

The aims will be met by:

- Offering a 'seamless' and 'joined up' service across all parts of the CJS.

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SDO Project 08/1713/210

- Focusing the start of the recovery pathway in the police custody suites.
- Support and advocacy during court proceedings
- Establishing individualised pre-release packages.
- Offering a variety of treatments to clients.

Programme Implementation

Interview and documentary evidence suggested the following mechanisms had been put in place:

i. Contact occurred at all stages throughout the CJS. Clients are met in police custody, at court, in prison and in the community.

ii. An initial meeting is made in the police custody suite where assessment, planning and advice are offered. This is seen as a key mechanism for beginning the recovery pathway at the earliest stage. Further support is offered in the form of court advocacy.

iii. More routine services include advice and information on safer drug use, one-to-one counselling, and referrals to GPs, the mental health team, detoxification and rehabilitation services, and a local community drug service, as well as sign-posting for educational and training opportunities. Advice is also given on general health and wellbeing, diet, dental care, housing, benefit and family support.

iv. Within the local prison practitioners provide on-going support for prisoners with class A substance misuse issues. Services are extended by contacting offenders returning to the county from prisons outside the area prior to release.

v. Pre-release plans are co-ordinated by meetings between practitioners, CARATS team members, external agencies such as housing and benefits, and family members if appropriate. In April 2010 the service was commissioned to take over CARATS and DRR services in the county.

vi. A DRR 'meet and greet' service is well used by clients attending for drug testing and provided an area for tea and an informal chat, contributing to engagement with the service.

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SDO Project 08/1713/210

vii. The service links with Supporting Others through Volunteer Action (SOVA), which offers support inside the prison and an 'at the gate' meeting service.

viii. Practitioners see the service as working well but that some services are not evenly spread geographically resulting in some clients being unable to access services locally such as training. Several of the interviewees suggested that the continuity of the service could be improved by the incorporation of group work. Clients had asked for this service, suggesting a high level of trust in the service team.

6.6 Police – offender health programme

Key recommendations of the Bradley Report are being addressed here with regard to improving understanding of mental health and disabilities across the police service, allowing for a more individualistic approach to clients. This may be shown in the reported de-escalation of situations and consequent reduction in number of detentions. The long term effects for the clients should be redirection into the appropriate health service before becoming involved with the CJS.

This constabulary is working with other agencies, for example National Autistic Society (NAS), to enhance the quality of the training programme and to facilitate links with community services. Flexibility was emphasised by the use of terms such as 'mindfulness of difference' and 'a people first service' (7205, 7202).

It appeared that communication at an organisational level had been enhanced for example through shared training with prisons and through the matching of protocols across different services. Some issues remain around agreement on exact areas of responsibility between ambulance services, police services and accident and emergency departments. Concern was also expressed over the availability of resources such as adequate places of safety and detoxification facilities.

Context and continuity

A southern police force have put in place a 'Training for Trainers' programme, run through the Offenders Health Service, to address the issues raised in the Bradley Report around the lack of understanding and expertise in mental health and learning disabilities across the police force. This training programme is focused within the police service and was

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chosen as a case study because of its potential to increase and cascade understanding of mental health issues across the police force at all levels.

Sources:

Telephone interviews were conducted with a mental health awareness lead practitioner, a head of training, a sergeant overseeing continuous professional development, a police staff trainer, and a police community support officer.

Documentary data was derived from government guidelines, booklets, leaflets and evaluation comments.

Programme logic

Aims:

- To improve awareness of clients' mental health and mental disability issues within the police service in order to enable more appropriate responses, de-escalation and improve signposting.
- To implement a co-ordinated, preventative approach by channelling clients with mental health issues into appropriate services.

Specifics:

These aims will be met by:

- The use of a cascading strategy with regard to mental health awareness training at all levels throughout the police service.
- The promotion of a multi-agency approach to improving mental health awareness and access to appropriate services.
- Improving detention practices through increased awareness of mental health issues, for example, the appropriate use of transportation and places of safety for detained clients.

Programme Implementation

Interview and documentary evidence suggest that the following mechanisms that have been put in place:

i. A key commitment of the programme is that dates must be in place for the cascading of training. On-going support and

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SDO Project 08/1713/210

refresher training has been put in place. Trainees are all provided with electronic documentation to support the training and are issued with a 'little red book' produced by the NHS detailing local agencies, support services and networks offering healthcare services (7202). Less people have been detained under section 136 of the Mental Health Act possibly because police staff have a better understanding of the presentation of mental illness and have been able to react sensitively and refer clients to appropriate services rather than proceed directly to detention (7201). Awareness of crisis teams and out-of-hours teams that can offer support has facilitated this process.

ii. Multi-agency working facilitates matching up of protocols of different services, for example, liaison with the NHS to ensure that police guidance dovetails into what the NHS is delivering in their mental health training (7203).

iii. Experts in mental health issues have been brought into the training process, for example, the NAS and the local mental health team have had a significant input into the awareness training

iv. The level of use of the 136 suite, which has been open for 2 years, has increased with a corresponding decrease in the number of people detained in police custody. It was reported that whereas one third of all arrests used to result in detention, it was now down to one quarter (7203). A problem highlighted was the shortage of places of safety because the suite can only take two people at any one time (7203). The problems arising from the complex mix of issues of mental health and substance misuse and intoxication was described as an area of 'hot debate' with disagreement still occurring between the police, ambulance services, accident and emergency departments and mental health teams in cases of unpredictable behaviour and intoxication (7203). A shortage of detoxification facilities was also reported.

v. It was recognised that the use of police transport reinforces stigma and increases tension for some clients and attempts were being made to use ambulances more for transportation of clients with mental health issues however, this was not always a consistent practice (7203).

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SDO Project 08/1713/210

6.7 Court based multi-agency project

Elements of the project show the potential for continuity of care, however, access to physical healthcare is not mentioned in any of the documentation. Offering services such as drug and alcohol advice, housing, benefits, counselling and mentoring implicitly suggests that anxiety and low level mental health issues may be addressed.

The problem-solving meetings steer the focus to a preventative strategy and potentially take an individualistic and holistic approach to the sentencing process. Having only one judge and all services located in the same building will also potentially add to building relationships of trust and understanding. Multi-agency working between organisations appears to have led to a high degree of communication between offenders and the services that may be appropriate to meeting their needs and enhancing the quality of life of the community.

Context and continuity

A community justice centre was set up in the North East of England in 2005. The idea of community justice is based upon engaging with the local community in order to break the cycle of low level offending. This centre was chosen as a case study because of its innovative, problem solving and holistic approach to addressing individual offender needs in an attempt to reduce reoffending.

Sources:

Documentary data was obtained from external reports and evaluations, a newspaper article, a professional journal, and a survey of local residents.

Programme logic

Aims:

- To identify and tackle the causes of offending behaviour and thus reduce the likelihood of reoffending.
- To develop a problem-solving and holistic approach to individualised offender programmes.
- To reduce fear of crime and increase public confidence in the criminal justice system.

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SDO Project 08/1713/210

Specifics:

These aims will be met by:

- Adopting a multi-agency approach to providing appropriate sentencing.
- The use of problem-solving meetings.
- Fostering increased involvement in, and responsiveness to, the local community.

Programme implementation

Documentary evidence suggests that the following mechanisms have been put in place:

i. This courts based project is a community resource – a one-stop shop for tackling crime, using a problem-solving approach with offenders, and delivering preventative and social services for the wider community. The centre's building, redeveloped from a disused school building, brings together a court and a range of services and facilities for people living in the local authority wards. The three foundation stones of the centre are the problem-solving approach, partnership working and the unique role of the judge (M5.1). A faster and more seamless approach to processing court cases is facilitated by the location of all CJS agencies in the same building together with the local authority anti-social behaviour team, and a HA agency. Other service providers located in the same building include substance misuse workers, a mediation service, Citizens Advice Bureau, education and vocational advice, debt counselling and mentoring. The focus is on reducing socially harmful behaviour and integrating the court services into the community. The centre also hears anti-social behaviour order applications, enforcement of confiscation orders, education welfare cases, local authority prosecutions for non-school attendance and environmental offences. The centre employs a single judge to enhance consistency and continuity in decision making.

ii. Problem solving meetings, aimed at identifying issues contributing to offending, are held at various stages of the court process. Each morning before court, police, probation and the court clerk get together to go through the day's cases. In this way it is claimed that problems can be anticipated, delays reduced and referrals made directly to support services. If an

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SDO Project 08/1713/210

offender pleads guilty or has been found guilty the judge can adjourn the case for a problem-solving meeting to be held prior to sentencing. Issues contributing to offending are discussed in a multi-agency forum and appropriate options are identified to address these underlying causes. These meetings are usually chaired by a probation officer or a YOT worker and involve the offender, a defence solicitor, a friend or family member if appropriate and relevant services that might help to address problems, for example, substance misuse treatment agencies and housing agencies. A survey of offenders showed that 42 out of 49 respondents (86%) believed that the problem solving meeting would help to deter them from offending again in the future (M5.2).

iii. All of the centres services are available to local people on a drop-in basis. The centre is also a base for community projects and diversionary activities. A programme of community activities functions as a two way process by encouraging increased awareness of the work of the courts and identifying local issues and projects for unpaid work. The community engagement team at the centre has arranged some awareness raising events and has worked with local community groups for example, arranging football tournaments and summer activities, as well as sessions on drugs awareness, sexual health and community safety. The data shows that up to 2007 approximately 100 events had been held attended by 2,904 people (M5.2).

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SDO Project 08/1713/210

6.8 Prison – resettlement strategy

This resettlement strategy integrates health services. Prisoners are given assistance in finding a GP and are informed about other health services in the community. This approach allows continuity of access to healthcare for prisoners throughout their prison stay. The emphasis throughout the work of the prison appears to be focused on maximizing successful resettlement, assuming this minimises the risk of reoffending. General healthcare and wellbeing appears to be well addressed with a wide range of health and social programmes, training and advice available. Communication between agencies appears to be good for example, the multi-agency resettlement programmes include input from all relevant agencies including healthcare. A holistic and flexible approach is taken to prisoner care through individual custody plans. Although healthcare follow-up in the community by prison staff is not possible due to time and resources, the resettlement packages are geared towards reducing reoffending.

Context and continuity

This is a case-study of an adult male category C prison situated in the Midlands with an operational capacity of 687. The prison holds convicted prisoners only and prisoners are either released directly into the community or transferred to category D prisons. The majority of prisoners are aged between 21 and 29 and most are serving between 4 and 10 years. This institution was chosen as a case-study because it has been highlighted as having good systems in place to ensure that prisoners are able to have continued access to healthcare on release.

Sources:

Telephone interviews were conducted with a CARATS practitioner, a general nurse and a mental health nurse. Documentary data was derived from several external and internal reports and evaluations.

Programme logic

Aims:

- To reduce reoffending by developing evidence based interventions to tackle offending and addiction (M6.2).
- To raise public protection by ensuring that the risks posed by discharged prisoners can be reduced and managed safely (M6.2).

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SDO Project 08/1713/210

Specifics:

These aims will be met by:

- Providing a healthcare service that assesses and meets individuals healthcare needs whilst in prison and which promotes continuity of health and social care on release (M6.5).
- Improving the health of individual offenders with substance misuse issues by implementing the IDTS, and providing harm minimization and health education.
- Using a multi-agency approach to meet the specific needs of individual offenders in order to maximize the likelihood of successful reintegration into the community (M6.5).

Programme implementation

Documentary evidence suggests that the following mechanisms have been put in place:

I. New arrivals receive a comprehensive health assessment by a nurse. All prisoners have a custody plan based on an individual assessment of risk and need. This is regularly reviewed and implemented throughout and after their time in custody. Prisoners and all relevant staff are involved in drawing up and reviewing these plans (M6.5). A wide range of practical skills workshops are offered to help the prisoners in their return to the community. Two prison health trainers have been employed to provide advice about diet, smoking cessation and health promotion (M6.1). Healthy eating information in several languages can be found in each house, in the library and in the gym. The gymnasium is one of the most intensively used areas and a wide range of physical education classes are provided. Prisoners are able to work towards qualifications in first aid, weightlifting, football, rugby and badminton and the positive attitude and enthusiasm of the PE staff have been noted (M6.5).

II. An integrated substance misuse service has been developed offering a wide range of interventions for substance misuse, but alcohol services were reported to be insufficient to meet needs (M6.5). CARATS provide on-going support for prisoners undergoing treatment for substance misuse and there is also a drug peer support group (M6.5). Various accredited programmes are offered to prisoners including Prisoners

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Addressing Substance Related Offending (PASRO), Thinking Skills programme, and Controlling Anger and Learning to Manage it (CALM). These programmes are reported to perform well with CALM having a zero dropout rate (M6.1). A recent independent report noted that 'risk reduction features in many aspects of prison life' and that interventions to improve prisoner attitudes and behaviour play an important role in the unit (M6.1).

Resettlement underpins the work of the whole establishment (M6.5). This is supported by strategic partnerships with services and agencies in the community. The resettlement department see all new arrivals during induction for an initial assessment and where specific needs are identified referrals are made to the appropriate departments. Three months before their release prisoners are interviewed to assess current resettlement needs and referrals can be made. A monthly resettlement clinic is also offered for prisoners close to release including debt advice, employment, education and welfare advice, a family liaison officer, and housing and resettlement advice with peer support. There is also a job club, a full day of activities to help prepare for release every Wednesday and a job search facility in the library (M6.6). The primary focus of the pre-release assessments is on training and employment but healthcare services are integrated into the resettlement strategy. Appropriate referrals are made, assistance is given in finding a GP and information about other health services is supplied. The mental health in-reach teams organize multi-disciplinary team meetings for patients known to them who are due for release. Where possible this includes the community mental health team from the area where the prisoner is due to be released. Good links exist with local drug action teams and drug intervention programmes (DIPs) (M6.5).

6.9 Summary of mini-case study findings

Key mechanisms for improving care are presented within key themes and issues in Table 21 as a summary of the mini case study findings.

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SDO Project 08/1713/210

Table 21. Summary of mini-case study findings

Key themes and issues	Key Mechanisms for improving care
Good communication between services	Inter-professional training, e.g. between the police and prison service (MCS4 police). Decisions at local level (MCS2 YOI). Links with a broad range of services including education, CJS and partners, promoting continuity (MCS2 YOI; MCS3 substance misuse). Multi-agency problem solving meetings examining preventative strategies (MCS5 court; MCS6 prison).
Novel ways of engagement	One to one informal approaches through the use of "health champions" (MCS1 probation). Flexible services appropriate for individuals (MCS1 probation; MCS3 substance misuse; MCS4 police; MCS6 prison). For example, "mindfulness of difference". A no blame culture for staff enabled a less stressful working environment (MCS2 YOI). The introduction of the care of pets to enhance self-respect (MCS2 YOI).
Education of probationers	Flexible health courses (MCS probation). Training police in mental health issues (MCS4 police).
Increasing trust and self esteem	Training as 'health champions' (MCS1 probation). A single judge and all services located in the same building facilitating trust and understanding (MCS5 courts). Familiarity with the team members and individualised and flexible plans facilitate personal trust between the clients and the service as a whole (MCS3 substance misuse).
Challenges of continuity from geographical dispersion / socioeconomic factors	Training around perceptions of health (MCS2 YOI). To reduce stigma and tension attached to transportation within police vehicles, ambulances are often used for clients with mental health issues (MCS4 police).
Holistic / integrated individual care	The health courses presented in a flexible way making adaptations relevant to the clients as a group (MCS1 probation). The focus to a preventative strategy, takes an individualistic and holistic approach to some sentencing

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SDO Project 08/1713/210

	processes (MCS5 courts). Merging health care and the custodial roles develops more individualised care (MCS2 YOI). A holistic and flexible approach of offender through individual custody plans (MCS6 prison).
Pathways	Multi-agency resettlement programmes input from all relevant agencies including healthcare (MCS6 prison). Initial meetings are important for recovery pathway in police custody (MCS3 substance misuse). Appropriate referrals supplied, such as finding a GP and extra health services (MCS6 prison). Gym passes engage clients with their own health, helping towards integration into the community (MCS1 probation).
Collaborative care	Low level mental health issues addressed through improving understanding of general health issues, exercise and wellbeing (MCS1 probation). The mental health in-reach teams organize multi-disciplinary team meetings for patients due for release (MCS6 prison). Health trainers set goals in partnership with offender managers (MCS1 probation).
Mandatory/routine screening	Continuity of healthcare was enhanced by a CPN package on release and a visit by the same CPN within two weeks of release if within the local area (MCS2 YOI). Whilst mandatory health promotion workshops were often complained about, the feedback and evaluation they gave were always good (MCS1 probation).
Access/ drop in times/ location	Courts services are available to local people on a drop-in basis (MCS5 courts). Supporting offenders both inside the prison and an 'at the gate' meeting service (MCS3 substance misuse).
Co-location	Individuals were seen to require different things at different stages (MCS3 substance misuse). A faster and more seamless approach to processing court cases is facilitated by the location of all CJS agencies in the same building (MCS5 courts).

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SDO Project 08/1713/210

7 Access and continuity of care for offenders

This final results chapter brings together the previous sub-studies. Section 7.1 presents reviewing updates of the literature on access and continuity, and offers a synthesis of the findings around the relationship between access and the different elements of continuity, developing an understanding of some of the mechanisms for enabling continuity of access, and highlighting issues of organisational continuity.

Section 7.2 then outlines recent changes in policy for healthcare of offenders in the UK and suggests key cross-cutting 'policy requirements' for facilitating continuity of care for offenders. The mechanisms within the revised theory about continuity are examined in each CJS context to develop a revised programme theory.

7.1 Recent continuity of care literature

Conceptions of continuity are both diverse and constantly evolving[38]. Definitions of longitudinal continuity of care, and implicit assumptions that this alone is enough, are increasingly challenged. Indeed, Freeman et al[80] argue that seeing the same doctor over a sustained period of time should not be confused with good healthcare contact. Longitudinal measures may represent a pragmatic way of tracking healthcare contacts over time but reveal little about the actual quality of care received; a shift towards relational understanding is seen as preferable[80].

It is increasingly evident that continuity means different things to different people (users, practitioners, policy makers). Socially-excluded and vulnerable groups are recognised as having contrasting needs and perceptions in terms of continuity of access[81]. User engagement with health services can be selective, continuity is not automatically valued and prioritised, and discontinuity can be an active choice[81].

The co-construction of continuity[80] which focuses on the interaction between patients, carers, professionals and policy makers is regarded as increasingly influential to the continuity debate[81]. Parker et al[81] argue that this embodies a "dynamic conceptualisation of complexity, discontinuity and change which more and more closely reflects the reality of the lived experience of patients and their families over time"[81] (p.35). There can never be a single way of delivering continuity; Parker[81] and Freeman[80] are clear that research must pay attention to the ways service users define and perceive continuity, based on their own experiences, and that healthcare pathways should be linked to this.

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SDO Project 08/1713/210

7.1.1 Initial access and continuity of access

Examination of offenders' accounts of their healthcare receipt provided data to construct hypothetical pathways of care. For example, Figure 15 illustrates a common pathway into, and on-going access to, healthcare. Continuity of access to healthcare was originally defined (quantitatively) as the rate of contact over time, in different settings and for different conditions. Figure 15 shows how initial or renewed access might be with a practitioner who is known already, but often offenders will meet someone new. On-going access may occur with the same practitioner within the same team (longitudinal continuity), but may not; and the lack of concern for this within offender accounts and within the case studies confirms a need to downplay the importance of this[76 77].

The first conclusion was to consider initial access and continuity of access as one process and to consider achievement of both initial access and then on-going continuity as *outcomes* of interest. For this analysis we have not included self care (often in the form of coping through problematic use of street drugs) as access to healthcare.

Initial access includes both the first ever, as well as more frequently, renewed access, to healthcare for a given problem. This study showed that access to healthcare does occur in both prison and community for a range of services, in particular for substance misuse. This did not change with increasing co-morbidity. Seventy-one percent reported easy access in general, leaving 29% not seeing access to healthcare as easy; and both offenders and practitioners talked about problems in obtaining access, particularly for mental health problems. Based on self-reported health needs, unmet need was higher for mental health compared to substance misuse and physical healthcare.

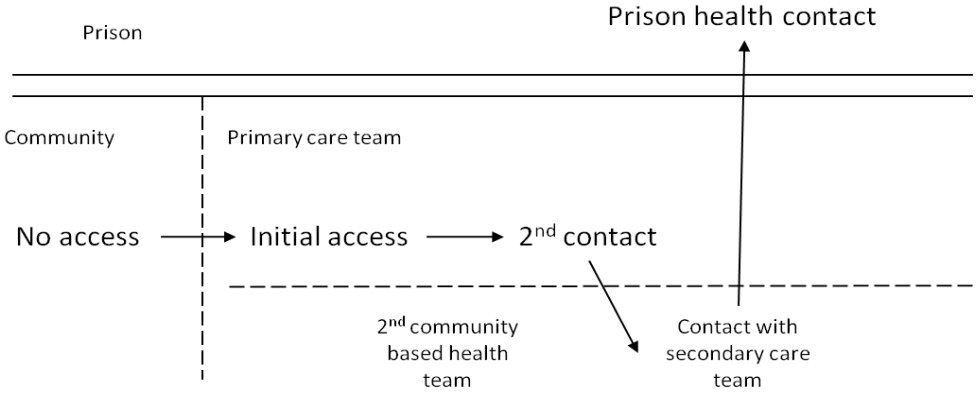


Figure 15. Pictorial representation of access and continuity of healthcare for offenders

The second conclusion about continuity for offenders was that on-going access for the same problem may be with an individual in the same team, a new practitioner from the same team or different practitioner from a different team, perhaps specialist care within the community. Time in

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SDO Project 08/1713/210

prison provides a significant barrier to on-going access but it may be resumed, for example an individual may be seen for their asthma by a practitioner in the community and then by the prison healthcare team. We have therefore defined continuity of access as either being with the same practitioner, with the same team, or with a different team. Related to these three sub types of continuity of access are the different ways in which these teams relate to each other, namely referrals onto specialist teams and transitions of care between teams in different CJS settings. Continuity of information – having access to information about previous encounters is a critical component of continuity.

The third important feature of offender accounts was the dominance of discontinuity, as breaks in access (or discontinuities) were common. These were frequently talked about when going into prison, as well as leaving, and related to all types of healthcare and in particular to changes to substance misuse regimes brought about by this transition in location. However, despite these concerns from offenders, access rates for substance misuse services increased after release, largely due to implementation of the IDTS programme. Other problems with continuity causing particular concern to offenders were accessibility to secondary specialist physical healthcare, such as hospital appointments. The initial examination of offender pathways and practitioners' and offenders' accounts revealed potential mechanisms for the creation of continuity. While relational and flexible continuity are seen in previous literature as facets of continuity, our data appeared to be suggesting they also helped create continuity of access.

While continuity of access is seen as an important process in its own right, the optimum level has not been defined. Both offenders and practitioners choose to create endings to healthcare pathways for many reasons. Practitioners choose to end because it is medically appropriate or there are system blockages. Sometimes an offender ends it for lifestyle choices that aren't medically motivated. Sometimes a mismatch between the system and the person causes an end and it's no one's 'choice'. The project has not focused on the investigation of appropriate endings of healthcare or stepping down to lower intensity or self-care.

Following this initial analysis these conclusions and working hypotheses were tested against each of the data sets and the results described below, in order to build a causal model of continuity.

7.1.2 Mechanisms for delivering access and continuity

Both the qualitative and the quantitative strands of analyses contributed to the development of the model of continuity shown in Figure 16**Error! eference source not found.** This section will describe how evidence from these sets of data contributes to, and illustrates, the model.

Although the model is visually linear, the pathway of an individual through the various CJS settings is an on-going and complex process; and breaks in

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SDO Project 08/1713/210

continuity are common. Access routes and pathways are different for different health problems, and gaining access for one does not guarantee access for other problems.

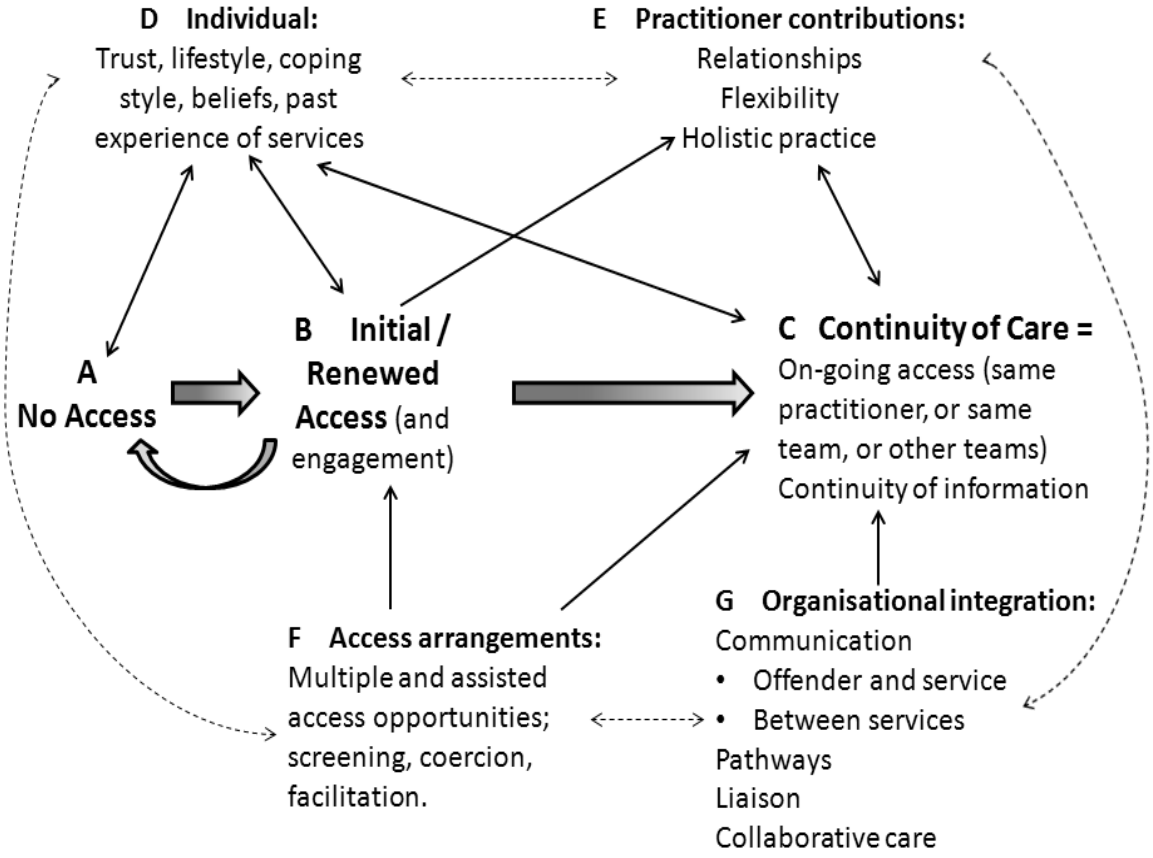


Figure 16. Access and continuity (individual and service level)

Each component of the model in figure 16 is explained below. Each component has been allocated a letter and is explained together with evidence from the synthesis.

Many individuals have no access (A) to formal healthcare. They can be at this point for various reasons, including negative issues they experienced when they gained access to healthcare in the past (D - past experience). The latter situation is shown by the reverse path from initial/renewed access (B) to no access (A). Individuals may reject their previous diagnoses, have had bad experiences in general, and not received what they thought they should have (D). Some may be self-caring, but for many offenders this means use of street drugs, which may again in itself reduce the impetus to re-access healthcare (B) (Section 5.2).

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SDO Project 08/1713/210

Even those who have not had previous experiences of accessing healthcare can hold negative representations of healthcare that mean they do not seek to gain access (A). Healthcare is also often not seen as a contributor to achieving important personal gains such as access to children or paid employment, further reducing the impetus to seek help. The exception is those who prioritise a 'chemical solution' and access substance misuse services. Furthermore several offenders talked of their right to gain opiate substitution medication, again contrasting with the stigma associated with mental healthcare. The experience of having to wait to be seen (F) can also put people off attempting to access services (A) (5.2).

Initial access can be facilitated by word of mouth recommendations from other service users/offenders, but initial access is not always a guarantor of renewed access. An oft-held perception is that gaining the initial access will result in all their problems being solved, and when this is not the case, continued/renewed access is adversely affected by anger and disappointment (D - beliefs, A) (Section 5.2).

Access gained for one health problem does not always lead to access for another, but this does depend on the primary health problem being seen for and which health service is being accessed. Those reporting dependency problems (specifically heroin) along with mental health problems have a higher access rate for mental health problems than those reporting mental health problems only (B). When those offenders with multiple health problems gain access (B) to a GP or to prison healthcare services for a specific health problem, they are likely to be seen for other health problems at the same time (F). This is not the case for other healthcare providers. Those offenders who are not registered with a GP often obtain their healthcare from accessing hospital (comparing access rates between those registered and not registered shows a near exact reflection of access rate ratio for hospital (1:3) compared to access rate for GP (3:1) (G, F, B) (Section 5.1).

CJS setting also influences the type of access that an offender is likely to get: the access rate for physical health problems is highest in prison, whilst in probation this is for dependency-related problems (G, F, B, C) (Section 5.1).

Rejection of previous diagnoses (that are perceived as negative or stigmatising, such as alcoholism or personality disorder (D)) that are given during the prison entry assessment and other encounters (F), can reduce their likelihood of attempting to regain access (B) (Section 5.2).

Personal situations such as being homeless can make it difficult to gain access (B, D - lifestyle), and disordered and chaotic lifestyles can also mean that individuals fail to attend appointments (Section 5.2). Access was increased when an individual felt settled in their area (Section 5.1).

Prison can however be treated as somewhere to 'top up health' and gain access for problems that may be difficult to gain access for in other settings (F, B, C). Prison was seen as providing a structure (roof, food) for those

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SDO Project 08/1713/210

with chaotic lifestyles which would improve health as well as sometimes a place to access medical care (D - lifestyle) (Section 5.2).

Trust is another individual factor (D) that can influence whether or not access is attempted. Build-up of trust over time has been shown to be important, both in terms of an individual's experience of services as a whole (D) and from interactions with individual practitioners (E). Experiences of breakdowns in trust can lead to individuals not choosing to attempt to gain access in the future (A, B) (Section5.2).

Keyworkers (care co-ordinators), who are , mandated by organisations to deliver on-going care (see organisational domain below), can build relationships based on trust with offenders (D, E, G). They can overcome barriers between services, promote co-ordination and communication. This can be achieved by the key worker working on behalf of an offender, but also by the training and teaching of skills to aid them in developing awareness of their own health and how to deal with it, and help in negotiating the system (F, G). This will help them overcome any assumptions that all pertinent services are sharing information and will do things for them, and transform this into a more proactive stance, in particular with respect to initiating communication with services (B). Offenders are likely to be only aware when communication does not happen, rather than when it is actively working (Sections 5.2 and 6).

The practitioner contribution (E) includes a range of components which appear important for promoting continuity of access and renewed contacts (B, C). Offenders particularly emphasise the importance of relationships: individuals report wanting to be listened to as a marker of interest in the person, being treated with respect and for those they are in contact with to be non-judgmental. Individuals reported that they value the care shown (E) rather than the clinical outcomes of treatment (Section 5.2).

This 'relational continuity', as it has been described, can be seen to be a multifaceted concept with many potential mechanisms within it, having therapeutic value in itself but also as a means of encouraging further or on-going access to healthcare (E, B, C) (Section 5.2). A further facet of relational continuity is the use of peer mentors both within and outside of prison (Section 6.8 MCS6 prison): through having a relationship with someone in a similar situation, trust may be transferred to health and other services.

Flexibility, for example when individual practitioners problem solved in a flexible way, and considering social issues beyond health (integrated or holistic care), are both important in themselves, and could also contribute to improved continuity of access (Sections 5.2 and 6.3 MCS1 probation).

Both individuals and practitioners contribute to continuity – the offenders' contribution (D) to generating continuity or discontinuity is as important as the organisation of services (F) and practitioners' approaches. It also appears that a positive interactional experience does not require a long term relationship with the same practitioner; experiences of positive

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SDO Project 08/1713/210

engagement may generate sufficient trust to allow transfer of that trust from one part of the system to another (Section 5.2). Lastly we suggest that the concepts of positive interactional experience, flexibility and integrated (holistic) care, while of great importance to offenders, are not components of continuity, but contributors to (and at times products of) continuity of access.

The organisational domain

The organisation of services can increase initial and continuity of access (F,G, B,C). Structuring access arrangements (F) (for example co-location, walk-in provision and flexible opening hours), in a non-stigmatising and flexible way means offenders are more likely to access and continue accessing care. Lack of access (A) can also be caused by the lack of a relevant service for a particular offender health problem (e.g. complex co-morbidity) (F) (Section 6.3 MCS1 probation).

We have defined the organisational domain in terms of communication and integration between services (G) but rather than extending Freemans' continuity of communication[37] to include these concepts we argue that they too should be seen as contributors to continuity rather than essential elements. Offenders are willing for services to share information about them, though this is not always accurately or efficiently done (G, C) (there is evidence of significant communication between prisons and community drug services, but not between GPs and prisons). From the offenders perspective communication between them and healthcare was more important than the communication between healthcare organisations and outside of health which was emphasised by practitioner accounts (D, G).

A range of other components of integrated care are also both of value in their own right and contribute to on-going access. For example carrying out proactive follow up can be important in maintaining on going access (C) (Section 5.4.4 and 5.4.6). Pathways to care between services are another element emphasised by practitioners from health and criminal justice settings (G) (Sections 6.3 MCS1 probation and 6.7 MCS5 court). Pathways to an intervention, rather than just an assessment, were required when referring from CJAs to health services and for when referrals were made from one health service to another. Pathways for healthcare, both entering and leaving prison were also important and were often achieved for substance misuse and in one case study site also for mental healthcare (B) (Section 6.8 MCS6 prison).

There is also now evidence and general policy support for seeing an individual as a whole and for making a bio-psycho-social assessment of needs (F), in particular for those with long term and complex conditions. This type of assessment requires collaboration between services within some prison settings, collaborative care between criminal justice and health occurred in probation and, since the service reorganisation, within prison between primary care and mental health services (G) (Section 6.1). The

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SDO Project 08/1713/210

components include joint meetings, procedures for shared decision making about individuals and joint record keeping. Collaboration can be seen as the institutionalisation and formalisation of integrated/flexible/holistic care at the individual level.

The role of criminal justice system

Access and help in negotiating the system is supported by community CJS staff (Section 6.3 MCS1 probation) (F), and also by proactive follow up (G) (Section 6.4 MCS2 YOI). Twenty percent of all healthcare contacts are influenced by CJS contact, indicating that a significant minority of access is achieved with the help of the system (G, B, C) (Section 5.1.6). Proactive follow up by CJS staff was appreciated by offenders, seen as important by practitioners and systematised in some services.

A range of protocolised, or compulsory mechanisms can also facilitate access (F, G) (Section 6.4 MCS2 YOI). Routine screening tools were not evident in any site, but have been suggested in Lord Bradley's review[82]. Mental health treatment orders were reported as not being widely used in either main site which contrasted with widespread use of drug and alcohol treatment orders. More subtle mechanisms for engagement in health activities had been established in two mini case studies where involvement in health related group work was normalised, rewarded or semi-compulsory.

Together all these elements of the organisational domain have the potential to lead to smooth transitions between services with the following characteristics:

- An integrated and collaborative package of care,
- A shared understanding of outcomes and goals to be achieved,
- Offender involvement in decision making

These lead to the possibility that if health and social outcomes are achieved, access will be no longer required.

In summary, the mechanisms for the delivery of continuity of access include organisational factors (from simple communication to collaborative care) as well as specific mechanisms (encompassed within the concepts of relational and flexible continuity). The differing trust levels, lifestyles, coping styles, beliefs, and past experiences of offenders also influence the organisational factors and specific mechanisms. The latter can make it more likely that, despite their differing individual characteristics and experiences, offenders will make the first steps to initiate or renew contact with healthcare, and also sustain that contact.

Continuity inevitably emerges as a complex concept in the CJA setting: as to the specifics of the actor(s) involved (individual practitioner, team, individuals or organisations in wider system), for when continuity is useful

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SDO Project 08/1713/210

to the offender, and with regards to how many practitioners and organisations are required to collaborate to achieve optimal continuity. It is intrinsically linked to ensuring initial access. We have therefore developed a model which makes this link explicit; but we have also proposed, rather than widening the concept of continuity to include interpersonal interactions and mechanisms of integration, that these should be seen as important elements of health care in their own right which can contribute to continuity.

These issues each have distinct policy and managerial implications regarding selection and re/training of professionals, line management, inter-agency network management, and joint commissioning.

7.2 Towards a revised programme theory for access and continuity of health for offenders

Having used our results to theorise about access and continuity, the next step involved developing conjectured theories about how the key mechanisms could be implemented across the criminal justice setting.

During the course of the project two important policy documents were released. First, Lord Bradley's review of services for offenders with mental health and learning disabilities and difficulties[86], and secondly, the Government's response, Improving Health and Supporting Justice[90]. Lord Bradley's[86] review was widely accepted as being comprehensive, achievable and necessary. Improving Health and Supporting Justice incorporated the majority of recommendations within a wider offender health strategy. The coalition Government has continued to support the recommendations and offender health has been writ large in the mental health strategy. Our original plan had been to revise the packages and components underlying the policy presumptions developed in the first stage of the study. However, this new policy context and our findings led us to an alternative strategy of synthesis: firstly testing the new policies against our findings, then using our key findings (the mechanisms for creating continuity), along with wider evidence related to health services delivery, to develop an outline programme theory.

Policy requirements and mechanisms

We examined the implicit and explicit policy assumptions and key mechanisms within these two key documents against both our original programme theory and the empirically derived model for access and continuity. The new policies contained much stronger explicit mechanisms for achieving health benefits; the main additions were the introduction of a preventive and early intervention requirement, and a strengthened emphasis on identification within criminal justice settings and referral on to mental health services. There is less emphasis on the prevention of deaths in custody and much more emphasis on a positive recovery orientation.

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SDO Project 08/1713/210

There were no recommendations which contradicted the provisional programme theory (Section 3.3) or the overarching theory for continuity and access developed above (7.1.1).

In addition to the emphasis on assertive recognition, the use of mandated mental health requirements in sentencing and the development of 'continuity of assessment' as individuals pass through the CJS was emphasised. However there were two areas in which our theories suggested a need for additional policy requirements:

- The importance (and difficulty) of engagement with individuals who have maladaptive coping strategies.

- The need for collaborative (health and CJS) mental health interventions that are delivered early without reliance on onward referral to existing mental health services.

The latter was alluded to briefly[90] but only related to significant personality disorders.

Table 22 shows the revised policy requirements derived from our empirical findings and informed by recent policy changes.

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SDO Project 08/1713/210

Table 22. Revised policy requirements/objectives for healthcare across criminal justice settings

Proactive interventions should be used to prevent later health problems and criminal justice involvement *//***
Healthcare can contribute to criminal justice as well as health service aims */**
Criminal justice settings are often good opportunities for identification of significant health problems *//***
Healthcare services in criminal justice settings should proactively identify healthcare needs to plan for future *//***
Healthcare assessments and information should be shared, passed on and added to *//***
Outcomes of abstinence, employment, and stable accommodation are long term health and justice objectives *//***
Engaging with offenders' strengths, motivations and coping styles will optimise resettlement *
Collaborative arrangements at point of delivery of interventions will enhance ability to deliver for personality disorders/ and all other mental health problems***
Origin of statements:
Bradley Report*; Improving Health Supporting Justice**; our research***

Key mechanisms across CJS settings

The Bradley report[86] provides an excellent template for understanding the stage in the criminal justice process at which key mechanisms are required so, rather than rehearse this again, the mechanisms identified by our research and other recent policies are listed in Table 23. This specifies which mechanisms, according to our data, have the potential to improve access to, and continuity of, healthcare in each CJS context.

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SDO Project 08/1713/210

Table 23. **Key continuity mechanisms to promote initial and on-going access to healthcare through the criminal justice process.** (**Bold** for the first time mechanisms are indicated in this table).

Pre arrest

- **Identify, Signpost */ **/ *****
- **Engage/show understanding *****
- **Refer via pathways */ **/ *****
- **Liaison **/*****
- **Informal diversion *****

Arrest and time in police cells

(Fitness for custody/to be interviewed)

- Identify, Engage, refer etc (detailed under pre arrest)
- **Onward communication of health information (continuity of assessment) */ **/ *****
- **Flexible integrated approach *****
- Liaison / **Co-location ***(eg Mental health worker drops in)**
- **Diversion (informal and formal via Section 136)*****

Charging and court process

(Fitness to plead, level of understanding of court process so that participation (and thus due process) is maximised - CPS decision, pre-sentence reports)

- Identify, Engage, refer etc (as above)
- Onward communication of health information */ **/ *****
- Flexible integrated approach *****
- Liaison / Co-location (eg Mental health worker drops in)*****
- **Mandatory healthcare contact/intervention (treatment orders etc)*/**/*****
- Diversion*/**/

Prison Sentence or remand

- Identify, Engage, refer etc (as above) Onward communication of health information */ **/ *****
- Flexible integrated approach *****
- Liaison / Co-location (eg Health, CARATS and resettlement officers)*****
- Mandatory healthcare contact/intervention*/**/*****
- **Collaborative delivery of interventions (eg health with education)**/*****
- **'Through the gates' schemes */**/*****

Community Sentence

- Identify, engage, refer etc as above
- Onward communication of health information */ **/ *****
- Pathways/appointments/referrals */ **/ *****
- Flexible integrated approach *****
- Liaison / Co-location ***(eg Health in probation offices)
- Mandated health intervention**/*****
- Collaborative delivery of interventions **/*** (eg health with programmes)

Bradley *; IHSJ **; our research ***

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SDO Project 08/1713/210

These mechanisms refer to health services embedded in criminal justice settings. What we see is that the mechanisms of engagement and identification are common to all points. With sustained CJS contact, in prison or probation, more sophisticated or collaborative mechanisms are feasible.

The model of continuity and access (7.1.1) is an overall theoretical framework, and the mechanisms identified here are the drivers for ensuring that more offenders gain access to (and continuity of) care when required. Even for those with stable substance misuse problems, many offenders have personal factors (experience, coping style, social situation) which militate against access to healthcare; for this reason services need to be organised so that the key mechanisms are in place within each criminal justice setting.

Context dependence

We then examined our findings to identify any further context dependence for each key mechanism. Firstly, we compared mental health problems, physical health problems and substance misuse problems. All the mechanisms identified had been shown to be relevant for both mental health and substance misuse (being used in the best practice sites or were recognised as a deficit). It is possible however that these mechanisms are even more important for mental healthcare where the deficit in access is more problematic. For physical healthcare most offenders saw care as 'an as and when' process and not particularly problematic. However, a few individuals with long term physical conditions had discussed significant disruptions to care; the mechanisms to ensure improved communication will be required for them. The data therefore supports the concept of limits to the extent that continuity should be facilitated.

We also examined the context of coping style. While most of the continuity mechanisms identified above appeared likely to be of importance for offenders in both groups, there was little evidence in our findings, or the wider literature, to suggest how to mobilise individual offenders' intrinsic strengths to improve their health for different coping styles and personality traits.

Packaging continuity mechanisms

The provisional programme theory had grouped mechanisms into packages for achieving a particular objective; in the revised theory, our empirically derived mechanisms were less specific and more similar to Merton's[7] mid-range theories. Rather than develop highly specified packages, we explored several issues: the role of multiple mechanisms; sequential mechanisms; self-care; and collaborative care.

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SDO Project 08/1713/210

It is evident that several key mechanisms acting together might further improve continuity of care. Sometimes key mechanisms can be brought together within a single conversation between an offender or health practitioner of either health or the CJS. Identification, making the links between health, substance misuse and social inclusion goals (integrated care), and conversing in a style which will build trust can all be brought together in one healthcare contact in order to promote engagement and on-going access.

On the other hand, other mechanisms need to operate sequentially. Initial identification and referral must be followed by appropriate transfer of information, and subsequent interaction with a healthcare professional, where the concept of integrating health and resettlement goals, alongside the development of trust, are achieved.

As emphasised in the chronic disease and long term condition literature, self care[88,91,92] is critical, not least because individuals provide the greatest contribution to on-going care in the majority of cases. None of the case studies, or interviews, addressed these issues directly. The collaborative care model[87] emphasises individual's defined goals, supported self care and joint work between specialists and generalists. Actually working together – offenders, healthcare practitioners and criminal justice staff – to co-create and implement a resettlement package is in some ways the epitome of continuity of care. It requires trusting relationships, integration of social inclusion and health, and the support of organisational arrangements prioritising excellent communication and collaborative care.

It is with mental healthcare that the problem is greatest. For many, routine collaborative arrangements are an opportunity for ending the dichotomy between healthcare 'treatment' and CJS 'punishment and rehabilitation'. While progress can be initiated in police and court settings following identification and engagement, it is probably only in prison (Section 6.4 MCS2 YOI) and probation (Section 6.1 SWCS and Section 6.3 MCS1 probation) that a stable enough context for collaborative work can be found. Our in depth analysis of offenders' coping styles and approach to self care suggests that offenders' mind sets encompass both unhealthy and illegal activities, and have to be the starting point of any change. This has been discussed elsewhere[93-95]. We suggest that for many with a broad range of common mental health problems, positive mental health promotion and a recovery focussed[96] treatment and resettlement plan, endorsed by all three parties, is more likely to result in better outcomes than separate mental illness treatments and offence related 'thinking/behaviour' courses. This is now enshrined in policy[4]; the research challenge is to demonstrate an effect.

We therefore end with the paradox that while we have been looking for mechanisms to deliver continuity, it is relational and integrated continuity – what practitioners from health and CJS do with offenders – that is most likely to generate emotional wellbeing, resettlement and reduced offending. The challenge is to use the relatively stable context of probation and prison

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SDO Project 08/1713/210

to exploit the potential for positive feedback cycles – positive relationships fostered during initial contact, and plans based on the whole individual can lead both to further contact and benefits in themselves.

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SDO Project 08/1713/210

8 Discussion

8.1 Evaluation of results against previous literature

8.1.1 Prevalence and access

Significant numbers of individuals (37%) perceived their health to be poor. Respiratory and musculo-skeletal were the most commonly reported physical health problems. The self-reported prevalence of drug and alcohol misuse was 53% and 36%. Almost 60% of individuals reported having less severe mental health problems, with 15% regarding themselves as having a severe mental illness. These subjective reports are in keeping with the high levels of physical and mental health problems found in previous prisoner surveys (self-reported need[11]; clinical survey[1]; self-reported need and prevalence[97]).Recent surveys also appear to suggest that the prevalence of mental illness among prisoners is substantially higher than that of the general population and the prevalence of severe mental illness is rising[11].

For some health categories the current findings suggest higher prevalence rates than other studies. For example, levels of severe mental illness have been reported to be 8% and 10% in prisoners and 0.4% in the general population. The current finding of 15% is, therefore, noticeably higher and likely related to reporting possible SMI, following uncertain or contradictory clinical encounters in the past. Transition from prison to other settings led to higher access rates for dependency problems, as did transitions from the community to probation. Transition from probation to community led to a reduction in access rates for dependency problems, and transfer to prison led to an increase in access for physical health problems. Police and the courts had the lowest numbers of healthcare contacts for any of the health categories (dependency, mental and physical health problems). Overall, a high rate of individuals (54%) reported triple co-morbidity; dependence on drug or alcohol, mental and physical health problems. The same rate was also found for those in prison. For those on probation the proportion of individuals with triple co-morbidity was slightly less (but still high) at 34%. Overall contact with services for individuals with triple co-morbidity was not increased except for those reporting severe mental health problems.

Access rate compared to normal population

A survey of psychiatric morbidity in the general population found that of the people with a probable psychotic disorder, 85% were receiving treatment at the time of interview[98]. For people with drug use problems (excluding cannabis), 16% reported being in receipt of some form of treatment. For those with hazardous levels of alcohol consumption, around 10% were taking any central nervous system (CNS) medication. Of the respondents in

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SDO Project 08/1713/210

the Singleton survey[98], who had less severe mental health problems, 24% were assessed as having neurotic disorder and were in receipt of some form of treatment, with around 9% having counselling or therapy.

The annualised primary care access rate for the general population was 5.5 contacts in 2008/2009, and for the modal range of our sample (20-25 years) the access rate for men was 2.5 contacts per annum[99]. The direct comparison in access rates in our sample was 13 p.a., i.e. ten times that for young men in the general population. However this rate reduces to 7p.a. when substance misuse contacts are excluded.

Access rates compared to those with mental health problems

A study by Rodriguez et al[100] found that the odds of contacting mental health services were higher for offenders.

Harty et al[101] found that people with psychosis who were sent to prison had far higher levels of need and lower levels of treatment and care than non-offenders with mental health problems, suggestive of an inverse care law. To some extent, this is consistent with the present findings that those with a disability or mental health problems appeared less likely to receive the care they required. A previous study[97] with a probation sample indicated an overall low level of access for services, with more unmet need for mental health problems compared to substance misuse problems. This is in agreement with the findings from the current study.

Ratings for quality of care

The quality assessment of contacts in prison was lower than for the other CJS settings, though the majority of contacts in all settings were rated positively. This replicates previous studies of patient satisfaction, where respondents were unlikely to express dissatisfaction[102]. The 'discrepancy model' suggests that positive responses can be viewed as contacts in which nothing negative happened, rather than contacts where care was good.

Other studies[103 104] focusing on the development of patient surveys found that overall satisfaction was influenced more by access than by inter-personal aspects of doctor or nurse care, and that responses were skewed towards an overall favourable impression of care.

Expectations of the type of care that will be received from different healthcare services may also influence quality assessments[105].

The duration of contacts for mental health problems for individuals in prison was shorter than the same type of contacts made in the community, while the opposite was true for contacts with primary care[106]. This is perhaps indicative of the relative lack of mental healthcare available in prison.

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SDO Project 08/1713/210

8.1.2 Narrative accounts

Illness narrative accounts are often told in terms of the dominant cultural accepted trajectories for that illness[107] in a coherent, linear trajectory. 'We are all tellers of tales. We each seek to provide our scattered and often confusing experiences with a sense of coherence by arranging the episodes in our lives into stories.'[108](p.11). Narrative life accounts frequently contain recognisable tropes, such as 'heroic' or 'victim' based narratives. The accounts given by participants in this study were substantially different to these types of illness stories. They did not follow a consistent linear trajectory, as participants often did not conceive of their lives as moving forward or progressing. They are probably best described as 'conflicted' narratives in which the accounts participants give of themselves, their health concerns and their lives, breakdown and disagree with each other within a single interview. It was useful to consider these apparent conflicts and difficulties in terms of Holloway and Jefferson's[109] 'defended subjects' for whom they try to develop an understanding of 'the effects of defences against anxiety on people's actions and stories about them.'[109] (p. 4).

Rather than describe conditions such as common mental health problems and substance addictions in medical terms, the participants described their abilities, and inabilities, to access support for these issues as 'a moral discourse that relies heavily on notions of agency and accountability', as was found by Owens and Lambert[110] when investigating parents' understandings of the suicides of their sons.[110] (p. 250). The accounts given of mental health issues, including "avoidant, numbing and escape behaviours which can lead to aggression, violence and suicide"[111] (p. 921) were more typical of male presentations of mental illness[112].

8.2 Strengths and limitations

This wide ranging multi-method study examining an area with little previous research, in difficult research conditions, inevitably has a number of strengths and limitations. This section outlines the primary issues which need to be considered for the project as a whole, and for each area of data collection and analysis. The main strength of the study lies in the use of multiple methods to examine multiple levels of organisation, interaction and individual care. This provides multiple perspectives both in terms of the individuals contributing their views and in terms of the research methodology. Peer researcher involvement running through the project, and also contributing several individual elements is a further strength. Perhaps most importantly, the use of the realistic evaluation framework to carry out a policy analysis at the start of the project provided a structure and themes which permeated the data collection and analysis.

These aspects come with limitations. The breadth of the study has meant that, at times, enquiry has been shallow rather than in-depth. It has been largely descriptive, laying out care as it is now and with an emphasis on

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SDO Project 08/1713/210

what might be possible, with relatively weak inferences of causation. More specifically, there has been little focus on within prison continuity, older offenders, black and ethnic minorities, and women; additionally while our sample represented young adults well our conclusions cannot be reliably applied to young offenders. Within the health areas mental health and drug problems have been paid more attention than physical health problems and learning difficulties. Health promotion in particular was not addressed fully.

8.2.1 Longitudinal offender study

The strengths of the longitudinal offender study lie in the large numbers accrued. Although the 200 recruited falls short of the upper limit of the provisional aim (300) it is the largest study of healthcare received by offenders in the community that we are aware of. Follow up rates were also relatively good. As well as collecting health data this was contextualised with data on social status and also with views on continuity of care and on barriers to continuity and access.

Sampling occurred at three points in the system, and although the data was considered as a whole, the statistical analyses controlled for variation in the sample. While follow up rates were different for recruits from different points, these were minimised by 'capping' follow up of those recruited under probation supervision. The study relied on offender reporting for contact rates, as collecting contact information from all healthcare providers for each individual would have been impossible. The pictorial diary of the six months data collection period, similar to that used by Morris and Slocum[74], developed with offenders, was found to be acceptable to virtually all those interviewed. The validation study carried out to compare these accounts with health records supports the use of this method.

Studies of health service use and epidemiology in offender populations are often complicated by the variety of potential denominators. In this study, we used entry into prison and leaving prison as sampling points, rather than a cross sectional survey, so distorting the sample towards those with shorter prison and community sentences; and also probably towards younger offenders. A second problem related to this is the difficulty in making normative comparisons with the general population.

We had originally planned to sample from a women's prison and from a central London prison, but problems with governance and practical issues prevented this, reducing the numbers of women and BME populations in the study. There are good reasons to believe that the conclusions may not apply to these groups.

Another issue for the study is that we used the offender viewpoint, not only to count the number of contacts, but also for the prevalence of different problems. The latter were not validated, meaning that perceived prevalence

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SDO Project 08/1713/210

could be an under or over estimate. However the results are consistent with objective epidemiological studies in the prevalence of most of the illnesses being described, as well as other surveys[98]. The survey tool tended to be inclusive, and for example for common mental health problems we included those reporting significant anxiety or distress. Reported rates might have been much lower had we asked about previous definite diagnoses.

Even within the validation study incomplete records were available. The scoring of duration of contacts was not validated against existing records. The quality assessment of contacts by offenders gives their perception of the contact at a general level, but this too has not been fully validated and the reasons for the quality assessment given (such as the different aspects of continuity) cannot be specified.

8.2.2 Qualitative studies

While we had originally anticipated carrying out in-depth interviews at the end of the quantitative interview or subsequent follow up interview, this was not found to be acceptable with the population studied (See Section 4.2.1 in method). However, imbedding qualitative and narrative talk within the structured interview schedule enabled examination of the narrative data in context, complementing the quantitative analysis. Secondly, we were able to contextualise offender views by examining how offenders portrayed themselves, their agency and health seeking. Focus groups allowed examination of ideas from different social groups. The limits of this part of the study were significant. Only a fraction of the 200 individuals had their data transcribed. The views of those who were more reticent and with poor cognitive ability, but perhaps also in distress, were less likely to be heard. While there were advantages to qualitatively analysing talk from within the structured interview, the pre-set questions constricted the participant's answers.

The within-case analysis approach allowed us to achieve within-case integrity and cross-case generalisability; as discussed by Ayres et al[115]. This analytical approach, however, reduced our ability to analyse the focus group dynamics and interactions[116]. Two or three potential areas of study arose from the focus group data, including: the dissonance between offenders desire to be healthy through better food and access to exercise, and the health service's approach to disease prevention; offenders acting as sources of information and recommendation to one another; the stepping down of care as people became more independent.

Case studies

The case studies were strongly influenced by the 'provisional programme theory' which provided a proposition for comparing the views of a broad range of participants about what happened in the system compared to the

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SDO Project 08/1713/210

policy presumptions outlined in 'programme theory'. The whole system approach, focusing particularly on those revolving in and out of prison and probation, was particularly important for contextualising the quantitative analysis. The whole system case study produced a combination of data from the offender longitudinal study and interviews with practitioners and managers, as well as documents, to provide an overall perspective on the interaction between health and criminal justice systems.

The case study element was limited to only two systems, one of which was reduced in size due to research governance issues. The mini case studies were effective in identifying possibilities of practice[117], but again covered a limited number of sites. The analysis was based on the theoretical framework running through the study and this dominated both the questioning, codes and analysis, thus potentially reducing the possibility of more emergent data and themes. The case studies did not examine the problems facing women, black and ethnic minorities or older prisoners. They focussed on young men with mental health and drug problems revolving through the system. Each case study involved a relatively limited number of interviewees and therefore multiple perspectives on the same issues were not always provided, nor were offender perspectives. In part these limitations were related to the time frames of the research.

Peer researcher contributions

The project benefitted from peer research contributions on several levels: direct involvement in shaping the direction of the data collection; detailed advice and input to data collection and analysis strategies; production of discrete pieces of research; involvement in interviews for research staff; and, perhaps most importantly, a subtle infusion of ideas throughout the project.

Facilitators for these achievements included having resources in the shape of researcher time, a paid peer researcher consultant, and finance to pay or remunerate peer researchers. However, there were numerous hurdles and problems, as well as unexpected paths along the way.

The first barrier was not being able to use the work placements or education opportunities in the prison as originally planned. This meant recruiting and setting up a group in the community amongst a transient and hard to reach population.

Another significant problem was the time spent by the researchers overcoming barriers with the University to working with ex-offenders: systems for contracts, criminal record bureau (CRB) checks and payment of expenses all had to be created especially. This took approximately 10 days of researcher time over 12 months. Several peer researchers dropped out during this time.

It had been anticipated that the group would do some 'personal reflection' research of their own choice, and then work as a group on a project agreed

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SDO Project 08/1713/210

on together. Due to strong personalities and differing agendas, this was not achieved. Furthermore the 'snow balling' strategy for recruitment meant that far from having a local SW group, the peer researchers spread from Cornwall to Wolverhampton to London. Providing adequate support to each individual/group was problematic.

An assessment of their involvement in the process by the peer researchers included the following positive outcomes:

> "*Getting affirmations for my contribution had a positive outcome and made me feel good. It enabled me to get over some barriers in my life that had previously stopped me from travelling alone*."
>
> "*I think I am a better person from my involvement. It gave me the ability to feel part of a team when I had been alone for such a long time I liked the honesty throughout the team."*
>
> "*It has given me a lot more confidence. I can now chair meetings thanks to the training I was given. I now have a more positive outlook on life."*

Synthesis

The case studies as a whole had multiple sources of data and therefore produced system wide understandings. They are being fed back to the local communities and although there was no formal respondent validation, the findings of the research are keenly awaited by commissioners and providers across both systems.

The development of theory regarding continuity of care for vulnerable groups was based on multiple perspectives. The Realistic Evaluation framework ensured that a focus on causation and potential mechanisms ran through the study; this contributed significantly to the development of an empirical theory, based on a synthesis of the wide range of data within the project: both quantitative contact rates and also views of practitioners and individuals in contact with the CJS. However both the causal model for access and continuity, and the programme theory for offender continuity are provisional conjectured theories which require testing in future research.

8.3 Implications for policy and practice

Many of the implications for policy and practice are implicit within Section 7.2. The following sections highlight key issues.

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SDO Project 08/1713/210

8.3.1 Importance of engagement and relationships

While the Bradley Report[86] and Improving Health and Supporting Justice [90] make strong arguments for some key technical drivers to improve continuity such as information management solutions and the use of screening tools, there is less emphasis on how to deal with a large throughput of distrustful, unengaged and often hostile young men and women. At each stage there is potential for both engagement and disengagement. The following could be embedded in policy and practice:

- Explicit reference in policy, service specifications and job descriptions, to the importance of engagement and personal care when dealing with offenders. This does not mean being soft. Concern, consistency and interest are potentially important.
- Excellent formulation (assessment), listening and negotiating skills for all practitioners. These need to reflect social goals and individual strengths as well as diagnoses.
- Skilful supervision to help both health and criminal justice staff deal with the imperative to provide on-going empathic support (modelling 'good' behaviour).
- Clarity about the extent to which criminal justice practitioners (police, judges, offender managers and prison officers) can take on a health and social care role in addition to their primary public safety mandate.

These changes will have significant implications for training of health and criminal justice practitioners. Both need to understand the particular psycho-social issues for offenders. Health practitioners would need to alter habits related to diagnosis led formulations, incorporating social goals and building on strengths which may be hard to elicit. Training could be largely 'in-house' or team based, related to role and service redesign. Joint training could be a particularly effective means of developing collaborative working between health and criminal justice staff.

8.3.2 Wider implications of the causal model for access and continuity

The causal model for access and continuity places the contested concept of continuity within a wider framework of quality of care – with links to development in interpersonal care, and to the development of organisational integration; it includes a number of novel features:

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SDO Project 08/1713/210

- The model includes the role of individual patient- practitioner interactions, and organisational mechanisms in promoting access and continuity; and explores the relationship between these.
- Both continuity of access itself (with its potential to increase uptake of evidence informed interventions) and these interpersonal and organisational mechanisms are all seen as contributing to the wider aim of improving health.
- The potential for positive and negative feedback loops: good experiences of interpersonal care make on going continuity more likely; and the reverse is also true.
- The model is flexible depending on individual context; this can be used to define the nature of the four major drivers of access and continuity for different situations. This makes it potentially relevant not just to offenders but to a wider range of individuals with complex problems for whom access is difficult, and whom are likely to benefit from continuity of care.

The model is therefore flexible and can be used by policy makers and those responsible for designing local services to consider the needs of individuals with a range of long term conditions. For mental healthcare, more generally, stigma and a fear of mental illness can militate against both initial contact and on-going continuity. This suggests that service configurations which are accessible, as well as practitioners who are willing to show that they care and consider individuals as whole people rather than as a set of disorders, are likely to be required to improve continuity. In contrast individuals with jobs and highly structured lives, with conditions such as diabetes or asthma will need and demand different approaches from both practitioners and healthcare organisations.

Vulnerable housebound older adults might require services to be flexible in terms of access arrangements. These might take the form of home visiting or alternatively well co-ordinated transport arrangements. Like offenders they would also benefit from improved communication with the complex range of healthcare providers that they require, which can be very confusing to those with even small degree of cognitive impairment. Integration of the range of teams providing care for those who are housebound could include the use of shared record systems and the accurate delineation of responsibilities. This integration in combination with working towards mutually agreed social goals are all elements of organisational continuity. They are beneficial in themselves and likely to improve continuity over time within and between teams and agencies.

8.3.3 Developing a shared concept of self care and independence

Self care is seen in health as a critical component of managing long term conditions[92]. The MoJ aims to rehabilitate[4] and encourage offenders into work, settled housing and independence. Yet healthcare and prisons have

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SDO Project 08/1713/210

the potential to foster dependence. Both sectors could work together to provide a coherent set of facilitators which can work across both sectors with individuals with the variety of survival and coping strategies, as well as controlling tendencies that we have illustrated. This might include:

- The use of an adapted version of Wellness, Recovery Action Plans[92].
- Expanding the use of peer support – both one to one mentors and groups.
- Developing psychotherapeutic techniques to support people with different coping styles to become more independent and embedding these into social inclusion services.

8.3.4 Mental health

The very low levels of access and on-going care indicate the need for a radical rethink about the way mental healthcare is delivered for offenders, to ensure it improves health and enhances resettlement prospects. There is a limited availability of mental healthcare within prison and barriers to access to mental health services to take on offenders based on diagnostic thresholds in community teams.

Resistance to diagnosis from individuals with common mental health problems and concern about stigma prevent initial access, even to primary care for many individuals. These two powerful effects appear to be acting synergistically to prevent offenders, often with several diagnoses (e.g. anxiety, depression, PTSD), co-morbid substance misuse and problematic personality traits (or actual disorders), from obtaining mental healthcare. While the evidence for treating these groups has not been established, the need and potential gain is clear.

Liaison, and for some diversion, is seen as an important step towards ensuring those with mental health problems get treatment. Lord Bradley's Review[86] has proved influential in deciding this course of action; the Coalition Government plans to roll out a national liaison and diversion service by 2014. However, while recognition is essential, there are two significant draw backs to relying primarily on this approach:

- That mental health services, often designed for single diagnoses, receiving referrals may not be equipped or willing (given high thresholds and exclusions) to deal with this new group of complex, co-morbid, 'reluctant patients'.
- That if practitioners are not tasked to take on a treatment role, the transactional costs of initial engagement and assessment,

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SDO Project 08/1713/210

and on-going referral will be very high, particularly if later take up of treatment is low.

There is therefore a lack of certainty about the best locus of mental healthcare. Resistance to diagnosis and further stigma indicates that mental health services in their current form may not be the answer. There is a need for service providers and commissioners to rethink the way they deliver healthcare and treatment to this group. Five mutually-compatible potential models for common mental health problems should be considered in order to ensure mental health needs are met as a part of healthcare:

- Primary care services incorporating specialist mental health and substance misuse have been recommended by the DH for vulnerable groups including offenders[118], they could also perform the liaison and diversion function in police and courts settings, but are currently not a substantial component of the MoJ and DH's joint offender health strategy[90].
- Adaptation or reconfiguration of the new IAPT services to allow access for those with some substance misuse and with difficult personality traits is a further possibility but will require a shift in the current policy about therapeutic modalities.
- Embedding care within a non health organisation (e.g. employment, training, addressing relationships), as has been used by the IceBreak team for emerging personality disorders[119]. CBT and motivational interviewing (MI) based approaches can be used with supervision, though awareness of PD will be essential.
- The in-reach services in prison could be reshaped to make better use of limited resources and be more primary care focussed.
- Integrating mental health promotion activities through collaborative arrangements between probation and prison resettlement and healthcare. This could involve a wide range of activities which are recovery rather than deficit focussed; this may result in better attendance.

8.3.5 Care for substance misuse

High levels of drug care in this study represent the large investment in drug services by MoJ. However, it is often not seen as healthcare by offenders and is separately commissioned and provided. Drug problems are seen as a separate diagnostic category or a lifestyle choice, rather than self management of mental health symptoms. Consequently opportunities for linking to physical healthcare and mental healthcare are often not made. The following are potential solutions to enhance flexible continuity:

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SDO Project 08/1713/210

- Linking therapy provided for those being seen more intensively to other resettlement activities.
- Developing clear guidance for allowing those with stable conditions (often only seen monthly) to move into normal mental health services to obtain therapy.
- Embedding physical and mental health promotion activities in substance misuse services.

8.3.6 Information Management & Technology (IM&T)

While this project has not focussed on the use of IM&T solutions, many of the mechanisms identified could be facilitated by or embedded within the new technologies:

- Need for linked health records (potentially the same record system) completed by the wider health team (primary care, substance misuse and mental health in particular) both in prison and in community settings. The move to a single system within prison for primary care and mental health[120] could be expanded to prison based substance misuse services. Links through to the community where there are multiple GP and mental health systems will be more complex, but could be set up for primary care based services for vulnerable adults in the community[118].
- Need for record systems which facilitate 'continuity of assessment' as offenders move rapidly through police, courts, remand and prison, and community sentences[90] (p 9-10). This will also prevent duplication of assessment, which is costly, time consuming and often at the expense of timely interventions and treatment.
- Need for transfer of the information (or automatically updated databases) between health and non-health services (e.g. social goals, responsibilities). Most offenders in the study supported this. This requires breaking down existing barriers to information sharing between health and CJ agencies. Protocols for information sharing and managing confidentiality will need to be established, but need to be simple to set up and use.

8.3.7 Joint commissioning and interdepartmental collaboration

The results of this project support the current direction of policy for health in criminal justice to prioritise outcome based commissioning[4 121]. Mental health policy in particular is focusing on offenders. The consultation on

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personality disorders and offending is particularly welcome as a good example of cross-departmental work[122].

However, likely resistance to policy implementation will require strong leadership and clear guidance if it is to be overcome. The following may be important:

- NOMS policy with separate streams for mental health and drug and alcohol, rather than integrating in to other resettlement streams could be reconsidered. Tackling dual diagnosis and linking it to recovery orientated programmes.
- Further incentives for mental health, primary care, prison health and DAAT commissioners to work together at PCT and sub-regional (prison cluster) levels. Data sharing initiatives are important.
- Further incentives and flexibility for local authorities, criminal justice agencies and health sectors to collaborate in the wider resettlement project. Particularly with implementation of 'Breaking the cycle'[4].
- Financial drivers to ensure large 'downstream' savings in other departments can be off-set against investment in healthcare for offenders.
- Training for mental health and all practitioners is also important so that they are better equipped to deal with offending behaviour, joint formulations and risk.

8.4 Implications for research

Inevitably this study produces numerous research questions. These relate to deficits in access, the organisation of services and the effectiveness of strategies for improving continuity and interventions to improve wellbeing and resettlement.

There is a dearth of good studies determining the effectiveness of mental health interventions for offenders with common mental health problems. Deficits in mental healthcare receipts have been shown by this study and this is the area for which research should be most highly prioritised. The following questions are likely to be of importance:

- What are the reasons for offenders choosing not to initiate and choosing not to continue to access care for mental health problems? What are the optimum points within the CJS pathway to initiate and maintain treatment?

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SDO Project 08/1713/210

- How effective are CBT interventions and other psychological interventions for offenders with low level problematic personality traits and a history of substance misuse?
- How effective are antidepressants for offenders with common mental health problems?
- Which locations are acceptable and effective for delivery for offenders with common mental health problems? (Within primary care teams for vulnerable populations, within IAPT services or embedded within other social inclusion programmes, i.e. for work and training?)
- How should care for low level co-morbidity across anxiety, depression, PTSD, as well as substance misuse and personality traits be organised?

This project has emphasised the need for developing acceptable models of self care for offenders whose offending behaviour, mental health problems and substance misuse are related. This is important for those who are dependent on services and for those who often reject services. The following questions are likely to be of importance:

- What is the nature of self care for offenders?
- Beyond the misuse of substances, what positive elements of self care are present? How effective are they?
- How can practitioners from health and CJAs facilitate self care?
- What is the role for peer support?

The project has redefined access and continuity for offenders. Screening and routine health checks have been recommended, however questions remain regarding the best ways of achieving improved initial access:

- What is the role of mandatory (sentencing and other mechanisms) mechanisms for achieving continuity of access?
- Can screening for the wide range of mental health problems be effective within criminal justice settings? Which screening instruments and which settings?
- How can practitioners' experience be used to most efficiently identify individuals with mental health problems, substance misuse problems, or learning difficulties?

Organisational components of access and continuity have been highlighted by the report. A number of mechanisms (e.g. flexible access arrangements, routine identification, pathways across organisational boundaries, key working, collaborative care) have been identified as being potentially useful at different stages of the criminal justice process.

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SDO Project 08/1713/210

Significant research questions remain as to whether these will be effective and how best they can be operationalised:

- What is the optimum combination of mechanisms in each criminal justice setting?
- How can different mechanisms be brought together in series to ensure on-going access of care?
- What is the optimum arrangement for collaborative care between justice and health staff in probation and prison settings in order to achieve improvements in mental health and resettlement?

Additional implications for research

This study has included a wide range of research methods in criminal justice settings, which point to further development of research in this area.

The mini-case studies proved extremely successful at identifying potential areas of good practice using the Realistic Evaluation framework. A comprehensive database of such brief evaluations could be commissioned.

Prison and probation, as well as substance misuse services, have proved effective locations for recruiting and following up offenders. Recruitment rates are high and follow up rates good. Governance procedures however, for accessing these sites, were extremely complex, involved and caused significant delays late in the project. Following up offenders within community settings away from criminal justice or healthcare is more problematic and procedures ensuring safety of researchers, whilst ensuring high levels of follow up, could be developed further.

During piloting we attempted follow up qualitative interviews (immediately following or on a different occasion) and this proved logistically difficult (arranging appointments) and less acceptable to offenders (problems with tiredness and concentration, as well as resulting in repeated stories). We developed a flexible interview method, encouraging free discourse while ensuring completion of a structured schedule, for both qualitative and quantitative analysis. This free-flowing, open ended approach was particularly effective in eliciting a broad range of offenders' views and perspectives, and further development of such approaches is warranted. A further related issue is how to ensure the narratives of those who are quieter, more anxious, and those with cognitive deficits are elicited and interpreted. This might require a specific project involving those with expertise in learning disability.

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SDO Project 08/1713/210

8.5 Conclusions

This study of offender healthcare has demonstrated that continuity of access to healthcare particularly for mental health problems, is far from perfect. Individuals as well as systems contribute to the problem. However, pockets of good practice and innovative projects have demonstrated the potential for improving continuity and, more importantly, the quality of care provided.

Perhaps the most important message is that health cannot be seen as an add-on to the criminal justice process. For individuals in distress, or in denial, their social problems, their mental health problems and their CJS involvement are not only intertwined but can be seen as one and the same problem. While continuity of care within the health system can potentially be established as a parallel intervention, the offender interviews and case studies lead us to the conclusion that at the 'highest' level of organisational continuities, collaborative care is the goal to be achieved. It is entirely in keeping with government policy[4] and, while it goes further than the identify and refer model suggested by the Bradley report[86], it is also compatible with onward referral for those who need more intensive mental health input. Not only will the combination of organisational mechanisms and individual practitioners providing integrated care lead to an improvement in continuity, these facets should in themselves improve outcomes for offenders and benefits to society as a whole.

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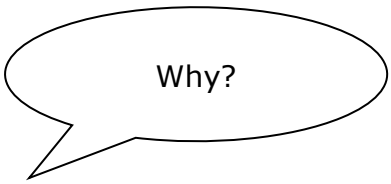
Appendix A: Friendly Invitation Letter

COCOA

Care for Offenders: Continuity of Access



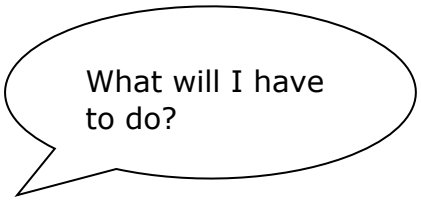
"Talk to a researcher from *institute name*, for up to an hour, about your experiences of healthcare."



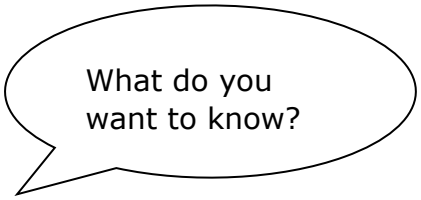
"To help improve healthcare service in *area* and how health and criminal justice work together across the country."



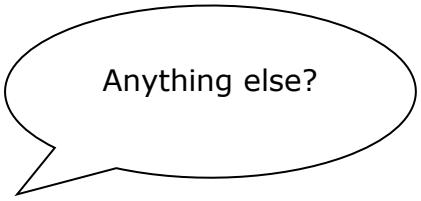
"We want to talk to offenders who are from, or who intend to return to, the *name* area. That includes men and women of all ages and people from ethnic minorities."



"Attend the appointment in healthcare, attached, and talk to the researcher".

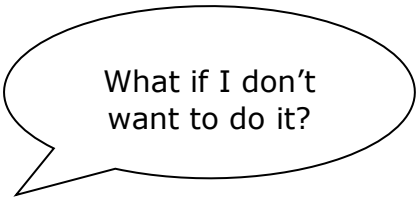


"How often you use healthcare services, what you think of the services you've used, what would encourage you to use healthcare services more"



"At the end of the survey you will be told about other ways you can be involved in the study."

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"Just tell the wing staff – it's your choice if you want to take part or not."



"Read the leaflet enclosed and take time to consider if you want to take part.

If you have any questions contact *staff name* in healthcare who will arrange for the researcher to come and talk to you.

Let the wing officer know and attend the appointment."

If you want to seek independent advice on whether to take part, or not, please contact Richard Byng. S.A.E.s are available from healthcare for this purpose.

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Appendix B: Offender longitudinal study questionnaire

Participant ID:	
	(To be completed by the researcher)
Completion date:	

THE HEALTH CARE YOU RECEIVED IN THE LAST SIX MONTHS

A survey carried out for the Care for Offenders: Continuity of Access (COCOA) Study

Research funded by the NHS Service Delivery Organisation (SDO) Programme





Primary Care Research Group, Peninsula Medical School, Plymouth

The Sainsbury Centre for Mental Health, London

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SECTION A:

ABOUT YOU

A.1. Are you: **Male / Female** *(delete as applicable)*

A.2. How old are you? ……years

A.3. Please tell us which ethnic group you feel you belong to *(tick as appropriate)*:

White English, Scottish, Welsh or Irish	☐	Black Caribbean	☐	Indian	☐
White Other	☐	Black African	☐	Pakistani	☐
Chinese	☐	Other Black Background	☐	Bangladeshi	☐
Mixed Background	☐	Other Asian Background	☐		
Any other ethnic background *(please specify below)*			☐		

……

A.4. Do you have any children (age 18 or under)? **YES/NO** *(delete as applicable)*

If yes, how old are they?

Ages……

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A.5. Do you have a partner at the moment? **YES/NO** (delete as applicable)

A.6. Would you say you have any problems with your children / family relationships?

YES/NO *(delete as applicable)*

- Quality of relationships
- Frequency of contact

……

……

……

A.7. Who do you normally live with? *(tick as appropriate)*

Husband/Wife/Partner *(delete as applicable)* ☐

Child or children aged 18 or under ☐

Parents/Parents-in-law/Step-parents *(delete as applicable* ☐

Other family or friends ☐

On own ☐

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A.8. Where do you live/plan to live on release? *(tick as appropriate)*

House or flat owned by you (including with a mortgage)	☐
House or flat rented from a housing association/local authority	☐
House, flat or room rented from a private landlord	☐
Residential home or sheltered housing	☐
Hostel	☐
Homeless or living on the street	☐
Staying with a friend or family but have my own room	☐
'Sofa surfing' (staying with friends or family but no bed)	☐
Other *(please specify below)*	☐

……

How much do you agree with the following statements?

(Use Prompt Card 1)

A.9. I feel settled in the accommodation I currently live in (or lived in before prison).

(tick as appropriate)

Agree Strongly	Agree	Neutral	Disagree	Disagree Strongly
☐	☐	☐	☐	☐

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A.10. I feel part of the area I live (or lived) in. *(tick as appropriate)*

Agree Strongly	Agree	Neutral	Disagree	Disagree Strongly
☐	☐	☐	☐	☐

A.11. Would you say you have (will have on release) any problems with accommodation?

- Security of **YES/NO** *(delete as applicable)*
- Confidence will happen
- Has CJS contact affected this?

……

……

A.12. Work-wise, are you/will you be…? *(tick as appropriate)*

	In Community	Before Prison	After Prison
In paid employment or self employment			
Unemployed			
Unemployed and looking for work			
Retired			
Unable to work because of long-term sickness or disability			
Looking after family or home			
In full-time education			
Doing something else *(please specify below)*			

……

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A.13. What is the highest qualification you have achieved? *(tick as appropriate)*

(Use Prompt Card 2)

Degree or equivalent	☐
Higher Education qualification (below degree level)	☐
GCE/GCSE A-levels or equivalent	☐
GCE/GCSE, O-levels or equivalent	☐
Other qualifications at NVQ level 1 or below	☐
No formal qualifications	☐

A.14. Do you feel you have (will have on release) any problems relating to Employment/Education/Training **YES / NO**
(delete as applicable)

- Anything to return to
- Confidence will happen
- Availability
- Has CJS contact affected this?

……

……

A.15. Do you have (are you facing on release) any problems with Finance, Benefit and Debt **YES/NO**
(delete as applicable)

- Has CJS contact affected this?
- Immediate and medium term issues (e.g. first week after release)

……

……

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A.16. What type of sentence are you currently serving? *(tick as appropriate)*

Community sentence	☐
Licence	☐
Prison sentence	☐

Are there any health related requirements as part of the sentence (e.g. drug/alcohol/mental health treatment requirements)? **YES/NO**

(If YES please state) ……

A.17. How long was the sentence you were given and when will it finish?

Length of sentence ……

End date of sentence……

A.18. Do you have any on-going legal / criminal justice issues? **YES/NO**

- On-going issues *(delete as applicable)*
- Stigma of CJS contact

……

……

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A.19. How many previous convictions have you had?

Prison sentences	
Community sentences	

"From what you've said it seems to me that the main issues for you at the moment are:

1)

2)

3)

Would you agree with that? YES/NO

Is there anything else that is an important issue in your life at the moment that we haven't discussed?

Now I've had chance to find out a bit about you I'd like to move on and look at how health fits into all of that and any problems that you might be facing."

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SECTION B:

ABOUT YOUR HEALTH

B.1. What does 'good health' mean to you?

B.2. How does your health compare to this?

B.3. What do you think would make your health better?

B.4. Over the past *6 months* would you say your health has been...? *(tick as appropriate)* **(Use Prompt Card 1)**

Excellent	Very Good	Okay	Not so good	Poor
☐	☐	☐	☐	☐

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B.5. Do you find it easy to see someone about your healthcare?

YES / NO *(delete as applicable)*

If NO, why?

_____

_____

_____

_____

B.6. Can you give me an example of a time when you received what you thought of as 'good health care'? *(Prompt to can you tell me what was 'good' about it, if necessary).*

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B.7. Can you give me an example of a time when you received what you thought of as 'poor health care'? *(Prompt to can you tell me what was 'poor' about it, if necessary).*

B.8. Are you registered with a GP practice (doctor's surgery) at the moment?

Yes ☐

No ☐

Not sure/lost contact ☐

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B.9. a) If 'Yes', how long have you been registered with your current GP practice?

Under 1 year ☐

At least 1 year, but less than 5 years ☐

5 years or more ☐

Can't remember ☐

b) If 'No', why not?

B.10. Has anyone in the Criminal Justice System ever tried to help you register with a GP?

Yes ☐

No ☐

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B.11. Do you have any health problems and/or disabilities currently, or in the last six months? *(circle as appropriate)*

(Use Prompt Card 3)

	Circle as appropriate	*Tick*	*Seen anyone*
Muscular Skeletal	Joint / Back / Pain/ Arthritis		
Cardiovascular	Heart problems/ Heart Attack / Arrhythmia / Hypertension (high blood pressure)/ DVT (deep vein thrombosis)/ PE (pulmonary embolism)/ Other		
Lung / Chest	Asthma / Chronic Bronchitis/ Emphysema/ Chronic Obstructed Pulmonary Disorder		
Neurological	Epilepsy / Fits / Headaches		
Skin / Rash	Psoriasis / Eczema/ Injection Site Problems		
Infections	HIV / Hepatitis / Sexually Transmitted Diseases		
Learning Disability			
Mental Health	Psychosis / Schizophrenia / Bi-polar disorder / Personality Disorder		
Stress / Mental Health	Depression/ Anxiety/ Post Traumatic Stress Disorder/ Obsessive Compulsive Disorder/ Panic attacks/ Self Harm/ Eating Disorders		

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Drug Misuse	Heroin / Crack / Cocaine / Benzodiazepines / Cannabis/ Methamphetamines / Other		
Alcohol Misuse			
Physical disability / limitation			
Blind / Deaf			
Problems under investigation			
Miscellaneous *(Other, please specify below)*	Cancer / Gastro / Diabetes/ Contraception …		

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B.12. What medication or treatment do you take / would you like for this / these?

Problem	What do healthcare think you should have for this? • Medication • Treatment • Follow ups	Are you getting this?	Why?

B.13. Are there any

- Medications
- Treatments
- Follow ups

That you think you should/ or would like to receive and aren't? YES/NO

Details

_____
_____
_____

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SECTION C:

WHAT HEALTH AND SOCIAL CARE SERVICES DO YOU USE?

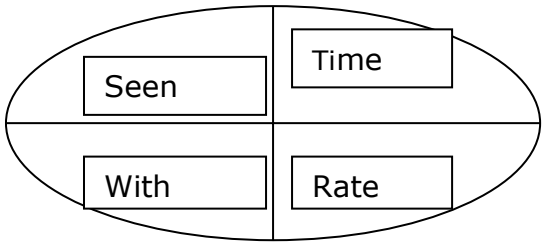
(Prior to interview researcher will have filled in months (for last six months) across first row)

In this section, I'd like to ask you about the health services you have used <u>in the last six months</u>. We are interested in how contact with different parts of the Criminal Justice System (CJS) affects the health care you receive. It's important for us to understand when things have gone well and when not so well.

First of all, if you're happy to tell me, we'd like to know when you have been in contact with the CJS in the last six months. (Prompt to prison/ probation/ police/ courts). (Also include Criminal Justice related systems such as bail hostels, drugs and alcohol rehab etc..)

- Researcher marks on these contacts as 'x' for short one off contact, or '_' for sustained period of contact across the appropriate months, across the second row.

The name of the part of the CJS they were in contact with should be written next to the contact mark.



Thank you. Now I'd like us to think about your health problems. Earlier you mentioned (researcher lists health problems identified in Question B.11). Is there anything else you would like to include?

- Researcher marks down each health problem in a separate box in first column under 'Health problems'
- If there are more than four health problems, the researcher will decide whether to use additional sheets and/or prioritise the health problems that seem most important to the person being interviewed.

I'd now like us to think about each of those problems in turn. Thinking about * (*name first health problem listed)**, when have you seen somebody about that in the last six months?** (Prompt Card 4)

- For each contact the researcher marks a circle (split into quarters) across this problem's row, under correct month (and if judged necessary – particularly in the case of multiple contacts within one month) in the appropriate third of the month.

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SDO Project 08/1713/210

For each contact researcher then asks:	For each contact researcher marks on grid:
Which organisation/ service/ professional did you see? **(Use Prompt Card 4)**	Put code for who seen for contact in top left-hand corner of contact circle. **(Use Prompt Card 4)**
How long in minutes did you see someone for?	Number of minutes in top right-hand quarter of circle.
How would you rate the quality of the contact? **(Use Prompt Card 4)**	Quality rating number in bottom right-hand quarter of circle. **(Use Prompt Card 4)**
Who went with you? Did any of the following prompt or suggest you should go?	Write 'FAM' or 'FRE' in bottom left-hand quarter of circle where family or a friend had a direct positive influence on the person accessing contact and/or accompanied them. AND/OR Where CJS contact had a direct influence on person accessing contact draw a dotted line between the healthcare contact being discussed and the relevant CJS contact in the top row. Arrow heads should be drawn to indicate direction of influence. If there is additional information that the researcher feels is significant about the interaction between health and CJS this can be recorded in question E.1.

Researcher then repeats this process for each of the health problems identified.

N.B. If there is a single contact which was about more than one health issue researcher should record one large circle, with one set of information across both health issues.

<u>When all Health and Criminal Justice contacts have been recorded please remember to ask about links between the two.</u>

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Contacts with services in the last six months

Months ⇨						
Criminal Justice System contacts ⇨						
Health Problems ⇩						

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SDO Project 08/1713/210

SECTION D:

YOUR USE OF HEALTHCARE SERVICES

D.1. At healthcare appointments ……

	(delete as appropriate)
Are you happy for anyone from healthcare who is treating you to know about your contact with the Criminal Justice System?	YES / NO
Are you happy for different health services treating you to share medical information about you with each other?	YES / NO
Do you want one person to have an overview of all your health needs? *(e.g. GP or keyworker)*	YES / NO
Are you happy for anyone from Criminal Justice System to know about healthcare treatment you are receiving?	YES / NO
Would like more information about what health services there are that you can use locally *(when you are released)*?	YES / NO
(Where appropriate) Are you happy for a /your GP to be sent a summary/record of the healthcare you received while in prison?	YES / NO
(Where appropriate) When being released from prison do you want the prison staff to have already made health appointments in the community for you?	YES / NO
(Where appropriate) When being released from prison do you want to be given a prescription for the next lot of medication that you may need?	YES / NO
(Women only) Is it important to you to be able to see female medical staff when you want to?	YES / NO
(Women only) Would you want to be able to go to a women's only healthcare service?	YES / NO

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SDO Project 08/1713/210

D.2. In the last year has there been anything that **you** haven't wanted to talk to healthcare staff about? *(delete as appropriate)*

YES / NO

If 'YES' why? *(please circle all that apply)*

Don't trust health professionals	Stigma of being 'labelled'	Not wanting to face health issues

Other *(please specify)*:

D.3. Is there anything that worries you about the potential consequences of using **healthcare** services? *(delete as appropriate)*

YES / NO

If 'YES', was this to do with *(please circle all that apply)*:

Employment fears and worries Access to children

Fear of mental health section Stigma

Fear of impact on Criminal Justice e.g. probation order or sentencing

other *(please specify)*:

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SDO Project 08/1713/210

D.4. Has being in contact with the CJS **ever** helped you to access healthcare

services?

YES / NO / DON'T KNOW / NOT APPLICABLE

If 'YES', please give details:

D.5. Do you think that being in the CJS has ever stopped **you** getting the

healthcare you want? *(delete as appropriate)*

YES / NO / DON'T KNOW / NOT APPLICABLE

If 'YES', please give details:

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SDO Project 08/1713/210

SECTION E:

LOOKING TO THE FUTURE

E.1. What is the biggest thing that will help you to avoid reoffending?

- Has any of the healthcare you have received helped you reduce your offending or with any of the social problems you identified earlier?
- Would having better healthcare help you stop reoffending in the future? If so, how?
- Is there anything else that is important to you that you would like to tell us about your health or the care you generally receive?

Thank you very much for completing this survey

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Prompt Card 1

RATING SCALES

AGREEMENT RATING SCALE:

Agree strongly	Agree	Neutral	Disagree	Disagree strongly
☐	☐	☐	☐	☐

QUALITY RATING SCALE:

Excellent	Very Good	Okay	Not so good	Poor
☐	☐	☐	☐	☐

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Prompt Card 2

EDUCATION LEVEL CATEGORIES

Degree or equivalent: *includes:*

- Higher and first degrees
- NVQ level 5
- Other degree level qualifications – e.g. graduate membership of a professional institute

Higher education qualification below degree level: *includes:*

- NVQ level 4
- Higher level BTEC/SCOTVEC
- HNC/HND
- RSA Higher Diploma
- Nursing and teaching qualifications

GCE/GCSE A-level or equivalent: *includes:*

- NVQ level 3
- GNVQ advanced
- BTEC/SCOTVEC National Certificate
- RSA Advanced Diploma
- City & Guilds advanced craft
- A/AS levels or equivalent
- Scottish Highers
- Scottish Certificate of Sixth Year Studies
- Trade apprenticeships

GCE/GCSE O-levels or equivalent: *includes:*

- NVQ level 2
- GNVQ intermediate
- RSA Diploma
- City & Guilds craft
- BTEC/SCOTVEC First or general diploma
- GCSE grades A* to C or equivalent
- O-level and CSE Grade 1

Other qualifications at NVQ level 1 or below: *includes:*

- GNVQ, GSVO foundation level
- GCSE grade D-G
- CSE below grade 1
- BTEC/SCOTVEC first or general certificate
- Other RSA and City & Guilds qualifications
- Youth Training certificate

Any other professional, vocational or foreign qualifications for which the level is unknown.

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Prompt Card 3

LIST OF HEALTH ISSUES

Muscular Skeletal: Joint / Back / Pain/ Arthritis

Cardiovascular: Heart problems/ Heart Attack / Arrhythmia / Hypertension (high blood pressure)/ DVT (deep vein thrombosis)/ PE (pulmonary embolism)/ Other

Lung / Chest: Asthma / Chronic Bronchitis/ Emphysema/ Chronic Obstructed Pulmonary Disorder

Neurological: Epilepsy / Fits / Headaches

Skin / Rash: Psoriasis / Eczema/ Injection Site Problems

Infections: HIV / Hepatitis / Sexually Transmitted Diseases

Learning Disability

Mental Health: Psychosis / Schizophrenia / Bi-polar disorder / Personality Disorder

Stress / Mental Health: Depression/ Anxiety/ Post Traumatic Stress Disorder/ Obsessive Compulsive Disorder/ Panic attacks/ Self Harm/ Eating Disorders

Drug Misuse: Heroin / Crack / Cocaine / Benzodiazepines / Cannabis/ Methamphetamines / Other

Alcohol Misuse

Physical disability/Limitation

Blind / Deaf

Problems under investigation

Miscellaneous (Other, please specify) Cancer / Gastro / Diabetes/ Contraception …

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Prompt Card 4

TYPES OF SERVICES YOU MIGHT HAVE USED IN THE LAST SIX MONTHS

Local doctor/ GP practice - GP	GP	Prison Healthcare Primary Care – GP	PHCGP
Local doctor/ GP practice - nurse	PCN	Prison Healthcare Primary Care – Nurse	PHCN
Other health professionals (Physio, OT)	OHP	Prison Healthcare – Inpatient	PHCI
Hospital (Out patient, In patient)	HO or HI	Prison Mental Health In-reach	PMH
Drug Service	DS	Prison Drug and Alcohol In-reach	PDA
Community Mental Health Service	CMH	Voluntary sector (e.g. support group) (AA, NA or VS)	AA/NA/VS
Self care	SC	Social Services	SS
Alternative therapies/practitioner	AT	Chemist	CH
Any other services *(please specify)*	OS		

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QUALITY OF YOUR CONTACT WITH HEALTHCARE

1	Excellent
2	Quite Good
3	So-So (neither good or bad)
4	Quite Bad
5	Really Bad

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SDO Project 08/1713/210

Appendix C: Ethical Issues

A number of steps were taken to ensure that the research was conducted ethically, protected the rights of participants and maintained confidentiality of the information provided by offenders and staff.

Voluntary nature of participation and right to withdraw

Information sheets for offenders and staff made it clear that participation in the study was voluntary. No undue pressure was placed upon offenders or staff to take part in the research, either by the research team or by prison or probation service staff or managers. It was made clear to offenders that their decision to take part or decline to take part in any part of the research would not affect the care they receive or their other legal rights. Similarly, staff were made aware that their decision to take part or decline to take part in the research would not affect their employment or other legal rights.

Informed consent

All offenders and staff who participated in any part of the study were required to give their formal signed consent before any data was collected. Such consent was sought after they were provided with full information about the research and what their participation would involve, and after they had sufficient time to consider the information and ask questions. Where the research team wished to obtain relevant data from an offender's medical records the extent of the information required, together with the reason and procedure for obtaining it, was explained and the offender was asked to give written permission for this to take place.

Offenders were not approached about the research if they were unable to give informed consent or if their current mental or physical health gave cause for concern. Similarly, offenders whose mental health may be adversely affected by taking part in the research were not approached.

Data protection and confidentiality

All personal information obtained about offenders or staff for the purposes of recruitment and data collection (e.g. names, addresses, contact details, including mobile phone, telephone numbers or e-mail addresses, medical diagnoses) remained confidential and such information was stored in a locked filing cabinet in the research team office and/or stored in a password-protected electronic database on the researcher's computer. Upon recruitment into the study, participants were allocated a unique 'participant number' which was used on their data collection documents

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(e.g. survey or follow-up questionnaires, interview tapes or transcripts). The researcher maintained a separate password protected electronic database of participant ID numbers and personal information on the researcher's computer. The names and contact details of participants were not shared with other individuals or organisations. The names of individuals who participated in the research will not appear in any written report on the findings of the study.

Safety of participants

Whilst it is anticipated that there may not be any direct benefits for individual offenders or staff who participate in the research, they have an opportunity to influence the future development of policy for offender healthcare by putting across their views and describing their own experiences of accessing and using, or delivering, healthcare services.

Consideration was given to ways in which taking part in the research might be harmful to offenders and steps were taken to manage these, should they occur. Reflecting on one's health or social problems and past experiences may have caused some offenders to feel distressed. Should this have occurred during an appointment with the researcher (e.g. during an interview or whilst completing a questionnaire), the researcher was able to offer support to the offender. Should an offender have remained significantly upset after the appointment, the researcher was able to (with the offender's permission) advise prison or probation staff involved in their management that the offender was distressed and, at the same time, give encouragement to the offender to seek further support available in their environment.

If, during an interview or meeting, an offender suggested that they intend to harm themselves , another person, or threaten the security of the prison, the researcher informed their doctor or another member of the prison or probation staff involved in their care In prison interviews this was also the case if the offender suggested anything which presented a risk to the security of the establishment. Offenders were made aware of this limit to confidentiality in the research information sheet.

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Safety of researchers

Consideration was also given to the safety of researchers meeting with offenders in prison and in the community. A Lone Worker Policy and 'buddy system' was adopted by the study's researchers.

All researchers underwent a period of training and induction to equip them with the skills, awareness and knowledge required for the safe conduct of research in prison and community settings. Prison and probation service procedures and guidelines for personal safety were adhered to at all times.

Meetings with offenders were held in a safe location within the prison or probation team premises and the researcher ensured that prison or probation staff were aware of their presence and ensured that they knew how to summon help in an emergency. Researchers sought and took heed of advice from prison and probation service staff about the likely risk of violence or other harm when meeting up with individual offenders. Staff involved in recruiting offenders to the study were asked to specifically exclude offenders who had a previous history of violence or who were currently experiencing a psychotic episode. If participants were still involved with health or criminal justice services, and had given their permission to be contacted through them, advice was taken from these services, at the point of follow up, as to the participant's on-going suitability for inclusion in the study considering both the risks to the participant and the researcher.

Informing participants about the results of the research

The opportunity for feedback to participants about the findings of the research was offered to all participants – both offenders and staff. Participants who wished to receive a summary of the findings of the study could request this by informing the researcher during or after their participation and providing contact details so that the research team could send the summary to them.

Incentives for research participants

In line with current guidance, as described in the Offender Health Research Network (OHRN) Researcher's Handbook and advised by one of the proposed prison sites, offenders located in prison were not given financial incentives for taking part in the research. Non-financial incentives included provision of information and provision of certificates detailing involvement in the research.

Offenders who were located in the community were offered a £10 voucher to thank them for their time and contribution.

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SDO Project 08/1713/210

Offenders in the community and staff interview participants (where they did not wish to be interviewed at their workplace) were reimbursed for any travelling expenses they incurred in attending their appointment(s) with the researcher – this included travel by public transport (bus, train, Tube) or by car (mileage) and car parking fees.

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SDO Project 08/1713/210

Appendix D: Quantitative analyses

Demographic tables

Table 24. Age by group and sex

Age group	Male	Female
18 to 21 years	31 (17%)	1 (5%)
22 to 25 years	37 (21%)	6 (27%)
26 to 30 years	27 (15%)	2 (9%)
31 to 35 years	27 (15%)	1 (5%)
36 to 40 years	24 (13%)	5 (23%)
41 to 45 years	18 (10%)	4 (18%)
46 to 50 years	3 (2%)	1 (5%)
51 to 55 years	8 (4%)	0 (0%)
56 to 60 years	1 (1%)	2 (9%)
61 to 65 years	1 (1%)	0 (0%)
Above 65 years	1 (1%)	0 (0%)

Table 25. Sentence type with duration (%)

Sentence duration	Community[a]	On licence[b]	Prison[c]	Remand[d]
Less than 1 month	7 (9%)[e]	0 (0%)	1 (1%)	1 (4%)
1-3 months	0 (0%)	0 (0%)	24 (32%)	3 (11%)
4-6 months	9 (12%)	0 (0%)	29 (39%)	1 (4%)
7-12 months	36 (46%)	6 (30%)	3 (4%)	2 (7%)
More than 12 months	24 (31%)	13 (65%)	16 (21%)	1 (4%)

The above characteristics were self-reported. [a] 2/78 (3%) data unavailable. [b] 1/20 (5%) data unavailable. [c] 2/75 (3%) data unavailable. [d] 19/27 (70%) data unavailable. [e] 7/78 (9%) durations are for unpaid work.

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Table 26. Previous sentences

Characteristic	Frequency (%)
Sentence being served (n = 200)	
Community sentence	78 (39%)
On licence	20 (10%)
Prison sentence	75 (38%)
Remand	27 (14%)
Total prison sentences[a] (n=200)	
No previous sentence	56 (28%)
1-5 sentences	76 (38%)
6-10 sentences	38 (19%)
11-15 sentences	3 (2%)
16-20 sentences	6 (3%)
More than 20 sentences	7 (4%)
Total community sentences[b] (n=200)	
No previous sentence	47 (24%)
1-5 sentences	102 (51%)
6-10 sentences	27 (14%)
11-15 sentences	5 (3%)
16-20 sentences	2 (1%)
More than 20 sentences	1 (1%)

The above characteristics were self-reported. [a] 14/200 (7%) blank value. [b] 16/200 (8%) blank value.

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Table 27. Healthcare need (according to health services) and whether met

N reported	Reported problem	Number (%) reporting healthcare need and whether met			
		Follow up	Medication	Treatment	Total
141	Dependency problems	28 (20%)	51 (36%)	11 (8%)	90 (64%)
	Are you getting this?	14 (50%)	45 (88%)	8 (73%)	67 (74%)
	Is there anything else you want/need?	7 (5%)	6 (4%)	6 (5%)	19 (13%)
68	Disability problems	1 (1%)	5 (7%)	12 (18%)	18 (26%)
	Are you getting this?	0 (0%)	3 (60%)	6 (50%)	9 (50%)
	Is there anything else you want/need?	4 (6%)	3 (4%)	7 (10%)	14 (21%)
122	Mental health problems	12 (10%)	64 (52%)	21 (18%)	97 (80%)
	Are you getting this?	6 (50%)	39 (61%)	6 (32%)	51 (53%)
	Is there anything else you want/need?	8 (7%)	19 (16%)	18 (15%)	45 (37%)
183	Physical health problems	22 (12%)	101 (55%)	57 (32%)	180 (98%)
	Are you getting this?	11 (50%)	82 (81%)	35 (61%)	128 (71%)
	Is there anything else you want/need	13 (7%)	24 (13%)	27 (14%)	64 (35%)

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SDO Project 08/1713/210

Time series analysis

Unadjusted Poisson random effects regression models for number of healthcare encounters by health problem category (showing *IRR* (*SE*); *p-value*)

Table 28. Unadjusted Poisson random effects regression models for number of healthcare encounters by health problem category (showing *IRR* (*SE*); *p-value*)

TRANSITIONS	Dependency (n=143)	Physical health only (n=187)	Mental health only (n=127)	Physical, Mental & Disability* (n=195)
Prison -> Other	1.80 (0.29) p<0.001	1.00 (0.21) p =0.99	1.07 (0.27) p=0.80	1.17 (0.20) p =0.36
Other -> Prison	1.00 (0.15) P=1.00	1.77 (0.32) p <0.001	1.07 (0.23) p=0.76	1.65 (0.24) p =0.001
Probation -> Community	0.26 (0.09) P<0.001	0.75 (0.25) p =0.39	0.84 (0.31) p=0.64	0.80 (0.20) p =0.39
Community -> Probation & Police	1.94 (0.30) p <0.001	1.01 (0.19) p =0.96	0.99 (0.18) p=0.96	1.14 (0.17) p =0.37
Other	1.61 (0.34) p =0.03	0.66 (0.15) p =0.07	1.32 (0.33) p=0.27	0.88 (0.15) p =0.45

* the individual model for disability is excluded due to issues with model convergence

Duration of healthcare contacts

By CJS contact and broad care group

In each CJS setting, the average reported duration of contacts (in minutes) was calculated for each broad care group. These durations were based on self-reported timings. Every recorded month for a participant in the study was coded as a single CJS setting, although participants could pass through more than one setting in any given month. This was dealt with by priority coding, given to Prison > Probation > Police/courts > No CJS contact.

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SDO Project 08/1713/210

Table 29 shows that the average duration of healthcare contacts was higher in probation than in the other CJS settings.

Table 29. Average duration of healthcare contacts for each major category of health problem in each CJS setting (in minutes (SD))

CJS Setting	Dependency	Disability	Mental	Physical
Prison	30 (38)	14 (19)	20 (17)	11 (14)
Probation	62 (56)	58 (7)	24 (27)	13 (13)
Police / Courts	26 (16)	10 (0)	36 (24)	16 (14)
No CJS contact	24 (24)	36 (21)	26 (30)	16 (18)

A multivariate analysis was used to compare the total duration of contacts across the different CJS settings. Participant was included as a random effect and the analysis was adjusted for the month of data collection and for broad care group. The total duration of contacts made by participants was significantly higher for those in probation than for those in prison (p = 0.003). No significant differences were found between the duration of contacts made in prison and police and/or courts (p = 0.726), or prison and community (p = 0.877), and adjustments for participant demographics, recruitment site and follow up status did not affect the inferences.

The analysis was repeated with "community" (e.g. no CJS baseline).The analysis shows that the total duration of contacts was significantly higher for those made in probation than in the community (p = 0.004). There was no significant difference in healthcare contact rate for participants in the community compared to prison (p = 0.797) or police/courts (p = 0.815).

Adjustments for participant demographics and recruitment site did not affect this pattern, where the total duration of contacts was significantly higher for probation than for community (p = 0.006). Adjusting for recruitment location (excluding those who were not followed up) shows that the total duration of contacts made in the community was significantly higher than for those made in prison (p = 0.018).

By recruitment site

Multivariate analyses were used to compare the total duration of contacts across the major recruitment sites. SE probation was used as the reference category, to which SW prison and SW probation were compared.

The analysis shows that the total duration of contacts of those in contact with the SE probation service was no different to those from the SW probation service (p = 0.734) or SW prison (p > 0.799). This inference did

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SDO Project 08/1713/210

not change when participant demographics or recruitment site or follow-up status were adjusted for.

By healthcare service

Table 30. Average duration of healthcare contacts for each health service type.

Health service type	Average duration of healthcare contacts (minutes (SD))
Alternative Therapies / Practitioners	73 (55)
Substance misuse service	69 (50)
Primary care	10 (10)
Hospital (in- and out-patients)	262 (50)
Mental Health Services	49 (28)
Other services	50 (27)
Prison Healthcare Centre	21 (11)
Prison Mental Health	20 (19)
Missing data	33 (16)

For each type of health service the average duration of healthcare contacts (in minutes) for each healthcare type was calculated. The longest average duration can be seen in hospital (262 minutes). A more detailed account can be seen in Table 30. The data suggests that contacts with the prison mental health service were much shorter than those contacts with mental health services in the community. However, contacts with the prison healthcare centre were on average twice as long as contacts with primary care in the community.

By broad care group

The total duration of contacts for each broad care group was calculated, as was the number of participants with problems in each category. As participants could have multiple health problems the total number of participants in Table 31 is more than the total number of participants in the study sample. The number of contacts for dependency was higher than for the other major healthcare categories, as was total duration of contacts.

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SDO Project 08/1713/210

Table 31. Number of contacts and participants in each broad care group with total contact time (in minutes)

Major Category of healthcare problem	Total contact time (minutes)	Number of contacts	Average contact time (minutes (SD))
Dependency	60855	1539	40 (50)
Disability	1153	44	26 (24)
Mental	8970	455	20 (25)
Physical	7125	762	9 (15)

Multivariate analyses were used to compare the duration of contacts in the different major healthcare categories. Participant was included as a random effect and the analysis was adjusted for the month of data collection and for CJS setting. Dependency related problems were used as the reference category. The duration was significantly longer for contacts for dependency related problems than for problems in the disability ($p < 0.001$), mental health ($p < 0.001$) and physical health ($p < 0.001$) broad care groups. This inference does not change when adjusting for participant demographics, recruitment site or follow-up status.

By CJS setting

The total duration of contacts in each CJS setting is shown in Table 32.

The total duration of contacts was higher in probation than the other CJS settings, and longer in average duration (minutes). The total duration of contacts was significantly higher in probation.

Table 32. Average duration of healthcare contacts for each CJS setting

CJS setting	Total contact time (minutes)	N of contacts	Average contact time (minutes (sd))
Prison	11227	551	20 (28)
Probation	50036	1001	50 (52)
Police / Courts	3227	130	25 (19)
No CJS contact	9602	420	23 (24)

Multivariate analyses were used to compare total healthcare contacts for each broad care group for each CJS setting. For dependency related problems, the duration of contacts was significantly higher than disability ($p < 0.001$), mental health ($p < 0.001$) and physical health ($p < 0.001$) in the different CJS settings. Adjustments for participant factors and recruitment site made no difference to the outcome, nor did the exclusion those who failed to follow up.

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Scatterplots for validation study

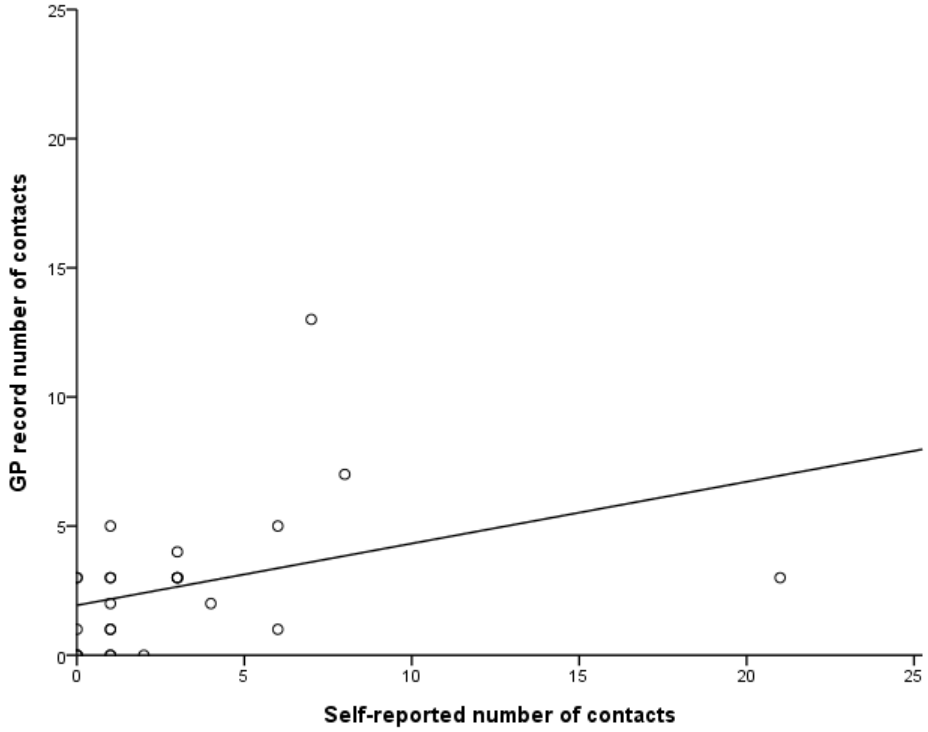


Figure 17. Scatter plot of offender's self reported contacts with primary care services and GP records

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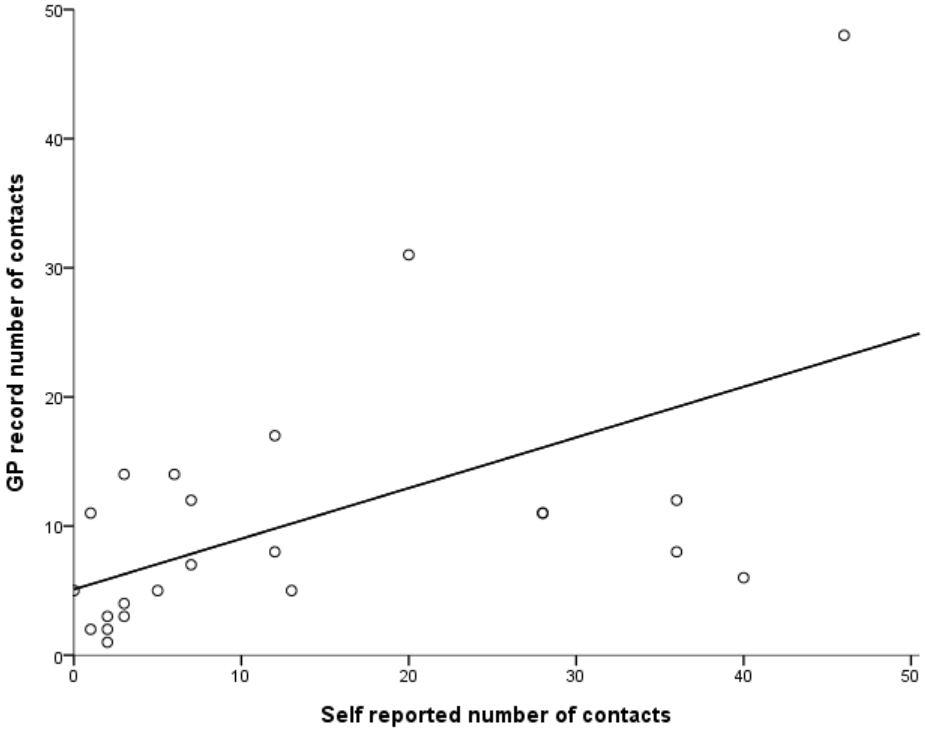


Figure 18. Scatter plot of offender's self reported contacts with drug services and GP records

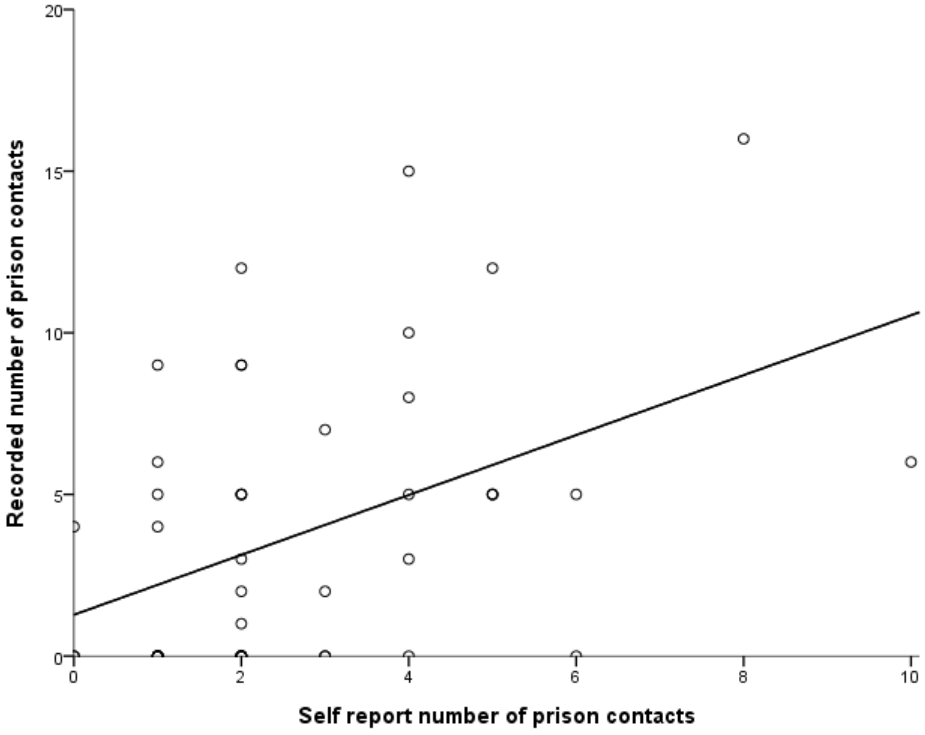


Figure 19. Scatter plot of offender's self reported prison contacts and prison records

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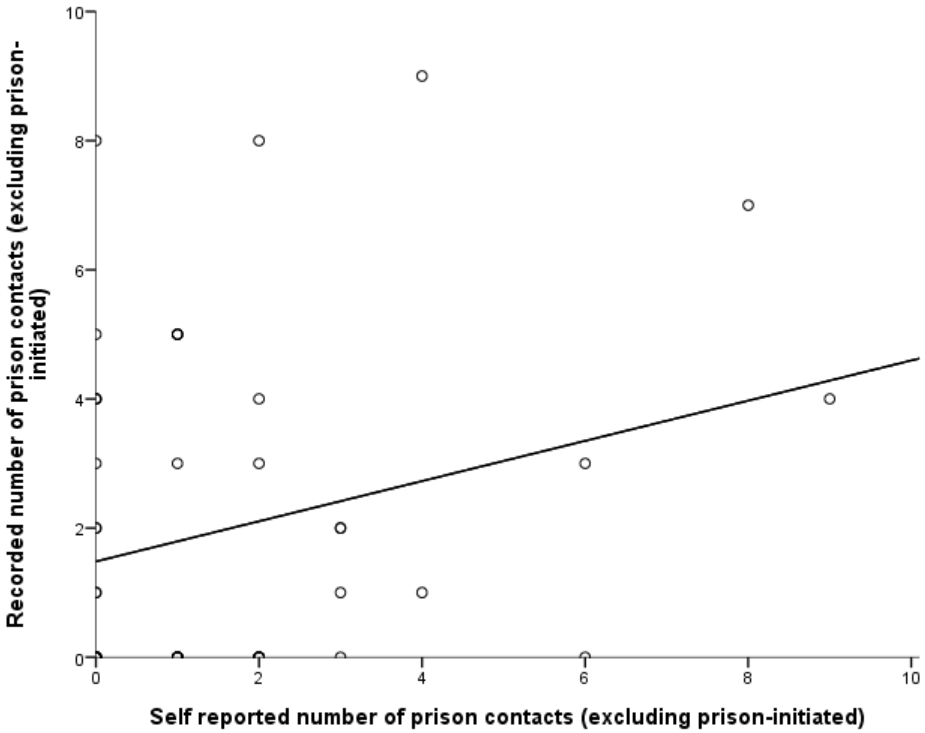


Figure 20. Scatter plot of offender's self reported prison contacts and prison records (excluding prison initiated contacts)

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Appendix E: Peer researcher contributions

"Services make very silly mistakes."

"There is a lot of bureaucracy."

"Services don't like you to stagnate. You get stuck in a rut."

"I need services to have the time to fully read my notes."

"I didn't know what services were available."

"I felt marginalized."

"I have a better relationship with my key worker than I do with my family because he is less judgmental."

"GP's could benefit from having a mental health nurse present once a week at their surgery."

"Police Custody Suites could also have access to RMN."



"I was too embarrassed to approach my family with my drug problem."

"Because I had spent all my money on drugs I couldn't pay my rent."

"I did feel worthless 'cos of what I did. I need to accept it, move on, and help others."

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Appendix F: Offender vignettes

Vignette A

A 34-year-old homeless male who reported a high level of heroin misuse. He had only ever had one job, as a glass collector for three weeks, when he was 15. He was resigned to his life continuing to be dominated by heroin:

> "I said to my CARATs worker it's pointless really cos I know what I'm gonna do when I get out. I said I've been doing heroin for 13 years and nothing's changed when I first started. I know it's sad, it's pretty sad innit, but you know what I mean".

He used periods of time in prison to allow his body to recover from taking heroin, but then had to face the consequent effects of withdrawal and introspection. He described a "hectic" lifestyle and "lacks motivation" to see a doctor. He made it clear that as a drug user he believed that he was looked down on, that doctors in general treated him differently; they "look at you funny… never smile… don't diagnose you properly." His long term goal was to stop using illegal drugs and lead "a more constructive lifestyle". In the immediate future, he said that he might give up drinking alcohol, but he was adamant that there was no chance he would stop using heroin.

Vignette B

A 45-year-old male with on-going physical health problems. He and his partner were living on a limited budget and received sickness benefits. He experienced kidney failure last year and described the local hospital and doctor who were treating him in very positive terms. He said that he was also a long term drug user and was on a methadone prescription which limited the work that he could do because he couldn't operate machinery. He would like to stop taking methadone in the future.

> "It's keeping me off street drugs and it's keeping me off illegal drugs so yeah, it's a benefit in that way. You know, it's not the thing I want, I do actually want to be clean."

He said that these, and his other health problems, were the reason that he wasn't working, not a lack of qualifications.

He described it as being very difficult to manage his health in prison, with his kidney problems because of the set diet and limited access to food supplements that he was taking in the community. He was very concerned about becoming ill while he was locked in his cell and help taking time to arrive. He was also worried that his health, which had been improving while he was in the community, was just staying the same in prison. He

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suggested, at several points, that it hasn't become worse due to luck, rather than proactive care; "I've been lucky since I've been in".

Vignette C

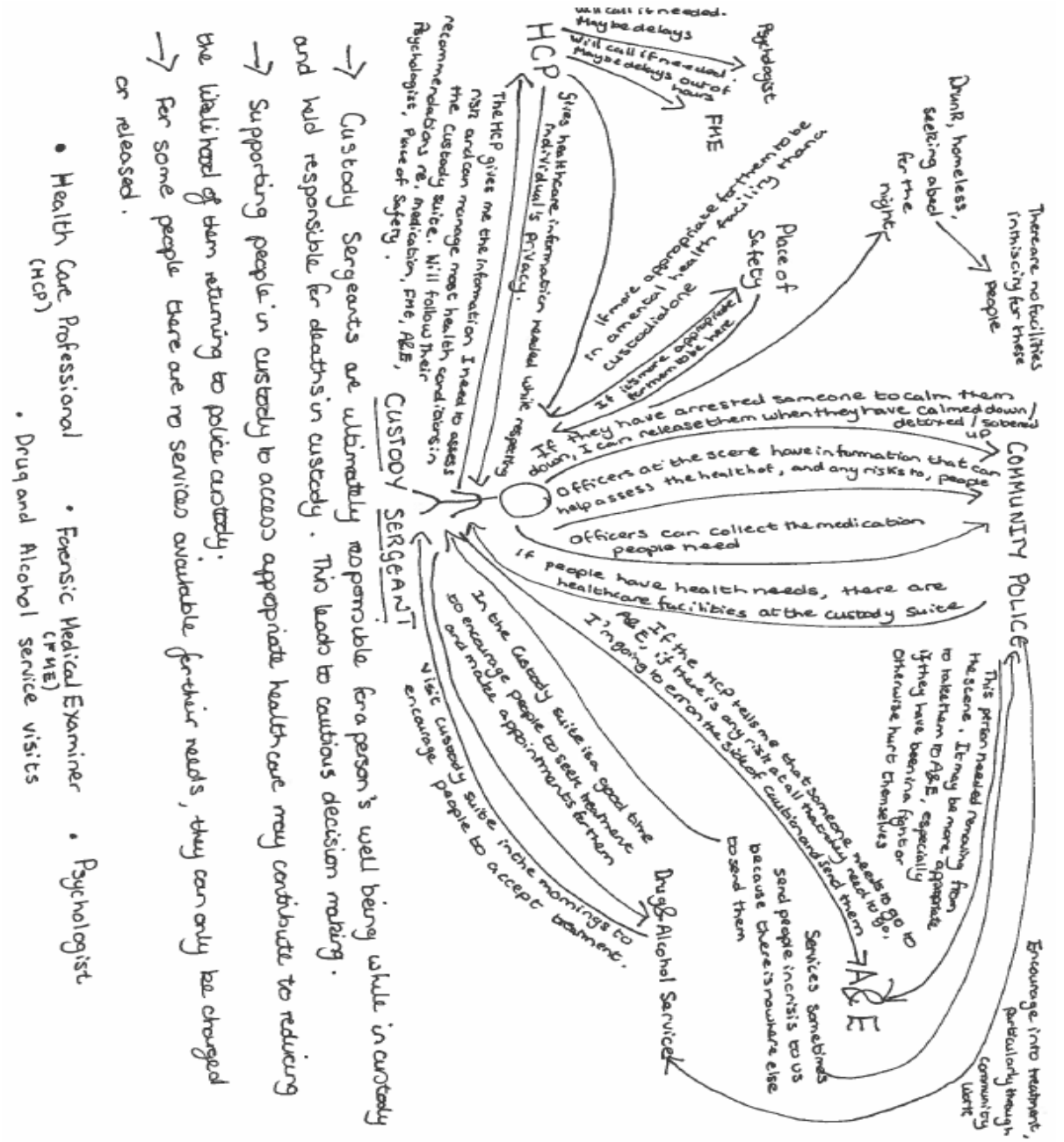
A 33-year-old male with a history of mental health problems exacerbated by drug misuse. "About 5 or 6 years ago" he was addicted to heroin but has since stopped taking it, he was given methadone but "ended up telling them to stick it" because of how addictive he found it. Cannabis has caused him more problems than heroin; he explained that "it had a real hold on me". Although he says that he loves nothing more than to relax and smoke a joint, he recognised that it was taking over his life and has now decided that he "can't be bothered with it".

He felt that he had a good package of support from his GP, social worker and psychiatrist before going to prison. He was receiving regular counselling, and considered himself to be on the right medication and monitored in the right way. Since leaving prison he finds his new psychiatrist "is just not interested at all", while his GP "is expecting too much of me too soon." He was deeply frustrated that all his treatment was "only medication. I have medication, story of my life, medication, medication". He described the antidepressants and benzodiazepines that he was prescribed as "all they do is numb the pain so you can cope with it, that's all it does".

He believed that finding a job would be the best way to avoid reoffending, "just going to work, you know, can give you a whole new world, socially, financially", although he said that there was little point in doing so until his mental health issues had been addressed, "it's no point getting a job you know if you ain't going to stick at it" (2020a).

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Appendix G: Pictorial representation of the relationship between criminal justice practitioners and healthcare



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→ A Magistrate's primary responsibility is to deliver justice; they also wish to support people not to reappear in court.

→ Mandated Drug, Alcohol and Mental Health treatment is limited.

→ Additional support services are limited.

→ It is hard to link a 'holistic person view' with what happens to them in the CJS.

- Public Advice and Support desk
- Volunteer drug and alcohol advisers
- Police & Probation representatives

Only on Community court days, 2 a week.

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Appendix H: Implementation of policy presumptions in SW case study area

POLICE

PP1: Identifying healthcare needs can contribute to rehabilitation.

Healthcare needs are identified by information given by the individual, experience of the custody sergeant, previous CJS information, HCP and HCP records from the last three months. Other services, such as FME, psychiatrist and A&E are used for assessment and treatment as appropriate. Those with identified addiction needs are encouraged to accept a referral for treatment.

PP2: **The police service should provide urgent and immediate healthcare input while someone is under their care.**

Urgent and immediate care is provided while under police care by: HCP, FME, psychiatrists, place of safety and A&E.

PP3: The police service should ensure or facilitate on-going healthcare for people who pass through their care.

Signposting to on-going support for healthcare for offenders is facilitated by a combination of suggestions that they should seek help for the issues that have brought them into custody and offering to make appointments for them with drug and alcohol services. This is only possible where community services exist and so occurs infrequently for mental health problems.

PP4: The police service should provide healthcare input to determine fitness to be interviewed.

This is provided by HCP, FME and psychiatrists; as appropriate. If someone is not fit to be interviewed they may be sent to a 'place of safety' or A&E. People who are currently violent or intoxicated are usually held in custody cells because of a lack of alternatives.

COURT

PP5: Health and social care service provision in or through courts will be based upon assessed needs and provided at an equivalent standard to that in the wider community.

There are no mechanisms for providing mental or physical health assessments in the courts. Healthcare needs will only be presented to the judge if brought to their attention by the defendant, their legal representative or a probation officer. The courts lack access to timely psychiatric reports. There is a lack of suitable mental healthcare provision for this group in the locality.

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PP6: The court is a conduit for passing patient healthcare information and medication between the community and the CJS and between different bits of the CJS.

Due to a lack of initial healthcare assessment, or an individual with overall responsibility for healthcare needs within the court, the passing of healthcare information and medication happens in an idiosyncratic manner. Assessment of health needs is driven by CJS concerns, rather than clinical ones. The passing of medication is driven by individual's initiative and facilitated, or limited, by secure transport services.

PP7: The court should sometimes facilitate the availability of healthcare information or assessments to determine someone's fitness or ability to stand trial or to inform appropriate sentencing.

Magistrates will, if they have been alerted to a health need by an individual or their legal team, order PSRs which can incorporate healthcare assessments. This is only possible for those for whom a custodial or community sentence is being considered. Access to psychiatric reports is severely limited. Access to substance misuse services is better for those reaching treatment thresholds and receiving a mandated order. Sign posting and support in accessing services available for those with low level needs is limited by the services available and the court attended.

PROBATION

PP8: Health and social care service provision in or through probation will be based upon assessed needs and provided at an equivalent standard to that in the wider community.

Probation systems do not have a statutory tool or process that adequately assesses healthcare needs. People serving probation sentences are, theoretically able to access community healthcare provision; however they often lack the skills and capacity to do so. To provide 'equivalent' services for this group involves providing services in a format which they are able to access. The case study area has a number of initiatives which have started to do this.

PP9: Supporting offenders to access healthcare can contribute to rehabilitation.

Probation officers are doing this by supporting their clients to access drug, alcohol and mental health services. Alcohol services have a waiting list. Mental health provision is inadequate.

PP10: Identifying healthcare needs can contribute to rehabilitation.

Healthcare needs are inadequately identified through the OASys risk assessment form. Probation officers identify healthcare needs through self report, any mandated treatment required by the courts, information in PSRs, information from the prison and their own experience. There is no systematic clinical assessment of healthcare needs.

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PP11: Addressing healthcare needs can contribute to rehabilitation.

Healthcare needs can be addressed with the support and initiative of the probation officer, based on their local knowledge and experience. They may encourage, or support, offenders in accessing services. Healthcare services which are based in the probation service building are more likely to be accessed by offenders and provide the opportunity for collaborative working with probation staff.

PP12: Effective partnerships are required across criminal justice and health agencies.

Partnerships have developed between probation and a number of services. The partnership between the probation Service and the CFMHT is not functioning as well as it could. To make the most of all services, and potential partnerships, probation officers would require up to date information on all the services available.

PRISON

PP13: Knowledge of an individual's healthcare from before their reception into prison will support both their settling into prison and their pre-release planning.

Healthcare knowledge from before reception is gathered mainly through contacting community services and reviewing previous prison health records, very little information or medication accompanies the individual through the CJS. When this information is not available clinical decisions are made on the judgement of the prison doctor.

PP14: Prison healthcare should proactively identify healthcare needs.

The best opportunity to proactively identify healthcare needs is at the second reception screening. A well developed tool allows for healthcare needs, and health protection information and advice, to be identified and supplied. This opportunity is sometimes compromised due to the lack of dedicated time and facilities for this process.

PP15: Planning for release should begin at prison reception. Information about healthcare that has been received in prison should be passed to the community to support resettlement.

Planning for release is more thorough for those already receiving higher levels of support from IDTS, CPA or with high levels of physical care needs. Prison healthcare teams use a variety of methods to pass information back to the community, dependant on the circumstances of the individual. The unplanned release of prisoners present particular challenges for the prison healthcare teams.

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PP16: Healthcare in prison should be equivalent to healthcare available in the community in meeting needs.

Healthcare in prison is, in some aspects, different to healthcare in the community. For example, more support may be available in prison and substances to support addictions are harder to obtain. Differences of opinion and dissatisfaction arise when there are different prescribing regimes in the community and in the prison. Prison may be the first opportunity some people have had at addressing their healthcare needs.

PP17: Healthcare in prison prioritises harm minimisation and reduction of self destructive behaviours.

Prison healthcare and prison staff work well together to deliver this, the initial reception health screen is an important opportunity to do so.

NO CJS SUPPORT

PP18: Populations vulnerable to offending include: Illegal drug users, alcoholics, homeless people, people with previous CJS contact, people with untreated mental health needs, women who have experienced domestic violence.

There are no policy initiatives directed at these groups within the 'health provision within the CJS' literature this study has focussed on. Policy for these groups, when they are in the community without CJS support, will be found in other documents directed at the specific needs of these groups.

There are various initiatives directed at the vulnerable groups listed above, which are also accessed by, and meet the needs of, offenders. There is no strategic linking of these initiatives and services and no healthcare pathways for offenders, particularly when they are not currently in contact with the CJS.

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Appendix I: List of Peer Researchers

Dean Harrison

Fran Bellamy

Carole Bressington

Alison Cotterill-Drew

Martin Evans

Joanna Grant

Michelle Harvey

Alan Kilmister

David Munroe

Leroy Simpson

Jay Solzberg

Charlie Taylor

David Weeks

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SDO Project 08/1713/210

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. From January 2012, the NIHR SDO programme merged with the NIHR Health Services Research programme to establish the new NIHR Health Services and Delivery Research (NIHR HS&DR) programme.
Should you have any queries please contact Hsdrinfo@southampton.ac.uk

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