

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

Published June 2012

© Queen's Printer and Controller of HMSO 2012. This work was produced by Byng et al. under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 08/1713/210

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

This report should be referenced as follows:

COCOA: Care for Offenders, Continuity of Access. Byng, R., Quinn, C., Sheaff, R., Samele, C., Duggan, S., Harrison, D., Owens, C., Smithson, P., Wright, C., Annison, J., Brown, C., Taylor, R., Henley, W., Qureshi, A., Shenton, D., Porter, I., Warrington, C., Campbell, J. Final report. NIHR Service Delivery and Organisation programme; 2012.

Copyright information:

This report may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to NETSCC, SDO.

Disclaimer:

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health. The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health

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.

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.

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.

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, 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.

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. Should you have any queries please contact sdo@southampton.ac.uk.