Good person-centred health care for offenders in the community
Evidence to support Care Quality Commission inspections

May 2014

About Clinks

Clinks is the membership body that supports, represents and campaigns for voluntary sector organisations working with offenders and their families. Clinks aims to ensure the sector and all those with whom they work, are informed and engaged in order to transform the lives of offenders.

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Introduction

This paper sets out what good person-centred care looks like for offenders in the community. Clinks recognises there are specific issues experienced by people in prison with accessing health care, as well as areas of good practice, but due to the limited time available for this paper we have focused on the experiences of offenders in the community.

We highlight barriers or challenges experienced by offenders accessing health care as outlined in research reports and from evidence from our members, before suggesting ways that these could be addressed. This is done using the five questions highlighted by the Care Quality Commission as a framework. However, all these 5 attributes of good care – well-led, effective, responsive, safe and caring - can only be demonstrated and become relevant if offenders are able to access health care services. As such, we have added another question to the framework- ‘is it accessible?’

It is important to note that the ‘offender population’ is not a homogenous group, as women, people from Black and Minority Ethnic (BAME) communities and disabled people for example experience unique challenges in terms of accessing healthcare, that therefore requires a unique response.

The paper then gives four stories of individual offenders’ experiences when accessing health care in the community, covering the key themes and potential solutions identified in the main report. Please note, these are fictionalised stories developed from discussions with Clinks member organisations providing frontline services to offenders, each based on case studies of one or more individuals. All names have been changed.
Offender health

It is beyond the scope of this paper to consider in detail the needs of those in the ‘offender population’ but it is well documented that they have higher health needs than the general population. Key statistics relating to the health needs of this heterogeneous group include:

- According to the Community Cohort study carried out by the Ministry of Justice (2013), 51% of adults supervised in the community had a long term medical condition or disability; 46% of women and 40% of all those aged 40+ had a mental health condition.
- 39% of adult offenders under supervision in one probation area had a current mental illness; 49% had a history of mental health problems (Brooker et al, 2011 as cited by Revolving Doors Agency 2014).

The Department of Health (2012:7) also highlights that “children and young people in contact with the Youth Justice System (YJS) have more - and more severe - unmet health and wellbeing needs than other children of their age”. The large majority of these young people in contact with the YJS are in the community rather than in custody.

A high proportion of offenders also experience multiple or complex needs, which means that:

- they experience several problems at the same time, such as mental ill health, homelessness, drug and alcohol misuse and family breakdown;
- have ineffective contact with services, including health services; and
- are living chaotic lives (Making Every Adult Matter, 2014).

For example, one of our member organisations reports that women coming to their service have needs in an average of 4 or 5 of the 9 offending pathways set out by NOMS, which include mental and physical health, and drugs and alcohol (ISIS Women’s Centre, interviewed January 2014). This is supported by the Department of Health (2012:7) which states that adults, children and young people in secure settings “have typically led chaotic lives prior to incarceration, characterised by little formal contact with NHS services.”

As such, providing high-quality, person-centred health care to offenders presents some specific challenges; but can have a significant impact on both health and broader social outcomes when these challenges are creatively addressed.
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<thead>
<tr>
<th>Framework question</th>
<th>Challenge to engaging with healthcare</th>
<th>Potential solutions</th>
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| 1. Is it well led? | **Fragmented service response**  
A literature review by Revolving Doors Agency (2011) outlines that when service users are accessing health care from multiple agencies or services, care was typically poorly co-ordinated and services failed to communicate with one another. This often meant that service users were repeatedly and separately assessed, which caused some stress but also meant that the severity or ‘depth’ of the interconnected nature of their needs was not identified.  

This is supported by Homeless Link (2012: 2) which found that homeless people cannot access the treatment they need because services are set up to deal with “one need at a time” and are therefore ill equipped to meet their complex health problems. It is important to note that many homeless people have experience of the criminal justice system.  

**Poor continuity of care**  
This can especially be true for offenders at transition points, which can include being referred from children’s to adult services and on release from prison into the community. | **Joined up provision of services**  
As many service users will need to access more than one service at a time, it is essential that these services are joined up and/or work in partnership with each other. This ensures that service users don’t fall through the gaps and are able to access all the services they need. Indeed, the Centre for Mental Health (2013: 6) highlight that “it is essential that statutory and community agencies work in partnership and forge a network across which knowledge can be shared.”  

One way of co-ordinating services is through the ‘MEAM Approach’, which is a non-prescriptive framework for co-ordinating services for people with multiple and complex needs (MEAM, 2014).  

Much of the literature highlights that voluntary sector organisations often ‘fill in the gaps’ and are adept at acting as a link between different services, from different sectors, on behalf of their service users. |
| 2. Is it accessible? | **Low engagement with health services**  
Offenders often have poor experiences accessing formal services, and can be reluctant to engage with health services until their needs are particularly severe. 40% of prisoners declare no contact with primary care prior to detention, for example (Public Health England Offender Health website). This is despite experiencing a higher prevalence of many health needs compared to the general population, including problematic drinking, smoking, and Blood Borne Viruses and Sexually Transmitted Infections | **Location of services**  
Enabling service users to have access to services at locations where they already need or want to be present (such as at a Women’s Centre or in a housing project) can help to ensure they engage. This is particularly beneficial where attendance at the location is voluntary, so that accessing health care services does not become negatively associated with compliance requirements, as may be the case if co-located with probation services for example.  

Care in these locations can be provided either as an outreach service from a... |
This results in an over-use of emergency services and less successful health outcomes. This can be exacerbated by a reluctance on the part of health care services to accept patients who they see as problematic, either because of presenting with challenging behaviour, or as coming with an additional set of needs the health professionals do not feel able to meet (Revolving Doors Agency, 2001: 10-14). Probation services and bail hostels report needing to enter into specific contracts with GP services to accept their clients as patients, in breach of the NHS constitution.

Problems navigating systems
Many offenders are likely to be experiencing multiple needs and will therefore need to access a plethora of health and care services. This can be daunting for many service users, as it will require them to navigate complex systems and rules, as well as being required to access many different services, at different times and at different locations; and is especially challenging for offenders experiencing multiple needs or who live “chaotic lifestyles” (Department of Health, 2012:7).

In addition, offenders often have limited information regarding these services or the information they do have is not in a format that is accessible. For example, English may not be their first language or they could have poor literacy levels, which makes engagement challenging. In addition, 20-30% of all offenders have learning disabilities or difficulties that interfere with their ability to cope with navigating complex systems (Prison Reform Trust, 2014b: 5).

Supporting service users to navigate complex health systems
As accessing multiple or even singular services can be challenging for service users, and those with learning difficulties or poor literacy, it is important they are supported when navigating complex health systems. This could be achieved by providing a service user with a key worker, who will support and assist them with accessing the services they need.

In some instances, such support can be provided by volunteers, who with sufficient training and support are well placed to attend appointments with service users and advocate on their behalf.

statutory health provider, or by commissioning a voluntary organisation to provide this care - please see stories 2 and 4 for examples of how each of these can be achieved.

Such provision should also include advice and information about general health issues, and healthy lifestyles.
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<th>3. Is it effective?</th>
<th><strong>Failure to involve service users in care planning</strong></th>
<th><strong>Taking service users’ views into account</strong></th>
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<td>Health services can fail to take into account service users’ views in terms of planning for their future care and how the service more widely addresses their needs. This can lead to poor communication between professionals and service users, with service users receiving different care from that which they expect or want, which can mean they are less likely to engage.</td>
<td>Service user engagement in health care would involve professionals and service users working in partnership to plan for future care arrangements. Working in this way ensures the service user is informed about their care, meaning they are more likely to receive the care they want and need and therefore making them more likely to engage.</td>
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<td>Service user involvement can take many forms and is increasingly adopted by health organisations. It is defined by the World Health Organisation (2002) as “as process by which people are able to become actively and genuinely involved in defining the issues of concern to them; in making decisions about factors that affect their lives; in formulating and implementing policies; in planning, developing and delivering services, and in taking action to achieve change.”</td>
<td>Ensuring health services adopt this approach would enable service users to give their views about how the service is successful and where improvements can be made. In light of this evidence, health services can alter what they are delivering to enable the service to meet the needs of the people using it. It is important that health services make particular effort to engage with marginalised service users, likely to include offenders or ex-offenders, to ensure their voices are also heard. Working in this way again means that service users are more likely to engage with the service.</td>
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<td>Early diagnosis</td>
<td>For health care to be effective, it is also important that service users’ needs, whether around physical or mental health or problematic drug use for example, are identified at the earliest possible stage. One advantage of this is that needs can be met before they escalate. Please see Story 2 for more information.</td>
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### 4. Is it responsive to people’s needs?

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<th><strong>A ‘one size fits all’ approach</strong></th>
<th><strong>Supporting diversity</strong></th>
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<td>As outlined in the introduction, the ‘offender population’ is a heterogeneous group, with women and people from BAME communities for example having unique needs. Health services need to be aware and responsive to these needs to ensure these groups experience successful health outcomes yet at times, health services have been found to be inflexible and take a ‘one size fits all’ approach to the way they are delivered and designed. The Centre for Mental Health (2013:3) highlight this issue in relation to mental health services for BAME communities “in a bid to address institutional racism some services inadvertently exacerbated the problem by positioning themselves as ‘colour blind’ or a ‘one size fits all’ service. This has now been recognised as culturally insensitive and ineffective but there is still some way to go.”</td>
<td>It is essential that the unique needs of offenders are met by health services. This requires a flexible and tailored approach to offenders with protected characteristics¹, coupled with an understanding that different inputs or services are required by different groups to achieve the same outcomes.</td>
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**Women**

Women are a minority group in the offender population but have very distinct health needs to men. For example, women have a higher rate of self-harm and eating disorders than men, their rates of depression and anxiety are twice that of men and are more likely to have a mental health disorder and associated with post-traumatic stress disorder (Department of Health, 2003). Many women in the criminal justice system are also victims of domestic violence or sexual abuse (Prison Reform Trust, 2014a). It is therefore essential that services are gender specific and can address the unique needs of women.

**BAME communities**

It is well documented that people from BAME communities are overrepresented in both mental health care and at all stages of the Criminal Justice System (CJS) and experience unique health needs. However, the Centre for Mental Health (2013) outline that people from BAME communities are under-represented within services such as drug court initiatives and Improving Access to Psychological Therapies (IAPT) programmes that may prove beneficial.

In a recent report by the Centre for Mental Health (2013) outlines key considerations related to BAME communities and health care:

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¹ Protected characteristics are defined by the Equalities Act, 2010 as including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
Perceived racism, language barriers and doubts about the cultural competency of services can lead to BAME communities having negative perceptions of mental health services (Cooper et al. 2012). Within some African-Caribbean communities a very real fear exists that “involvement with mental health services could eventually lead to their death” (Keating & Robertson, 2004). These factors can result in a delay in seeking help, meaning some BAME communities only access services when they are at crisis point and are reluctant to engage (Keating et al. 2003). It is therefore centrally important that individuals from BAME communities can access culturally specific support from health services. This can be done through partnership working, as highlighted by the Centre for Mental Health (2013:7) “where practitioners lack a particular cultural expertise they need to be able to effectively partner relevant culturally-specific agencies.”

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<th>5. Is it safe?</th>
<th>Delays in receiving help</th>
<th>Flexibility and creativity of services</th>
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<td>The literature demonstrates that at times, health services can fail to respond quickly when service users need or request help. One reason for this is long waiting lists. This was found to be the case at times of crisis, out of hours or at transition points (such as from prison into the community). Also, services can fail to respond quickly at times when service users have high motivation, which is particularly relevant to drug users. This issue can be especially problematic for offenders as “service users emphasised that they need support immediately if they were not to return to old habits” (Revolving Doors Agency, 2011: 8)</td>
<td>As highlighted earlier, service users are likely to have complex needs and many will live ‘chaotic lifestyles.’ This increases the likelihood of experiencing crisis, meaning health services need to work flexibly in order to address these issues as and when they arise. Working in this way can also help to reduce the delays service users can experience when accessing health care. It is also important that health services are open to creative ways of working, to ensure the client’s needs are addressed. This can also help to ensure service users are engaged with health service.</td>
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**Inflexible services**
Offenders with multiple needs will often have to access more than one service at a time. This not only involves negotiating a complex landscape, but also means that service users are required to make and attend multiple appointments, that can clash. If this happens, mandatory appointments with the Jobcentre for example can prevent attendance at a drug treatment service (Revolving Doors Agency, 2011).

**High threshold for services**
As highlighted earlier, offenders with multiple needs experience different needs at the same time, which can feed into and exacerbate one another. If taken in isolation, each need is experienced as a low-level issue which means that offenders often fail to meet high thresholds of services and consequently receive no support (Durcan, 2014).

**6. Is it caring?**

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<th>Non-judgemental attitude of staff</th>
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<td>Many offenders in the community, especially those with complex or multiple needs, often have ineffective contact with services. One reason for this, as argued by Revolving Doors Agency (2011) is that these individuals experience “unhelpful, insensitive and other negative staff attitudes.” An example of this is service users reporting a perception that general practitioners took their mental and physical health problems less seriously if they disclosed drug use. Negative staff attitudes can lead to a poor relationship between clients and professionals, which in turn can mean that service users have poor experiences of services and disengage from them.</td>
<td>This could be addressed by service user involvement, as it can allow service users to understand why decisions are made and facilitate more constructing relationships with staff. Also, staff may also develop a deeper understanding of the needs and behaviour of their clients, which can again help to break down the barriers between them. Working with and supporting offenders, especially those with multiple needs, can be challenging. As such, there needs to be adequate training and support for staff working with this group of clients.</td>
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Service user stories

Story 1: Andrew

Andrew is a white man in his early 40s living in north-west England. He was diagnosed as HIV positive while in prison, and a local community organisation who were in contact with him referred him to a local charity that works with people living with HIV and their families. Andrew also has substance misuse and emotional support needs.

A key worker from the HIV charity visited Andrew several times before his release from prison, offering him information and support to understand what living with HIV meant for him. Andrew’s key worker asked him for consent to share information about his HIV diagnosis with other agencies and relevant staff in the prison, which he was happy to give. Andrew did not have any accommodation to return to when he was released; so as the charity has strong links with partner agencies in the local area, they arranged an assessment for him from a local housing provider who offered him a place in supported accommodation. This meant Andrew would be able to continue to address his health issues after his release, rather than having to worry about the basics of where he was going to sleep and how he was going to eat.

As a result of the charity’s ongoing relationship with many health sector agencies, they were able to make referrals for Andrew to the local specialist HIV community nurse team, who saw him on the day of his release; and support him to register with a GP. The prison would not have made these referrals without the charity’s involvement. The community nurse was able to arrange an appointment for Andrew with a consultant at the HIV treatment centre in hospital within a week of his release to renew his prescription. This was especially important as when living with HIV, you would normally see your doctor every 3 to 4 months and be given medication to last between appointments, but Andrew was only given 1 week’s medication on release. This level of joint working meant there was no break in Andrew’s life-sustaining antiretroviral treatment and so this, along with his other ongoing health conditions, was managed effectively.

For the first few months after his release, Andrew’s support worker from the charity attended medical appointments with him, improving his attendance as well as giving him a greater feeling of consistency and enabling him to properly engage with his healthcare. They also stayed in open communication with the other services supporting Andrew, including his local cultural organisation, HIV community nurses, drugs services, occupational therapy, probation service and welfare rights support, to ensure all important information was shared. Holding multi-disciplinary meetings with Andrew allowed him to be involved in decisions about his care and support.

After 6 months in supported living, Andrew had gained sufficient confidence to search for accommodation himself through the local area social housing scheme, and accept an independent tenancy. It is now almost two years since his release, and his confidence to advocate for himself has increased significantly, to the extent that he has now attended drug worker appointments, probation and his GP on his own for several months. The service user-led approach and partnership working employed by the charity gave Andrew the space to address his health issues first, then wider family and emotional issues, so that he is now able to manage most of his issues himself.
Story 2: Robert

Robert is a white British man in his mid-30s, who has been diagnosed with paranoid schizophrenia. Robert is considered to be a ‘forensic offender’, meaning he has an identified, severe & enduring mental health condition, and his offending behaviour is directly linked to this. He has spent several periods of time in prison, most recently for assault; and is currently living in a supported housing project run by a charity in London.

The housing charity operate a long-standing partnership with the hospital providing mental health care in the area, under which the hospital provides clinical care and the charity provides support to help people maintain their recovery. A nurse from the mental health team at the hospital visits the project to meet with Robert; initially weekly, and now monthly as his level of support needs have reduced. This builds trust with him, and means the staff at the housing project can support his attendance at these meetings. In addition, Robert meets monthly with staff from both organisations for a joint case meeting, to agree strategies for managing his condition, giving him a high level of input into decisions about his care.

On his arrival at the housing project, the joint team met with Robert to agree a crisis management plan to be put into action if his health deteriorated whilst living there. This included signs he suggested they should look out for which would show his condition was worsening, and what action each party would take in that event, such as who they could notify. Establishing this right at the beginning, and involving Robert in the agreement, meant that when he did experience a crisis after a couple of months at the project he was prepared to co-operate with the agreed plan.

Close information-sharing between the agencies, based on mutual respect, has also helped to ensure Robert receives timely and appropriate support for his needs. If Robert misses an appointment for medication at the hospital, they notify his housing project within a day, allowing his support worker to discuss this with him and encourage him to re-arrange the appointment. Similarly, a traffic-light system also allows both agencies to inform one another quickly if they see any change in his condition.

A local GP also visits the housing project regularly to see clients, including Robert. Robert had previously been barred by a GP surgery for loud and aggressive behaviour in the reception area at a time when his mental health was poor; and consequently was reluctant to register with a GP. Holding surgeries at the project has helped him to overcome this, and has meant he has been able to access support for other health conditions and general health education, rather than only addressing his mental health.

As a result of this support, Robert has not offended or needed to return to hospital in the year since his release. He is sufficiently confident in managing his condition that he is now beginning to plan for moving on from the supported accommodation and returning to independent living, rather than being “trapped in the mental health system his whole life”.
**Story 3: Kwesi**

Kwesi is a young man in his early 20s, from a Black African background.

Kwesi has a history of misusing alcohol, cannabis and cocaine. He has been arrested, held in custody and appeared before court on numerous occasions, most of which are connected to his drug and alcohol consumption. After his most recent arrest, probation staff suspected Kwesi may have some form of mental health problem, and asked that he be seen by the NHS-funded liaison and diversion service at the local magistrates’ court.

The assessment identified that Kwesi had low-level mental health needs and a possible learning disability, as well his substance misuse. However, he did not meet the criteria to be referred to the community mental health team, as his condition was not severe enough to meet the thresholds set for this. Despite this, an essential part of the liaison and diversion team’s role is to maintain a detailed knowledge of the service landscape in the local area, developing good links with both voluntary and statutory organisations. This meant they recommended that he attend a local African community organisation offering a mentoring and support service instead.

Kwesi was initially reluctant to engage with the service, having had poor experiences attempting to access support in the past. However, the organisation were well known in his community and their centre was located close to where he lived, so he agreed to attend an appointment there the following day.

On meeting with a key worker at the community organisation, Kwesi felt he could identify with his cultural background and that they understood where he was coming from. This strong sense of connection made him more willing to listen to what the key worker said and to engage with the support being offered. In turn, his key worker took time to listen to him, and gave him the opportunity to express what it was he felt he needed.

The community organisation could not offer in-house support to help Kwesi address his drug and alcohol use. Instead, after meeting with his key worker several times he agreed they could refer him to another agency in the city who could provide this. Kwesi’s key worker contacted the agency on his behalf to make the referral, and then went with Kwesi to his initial appointment. Having someone with him with whom he had already built a strong relationship meant Kwesi was fully engaged with the service from the start, whereas previously he had often felt suspicious of professionals working with him and so had dropped out of attending services.

The community organisation worked alongside the drug recovery agency for around 6 months, attending appointments with Kwesi and supporting him in between to maintain his recovery. By the end of this time, Kwesi had developed a better relationship with staff at the drug recovery agency, and so continued to follow through with them and has now completed the programme.

Kwesi was also assigned a mentor by the community organisation who is continuing to work with him, supporting him in developing independent living skills and also in building up a support network to help manage his mental health.

Providing a culturally appropriate service was essential for Kwesi in enabling him to overcome his reluctance to engage with support, and take his first steps towards a successful recovery.
Story 4: Leanne

Leanne is a 30-year old white British woman, living in a large town in the north of England. Six months ago, Leanne was arrested for on-street drinking, her first offence, and was taken to a nearby custody suite. Whilst there she was met and assessed by a mental health triage nurse who works for a local voluntary sector women’s centre. The triage team are able to make referrals to a range of different services, for both low-level and more serious support needs.

Leanne scored severely on the Mental Health Minimum Data Set tool; but the assessment also included time and questions to allow her to discuss her situation and the reasons behind her mental health issues and offending behaviour. During this, she disclosed that she had significant debt problems; and that she had recently suffered a significant bereavement, driving her further into debt through the funeral costs, as well as adding to her emotional distress.

In the months before this point, Leanne had been diagnosed as suffering from depression, and at one point was admitted to A&E having attempted suicide. At the time this was treated solely as a clinical health issue, for which she was prescribed medication; and at the point of her arrest, she had been on the waiting list for counselling services (referred by her GP) for 12 months. None of these services had recognised her financial situation as being a key driver behind her depression.

The custody suite nurse referred Leanne for both debt advice and counselling support at her local women’s centre, and they were able to offer her appointments for both services within a few days. When she arrived at the centre for the first time, Leanne was welcomed by a volunteer who gave her a cup of tea and chatted to her while she waited for her appointment, helping her to feel relaxed and at ease about the meeting. Volunteers also texted her between meetings to find out how she was or to remind her of appointments, and she was able to drop in to the centre whenever she chose, so she was never left too long without support.

The debt advice service helped her to look through her bills, plan a budget, and liaised with her creditors to arrange reasonable repayments. Dealing with these underlying financial issues helped to reduce Leanne’s feelings of panic, and gave her the space to begin to address her mental health issues. Using a stepped-care model, the mental health service were able to provide her with one-to-one counselling followed by group support, all in the same place. Offering all these services under one roof at the women’s centre meant Leanne only needed to engage once, rather than having to cope with accessing multiple services in different places. And being in a woman-only environment gave her confidence to discuss her past experience of suffering domestic violence with the group, which she would not have done in a mixed environment.

Leanne was anxious about the medication she had been prescribed by her GP, but felt embarrassed to raise her concerns with him directly. As the women’s centre has good relationships with the GP surgeries in the area, a member of staff was able to call her GP on her behalf, and then talk about the answers in more detail with Leanne, until she felt happy to continue taking the medication. This also helped her to manage her condition more successfully.

Providing the mental health triage service at the point of arrest meant that Leanne was offered the support she needed immediately, rather than being drawn further into the criminal justice system; and the holistic approach taken by the women’s centre allowed her to address all her areas of need and not just the most obvious one. Leanne is now stable and is continuing to engage with the women’s centre, which is currently supporting her to apply for jobs and training.
References


