Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through intensive case management

A thesis submitted to The University of Manchester for the degree of PhD Psychiatry

2016

Alison Pearsall

School of Health Sciences
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Word Count: 75, 417
Glossary of Terms

Offender: a person who commits an illegal act

Criminal Justice System: a set of agencies and processes established by governments to control crime and impose penalties on those who violate laws


Criminal Justice Liaison (CJL): CJL aims to provide ‘assessment of individuals needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence." (Bradley Report, 2009, pp.16)

Arrestee: a person who has been or is being legally arrested

Remand Prisoner: used to describe the process of keeping a person in detention rather than granting bail. A prisoner who is denied, refused or unable to meet the conditions of bail, or who is unable to post bail, may be held in a prison on remand

Intensive Case Management: is a type of intervention. It consists of management of the mental health problem and the rehabilitation and social support needs of the person concerned, over an indefinite period of time

Social Support Network: is the perception and actuality that one is cared for, has assistance available from other people. A network of social interactions and personal relationships

Carer: a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person and is responsible for them

Integrated care: a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. A level of person-centred, coordinated care to provide the best level of support for the service user.
## Abbreviations

<table>
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<th>Abbreviation</th>
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<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
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<tr>
<td>AOT</td>
<td>Assertive Outreach Team</td>
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<td>ASI</td>
<td>Addiction Severity Index</td>
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<tr>
<td>CCTT</td>
<td>Complex Care and Treatment Team</td>
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<tr>
<td>CCG</td>
<td>Clinical Care Group</td>
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<tr>
<td>CfMH</td>
<td>Centre for Mental Health</td>
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<td>CGT</td>
<td>Constructive Grounded Theory</td>
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<td>CJL</td>
<td>Criminal Justice Liaison</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
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<tr>
<td>CRHT</td>
<td>Crisis Resolution and Home Treatment</td>
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<tr>
<td>CTI</td>
<td>Critical Time Intervention</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GTM</td>
<td>Grounded Theory Methods</td>
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<tr>
<td>IC</td>
<td>Inclusion Criteria</td>
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<tr>
<td>ICD 10</td>
<td>International Classification of Disorders Version 10</td>
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<tr>
<td>ICM</td>
<td>Intensive Case Management</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>IMR</td>
<td>Inmate Medical Record</td>
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<td>MHA</td>
<td>Mental Health Act</td>
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<td>MHI</td>
<td>Mental Health Inreach</td>
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<td>MoJ</td>
<td>Ministry of Justice</td>
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<td>MHTR</td>
<td>Mental Health Treatment Requirement</td>
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<td>NACRO</td>
<td>National Association for the Care and Rehabilitation of Offenders</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>OASys</td>
<td>Offender Assessment System</td>
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<td>OHC</td>
<td>Offender Health Collaborative</td>
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<td>OHRN</td>
<td>Offender Health Research Network</td>
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<td>PACE</td>
<td>Police and Criminal Evidence Act</td>
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<td>PANSS</td>
<td>Positive and Negative Syndrome Scale</td>
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<td>SMI</td>
<td>Serious Mental Illness</td>
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<td>SNA</td>
<td>Social Network Analysis</td>
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<td>SPoA</td>
<td>Single Point of Access</td>
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<td>TAU</td>
<td>Treatment as Usual</td>
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<td>TICM</td>
<td>Transitional Intensive Case Management</td>
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ABSTRACT

Introduction
This thesis is an exploration of the perspectives of recipients and providers of health and criminal justice services about the transitional needs of arrestees and remand prisoners, leaving short-term custody. The study context was short-term custodial settings in the North West of England; one remand prison and two police stations. The work is characterised as a policy and practice orientated exploratory study.

Materials and Methods
The study implements Constructive Grounded Theory Methods, underpinned by the Network Theory of Social Capital as the theoretical framework. Forty-two semi-structured interviews were conducted, with five participant groups; service users (arrestees/remand prisoners), family/carers, mental health staff (criminal justice liaison and mental health in-reach, community mental health teams), criminal justice staff (police/prison officers) and mental health commissioners. This was supported by the construction of 11 sociograms for service users, in both arrest (n=5) and remand (n=6) situations, to highlight the availability and functionality of support networks.

Findings
Participants provided unique perspectives about the health and social support, available at the transitional points of leaving short-term custody. Data was analysed and interpreted using Constructive Grounded Theory Methods with the theoretical framework of Network Theory of Social Capital. The over-arching constructed grounded theory is a need for a culture shift within health policy and practice to refocus on transitional care planning to optimise continuous care pathways. Associated themes include ‘lack of practical assistance’, ‘lack of crisis support’, ‘returning to the security of prison’ and ‘poor transition planning’.

Conclusion
In comparison to the general population the prevalence of mental health problems, experienced by individuals within the criminal justice system is strikingly high. In addition, there are difficulties in identification of mental health needs in generalist mental health services and within the criminal justice system at arrest, remand, through to sentencing and release. Entry into and release from the police station or prison are recognised as specific vulnerable points in offender care pathways. Transitions are particularly problematic in relation to linking offenders with appropriate community-based mental health services. Critical Time Intervention, a variant of case management has demonstrated benefits when applied to mental health and offender populations, transiting from hospital and prison settings. The programme contains all the components of service that service users, carers and staff identified as important to support transitions from short-term custody to the community.
Declaration

No portion of the work referred to in the thesis has been submitted in support of application for another degree or qualification of this or any other university or other institute.
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Thanks to my children, Mollie and Joe, for their support during this process and for pleasantly enduring a frequently absent and tired mother. A special thanks to Michael for his support, encouragement and carrying me through the long hours of writing, with music, oranges and coffee as without him this would not be finished. Thoughts for my Mum and Dad who are no longer around, but have been with me in spirit and to whom I dedicate this thesis. From you I have gained a sense of inquiry, resilience and determination that I hope passes to Mollie and Joe to aid their pursuits in life. Thanks to my brother Steve, Uncle Ken and cousin Mark for monitoring progress. To my special friends Karen, Michelle and Joanne, for simply ‘being there’ My appreciation goes out to work colleagues who have covered my workload during blocks of annual leave - cheers!

Finally, I would like to thank the participants who volunteered their time for this research. Without them this doctorate would not have been possible. For those reading this thesis, I hope it illustrates the importance of relationships, networks of support, service transitions and continuity of care and above all the belief in a person’s capacity to change.

“Continuity gives us roots; change gives us branches, letting us stretch and grow to reach new heights”
List of papers

**Paper 1**

*Published*

**Paper 2**

*In Review*

**Paper 3**
Pearsall A, Edge D, Doyle M, & Shaw J (2016), Into the Void: Exploring the Transitional Care Needs of Arrestees and Remand Prisoners

*In Draft*

**Paper 4**
Pearsall A, Doyle M, Edge D, & Shaw J (2016), Tying Up Loose Ends – Expanding the Social Networks of Offenders Released From Short-Term Custody

*In Draft*
Structure of the Thesis

This thesis has six chapters:

Chapter 1 defines the significance of the study and its objective to generate a theory of the health and social needs of offenders with mental illness during transitions in the criminal justice system, using Grounded Theory Methodology (GTM). The research questions and criminal justice setting are explained to orientate the research to the ‘where’ and ‘how’ the study is situated.

Chapter 2 is a literature review, in keeping with contemporary constructivist grounded theorists to provide insight into the prevalence and mental health needs of offenders at the entry and transition points within the CJS, to identify gaps and situate the study. The literature review pertains to the specific mental health and social issues for arrestees and remand prisoners and difficulties surrounding access and engagement with mental health care. The review examines different forms of case management, including Critical Time Intervention (CTI). Social capital network theory provides the theoretical framework for the study and this is explicated alongside the relevance to transitional mental health care. Finally, the utility of incorporating a social network approach to support the complex interactions between stakeholders involved in care provision (as recipients and providers) is explained.

Chapter 3 outlines the methodology of the study in detail, including the history of GTM and how it has evolved over time. The Network Theory of Social Capital (Lin, 1999) is introduced as the underlying theoretical framework for the study. The critical appraisal of the research
methods employed and a discussion of relevance and appropriateness is explained. The sampling strategy, participants, research setting, data collection techniques and methods of analysis are presented and discussed. Finally, the ethical concerns relating to the study with this client group are presented.

Chapter 4 is the first of two chapters presenting the findings of this study. Data from the Constructive Grounded Theory (CGT) analysis are presented. The overarching theory constructed is described with accompanying themes and codes.

Chapter 5 is the second findings chapter. Data from service users’ sociograms are presented. The basic structure of social networks and the characteristics of the types of support and resources available through membership, following release from short-term custody are discussed.

Chapter 6 concludes the thesis and considers the implications of the findings in relation to future mental health policy. Finally, the limitations of this study and suggestions for future research are presented.
Chapter 1

“We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care.

We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous”

(National Voices: National Collaboration for Integrated Care and Support, 2013, p.11)

1.1 Introduction

The above quote is directly relevant to the basis, justification and findings of this thesis. The quote relates to service users’ experiences in general mental health services, not a criminal justice population. The difficulties accessing and maintaining engagement with services, particularly at transition points are emphasised. Arguably, the referral and transfer processes are more problematic for service users involved in the criminal justice system due to the increased organisational boundaries, transitions and agencies involved (Bradley, 2009). The greater the complexity of service entry, transfer and exit points the greater the likelihood of deficiencies and failures (Allen, et al, 2014).

The aims of this study are consistent with the Department of Health’s strategy to improve the organisation and delivery of healthcare through developing new knowledge about current provision, models of service delivery, inter-agency communication and improved working practices (The Mental Health Taskforce, 2016). The study contributes to a coherent body of knowledge on intensive case management and specifically for offenders with mental health
problems transiting from short term custody that may reduce individuals “falling through the gap” between custodial and health agencies. This study establishes a grounded theory of the health and social needs of offenders at the entry points of the criminal justice system and identifies how Critical Time Intervention (CTI), a form of intensive case management may improve engagement in mental health care. The study setting is the entry points to the criminal justice system, where the opportunities for early intervention and effective transitional care are optimal.

The need to intervene to divert people with mental health problems at the earliest stages of the criminal justice system is identified in several research studies (Robertson et al, 1996; Bradley, 2009; McGilloway, 2004). This work stresses the importance of early detection of mental health problems and the need for swift delivery of holistic care, focusing on mental health, substance misuse, housing and financial support, to avoid the cycle of re-offending and continued imprisonment. There have been improvements in the identification of mental illness within police stations, court and prison settings through the establishment of Criminal Justice Liaison and Diversion and Prison Inreach Services. However, these teams operate differently across the country and are of variable quality (Lovell et al, 2002). Consequently, many opportunities to engage with individuals in a more pro-active manner, to stabilise mental illness before the development of refractory symptoms and more serious offending are lost.
Release from police stations, courts and prisons are vulnerable points in offender care pathways (Birmingham et al, 1997; Bradley, 2009, Shaw et al, 2009). NACRO (2005) and Revolving Doors (2006) have raised concern about the lack of continuity of care for prisoners with mental health problems leaving prison. The Prison Reform Trust (PRT) reports that 30% of people released from prison are homeless; despite research estimating stable accommodation can reduce re-offending by 20% (PRT, 2014). Furthermore, 49% of prisoners with mental health problems have no specific address to go to on leaving prison. Therefore, it is not surprising that release can generate exacerbation of symptoms and potentially an increased risk of suicide (Appleby et al, 1999; Farhall et al 2003; Pratt et al, 2006 and Binswanger et al, 2007). Contact with family and friends, as well as securing employment and housing, is stated by offenders as the most important issues affecting them on leaving custody (Prison Reform Trust [PRT], 2005; Shaw & Thornicroft, 2007). Pursuing resolution of these difficulties may affect offenders’ ability to initiate or remain in contact with mental health services (Shaw & Thornicroft, 2007). However, if mental health interventions included intensive practical social support to assist with such matters as housing, finding employment and sorting out benefits, more active engagement might be achieved.

The next sub-section (1.2) of this introductory chapter describes the criminal justice system to briefly orientate the reader to the research setting, although this is discussed in detail in Chapter 2. Sub-section 1.3 highlights the high and variable levels of health and social needs within this client group, to demonstrate the justification for the focus on this population. The section also introduces the difficulties individuals face in accessing and maintaining...
engagement although a more comprehensive discussion is located in Chapter 2 within the literature review. The fifth sub-section (1.5) presents a brief overview of mental health case management, including Critical Time Intervention (CTI) which is the focus of this thesis. The main evidence examining the case management interventions, including CTI is synthesised within the review in Chapter 2. Sub-section 1.6 introduces the research aims, objectives and questions.

1.2. The Criminal Justice System

The Criminal Justice System (CJS) is designed to provide ‘end to end’ punishment, rehabilitation, supervision and support services to offenders from entry to exit throughout the criminal justice pathway (Ministry of Justice, [MoJ], 2011). The CJS comprises a collective of agencies including the police, probation, prison service and independent sector providing individual responses and interventions designed to protect the public; whilst punishing and rehabilitating offenders. With high levels of substance misuse, learning disabilities, mental health problems and other social care needs the criminal justice system struggles to meet offenders’ needs, particularly at specific points of transition such as initial incarceration and release (Bradley, 2009). In many ways, the CJS fails to resolve the tensions between rehabilitation and punishment and has an overarching reliance upon traditional institutions such as prisons and courts (Revolving Doors, 2013).

Central to the criminal justice approach is the hypothesis of punishment through deprivation of choice, liberty and the agency’s fundamental control of individuals (Bradley, 2003). This dominance makes it difficult to embrace concepts such as well-being, citizenship, family life
and optimising employment prospects (Prison Reform Trust, 2012). The CJS is largely measured on its ability to reduce rates of re-offending rather than other markers such as offenders engagement in employment, despite research indicating that being in stable employment reduces re-offending (SEU, 2002; MoJ, 2010).

The recent criminal justice reforms, for example, within the probation service, might have intended to create service improvement and social innovation through progression from ‘centrally controlled services dominated by the public sector, towards a more competitive system that draws on the knowledge, expertise and innovation of a much broader set of organisations from all sectors’ (MoJ, 2010, p.8). However, with 20% funding cutbacks across the public sector and widespread funding deficits within the third sector, the ability of agencies to contribute to criminal justice innovation is severely hampered (Clinks, 2011). Reforms within the CJS may seek to replicate former changes within the health and social care sectors of moving from institutional care towards more community-based, personalised approaches (Webber et al, 2015). Whilst developments may have attracted initial service user satisfaction decades of reform have shown that decentralisation is not without its drawbacks as reinvesting in community-based, individual care-budgeting may result in a lack of provision for service users with specific or unusual needs (Davey et al, 2007).

Transforming the culture and mode of service delivery in the criminal justice system is a significant challenge. The CJS is weighted by responsibility and accountability for the delivery of punishment, rehabilitation, resettlement and overall risk management of offenders in custodial settings and in the wider community. Experience in health and social care suggests it
may be necessary to co-ordinate a whole-systems approach where the focus is on outcomes rather than process (McCarthy & Pose, 2010; Webber et al, 2015). One of the major stumbling blocks is the ability of the CJS to work in partnership with professionals such as health and social care, as well as service users and families (Weaver and Lightowler, 2012). Political rhetoric emphasises the importance of early intervention, policing, sentencing policy and prisons in the ‘fight’ against ‘crime’ (Evans, 2016). However, there is no evidence of a systematic approach to the delivery of support programmes at the entry points to the criminal justice system, resulting in progressive use of custodial sentences as an option for a range of offences including those that are non-violent. These sentencing decisions impact on prison numbers because many establishments across the prison estate operate at, or close to, maximum occupancy (PRT, 2015).

The prison population in England and Wales reached 84,372 in 2014; the highest in Europe (PRT, 2015). Between 1993 and 2014 the prison population in England and Wales increased by more than 40,000 people (91%), the rise demonstrating the impact of governmental policy to be ‘tough on crime’ by imprisoning people for offences across a range of severities (PRT, 2015). The inappropriateness of prison sentences for women has been raised because 82% are convicted for non-violent offences (MoJ & PRT, 2015). Most are sentenced for acquisitive/theft related offences and similar to male prisoners, most are serving short sentences (MoJ, 2015).

The risk benefit ratio of imprisonment is debated as to whether prisons can effectively contribute to the reduction in re-offending without causing further harm to individuals (Bonta & Gendreau, 1990). Despite increased service provision, re-offending rates for adults has remained
consistent over the last decade at 35-38% (PRT, 2015). Nearly half of released prisoners are re-
convicted within a year of release; which increases to 58% for those serving short sentences of 12 months or less (PRT, 2015), and is even higher in mentally ill offenders and those using drugs.

### 1.3. Arrests and Remands in the CJS

Around 1.1 million people were arrested for recorded crimes during 2012/3 (Home Office, 2014), and the police are often the first point of contact to deal with a range of psychiatric emergencies and disturbances. It is understood that arrestees may have significant health needs but are not accessing health care services (DH, 2007; McKinnon and Grubin, 2010). Mental health care of those in police custody, is one of the least recognised, discussed or researched parts of the offender pathway (Shaw et al, 2009), but liaison and diversion has only recently received additional funding as a priority area for service development (Bradley, 2009). Mental illness increases the risk of arrest and subsequent incarceration due to public anxiety about symptoms and behaviours in public places (Hirschfield et al, 2006). People with mental health problems are most likely to be arrested if their symptoms or behaviours are reported as concerning by other members of public, than if they are distressed and preoccupied but troubling no one else (Revolving Doors, 2006; Teplin, 2000).

During 2014, over 100,000 people were placed on remand; 70% of those awaiting trial and the remainder for sentencing (PRT, 2015). Fifteen percent of people (15,481) received a non-custodial sentence and one in ten people (10,688), were subsequently acquitted (Ministry of Justice, 2014). There are designated remand places within the prison estate. Prisons with remand
places are generally termed ‘local prisons’ due to the close proximity to Courts, town centres and local communities. People are remanded into custody for a variety of reasons outlined in the Criminal Justice Acts, primarily due to the severity of the offence, likelihood of absconding and risk of harm to the public (PRT, 2015). However, the remand population largely comprises of people accused or waiting for sentencing for non-violent offences (PRT, 2015), suggesting that severity and risk are not the main factors driving the decision for imprisonment.

Remand prisoners have greater health and social needs than sentenced prisoners and many have difficulties accessing support within prisons due to the limited length of stay, which averages nine weeks (PRT, 2013). Many experience significant financial and social hardship as a result of imprisonment and are not eligible for discharge grants at the point of release (PRT, 2015). Short-sentence prisoners have similar difficulties in accessing health support, educational courses and employment programmes due to time restrictions. Nearly half of sentenced prisoners are serving sentences of six months or less and the process of applying for programmes can take several months, limiting course and rehabilitation programme eligibility (Clark & Dugdale, 2008). Re-offending rates are even higher for short-sentence prisoners, which highlights the limited effectiveness and appropriateness of prison remand for less serious offences and the difficulties addressing the health and social needs of remand prisoners (PRT, 2015).

1.4. The Health and Social Needs of Offenders

The offender population is recognised as experiencing significantly more health inequalities than the general population (Sneed et al, 2006). These inequalities exist throughout the criminal justice pathway including serving prisoners, those released on licence, arrestees in police
custody and defendants appearing in court. Evidence suggests individuals experience multiple and complex health issues, including mental and physical health problems, substance misuse and learning difficulties that combined, result in elevated risk of premature death, poor quality of life and increased recidivism (Sneed et al, 2006). There is a high incidence of learning disabilities due to cognitive disorders, poor educational attainment and generalised learning difficulties with 20-30% of inmates experiencing additional difficulties coping with the effects of prison, which are not routinely identified (Loucks, 2007, Talbot, 2008).

The range of health and social needs among offenders are outlined in a report by the Social Exclusion Unit (SEU), (2002), stating that many offenders have grown up in households or among family members with previous criminal convictions. Compared with the general population, the SEU reports offenders are thirteen times more likely to be in care as a child and ten times more likely to have truanted. Nearly half were permanently excluded from school (MoJ, 2010), resulting in poor writing and numeracy skills; fifty percent have the reading ability of or below that of an eleven-year-old (McMahon et al, 2004). Half of prisoners have no qualifications and most were unemployed at the time of conviction (MoJ, 2012); highlighting increased levels of social and economic disadvantage. For many offenders going to custody is a time to consider change and engage in education or skill-based training (Prison Education Trust, 2012). However, Ofsted report that over half of prisons fail to adequately cater for the learning needs of offenders (Ofsted, 2014); contributing to low post-release employment rates.

Offenders in custody are recognised as having high levels of health needs with a third having physical or mental disabilities (MoJ, 2012). Nearly three quarters of offenders have a history of
drug use prior to imprisonment and over 70% have at least two mental disorders (SEU, 2002). Furthermore, more than half have previously experienced multiple forms of abuse both as a child and adult (Corston, 2007). A high proportion of serving prisoners have previous care experiences and parents with former CJS contact (SEU, 2002). More women are reported to have accessed mental health treatment than men; which is perhaps indicative of generally lower consultation rates by men rather than less ill-health (Wang et al, 2013).

Many prisoners struggle to cope with environmental factors and pressures; consequently 20% of males and 37% of females have made previous suicide attempts (PRT, 2015). In 2014, there were 25,775 incidents of self-harm incidents on record, with 1,749 requiring hospital attendance (PRT, 2015). The highest number (243) of deaths in custody were recorded in 2014, 84 of which were self-inflicted (35%) (PRT, 2015). One in five of these self-inflicted deaths were by remand prisoners (PRT, 2015). This may have coincided with a 2.9% reduction in the number of officers (PRT, 2015) and an increased use of cellular confinement.

Factors such as separation from family, boredom and isolation can significantly impact on individuals’ mental health and well-being during incarceration (Nurse et al, 2003; Smith, 2000; Wener & Keys, 1988). The prison regime and enforcement of rules can be damaging to individuals’ sense of self and subsequent engagement in healthcare (Hughes, 2000; Sim, 1994; Scott, 2004). The loss of personal responsibility can hinder rehabilitation because individuals become more accustomed to professionals assuming accountability for their lives. This suggests that individuals already recognised as having complex health and social needs experience further difficulties as a result of imprisonment. During imprisonment, one-third of people
become homeless, two-thirds lose their employment, a fifth incur further financial pressures, and crucially over two-fifths lose contact with their family, which limits opportunities for relational support, resettlement and community assimilation (PRT, 2014; Sainsbury Centre for Mental Health, 2008a; SEU, 2002). There are significant effects on prisoners’ families including children of offending parents are more likely to be involved with social services and are at greater risk of antisocial behaviour (Murray & Farrington, 2008) and consequentially the cycle continues throughout familial generations and communities (Corston, 2007; MoJ, 2012).

These underlying health and social issues are often exacerbated by limited identification of needs and poor access to the full range of health and social care services in the local community. Compared to physical disabilities, people with mental illness experience greater levels of discrimination, less access to community mental health services and poorer quality of life (Brodwin et al, 2002; Henry & Lucca, 2004; Hong, 2002). Offenders face a ‘double jeopardy’ through mental illness with the stigma of mental illness alongside the additional classification of being an ‘offender’ (Sneed et al, 2006). Poor treatment during imprisonment and limited access to support post-release contribute to high re-offending rates among individuals with mental illness (Sneed et al, 2006). This ‘double jeopardy’ has been recognised clinically and politically as evidenced by the following quote;

“there is still a group of people with complex needs who are not benefiting from services because their lives and engagement with services are too chaotic. These adults continue to face poor outcomes in the form of offending, long-term mental and physical health problems, poor family relationships, continuing substance misuse, worklessness and deprivation”

Cabinet Office, Reaching Out, 2006; pp. 74
Despite having high levels of need, including mental health, substance misuse and social issues including homelessness many people struggle to access and engage with services productively. People with mental illness are often considered to be irrational, illogical, unreliable and prone to violence and aggression (Sneed et al, 2006). However, the dual effects of mental illness and criminal justice involvement generate multiple and complex disadvantages among this population. The Social Exclusion Unit (SEU) highlighted the severe housing problems, limited experience of employment and few positive social networks. All of which may be further complicated by drug, alcohol and mental health problems for people involved in the criminal justice system (SEU, 2002). Given the complex and multiple needs that exist among this client group, it is concerning that so many are missed at various stages of the criminal justice system.

In 2006, the NHS assumed responsibility for all health care services across the prison estate, which has generated improvements, particularly in relation to physical and mental health services within the prison (DH & HMPS, 2001; DH & NIMHE, 2005; NTA, 2008). Healthcare policy states prisoners should have access to the equivalent standard and range of services as available to the general public (HMPS & NHS Executive, 1999; DH & HMPS, 2001). There are no such standards in place for other parts of the offender-health pathway such as arrest, remand and release.

People with complex health and social needs including mental health problems face frequent challenges including coping with symptoms, medication regimes, adjusting to lifestyle changes and accessing appropriate health care (Gallant, 2003), particularly in community settings after
release from custody. The relationships that individuals form with friends, family and professionals impact on purposeful engagement with health and social care services. The connections individuals make with others affects aspects of daily living. How people feel, what they know, how they act, their desires and beliefs are formed through a variety of influences and connections with others. Crucially, care for self and others, dealing with illness and ability to recover are dependent on communications, interactions and relationships with others (Christakis and Fowler, 2010). The effects of involvement in the criminal justice system significantly impacts on the maintenance of relationships (Revolving Doors, 2010).

Social relationships, interactions and organisational links form networks of support that are important for people with mental health problems (Berkman, 1995), but these can be adversely affected by involvement in the criminal justice system. Individuals may belong or connect to a number of informal and formal networks that shape thoughts, attitudes and behaviours, which can either be positive or negative. The recognition of illness, initial help-seeking and continued service contact is often supported by close or dominant familial members (Pescosolido et al, 1998). However, individuals’ thoughts, beliefs and attitudes affect the strength and depth of ties and thus the level of influence of family, friends or professionals. Personally held beliefs are dynamic, changeable and influential (Pescosolido, 2011) and can therefore motivate or dissuade access to mental health care.

Factors such as health and well-being, risk behaviours and resources may dictate the context or level of contact with health and social services (Gately et al, 2007). Importantly, mental well-being is associated with better social and economic outcomes; therefore, improving access to
health and social support may reduce social inequalities (Webber, 2008) and associated offending behaviour. Mental health interventions such as case management programmes comprise structured interventions designed to promote self-care and improve personal well-being; the success of which hinges on self-development and social relationships (Case Management Society of America [CMSA], 2010).

1.5. Mental health case management

Case management is a collaborative process of assessment, planning, care coordination, evaluation, and advocacy designed to meet individual and family comprehensive health needs, mobilising available resources to provide cost-effective outcomes (Case Management Society of America [CMSA], 2010). Case management is founded on the principles that health and well-being and improved functional capability provide benefits to individuals, their support network and health care delivery systems (CMSA, 2010). Case management promotes service user well-being and autonomy through communication, relationships, education and provision of appropriate supports and services.

Case management was established as a service modality, to co-ordinate and integrate health and social care within defined resources (Thornicroft, 1991). Following increased investment in mental health services it became the foundation for community care for people with complex mental health problems in the UK (Marshall et al, 1995). Evidence for the efficacy of case management is divided; it has been shown to improve engagement in mental health services, but provide limited health and social outcomes, increase hospital admissions and be more costly than standard care (Marshall et al, 1998).
Assertive Outreach Treatment (AOT), a variant of case management, was an established model for promoting engagement of people with mental illness (Marshall and Lockwood, 2004). In comparison to standard care those receiving AOT were more likely to stay in contact with services and less likely to be admitted to hospital, with no difference to overall cost of care (Marshall et al, 1998). An Australian study, reported AOT and case management as equally effective in reducing symptoms and improving social functioning but AOT was shown to reduce hospital admission rates (Ziguras et al, 2000). Similarly, other studies have demonstrated beneficial effects (Marshall et al, 1998; Christensen et al, 2008; Mueser et al, 1998; Rosen et al, 2008), including forensic populations (Healey, 1999; Loveland and Boyle 2007; Petersilia, 2000), particularly when social and housing support were combined (Nelson et al, 2007).

Critical Time Intervention (CTI) is an adaptation of AOT emphasising time-limited, intensive case management at times of transition, recognised as the most vulnerable part of the care pathway (OHRN, 2010). CTI was designed to establish a stable support network in the community, forging enduring links with local services for people with a lack of established community ties, for example those who are homeless or who have limited or absent close family support. CTI has been proven to be effective in promoting engagement in homeless people released from hospital (Susser et al, 1997; Herman et al, 2000) and released prisoners with mental health problems (Lennox et al, 2012).

CTI combines health and social support acknowledging sociological factors on health and illness. CTI enhances education and problem solving skills, thus supporting progression to self-
care within the programme. The degree to which an individual is able to self-care is dependent on the development of social resources within their everyday lives (Osborne et al, 2008). Social situations such as inequalities, poverty and childhood upbringing can impact on physical and mental ill-health. Furthermore, recovery is contingent on the effective management of these health and social circumstances. Care programmes must therefore include comprehensive health and social support.

This thesis presents a detailed examination of arrestees’ and remand prisoners’ needs and constructs a grounded theory of improved mental health provision at the entry points to the CJS. The influence of roles, responsibilities and the relationships of service users with family, mental health and criminal justice staff are explored. These factors impact on engagement and continuity of care, particularly at the transition points of moving from one team, or service, to another. The findings of this thesis demonstrate the need to provide effective transitional case management that focus on individuals’ linkage and community assimilation when leaving short-term custodial environments, such as police stations and remand prisons.

1.6. Aim and Research Questions

The aim of the study was to explore mental health provision for arrestees and remand prisoners at service transitional points, such as leaving short-term custody (arrest and remand).
The principal research question addressed is:

“What are stakeholders’ experiences and views of current mental health care provision for arrestees and remand prisoners and could continuity of care at these transition points be enhanced through transitional case management?”

Objectives:

• To explore participants’ experiences of health and social support (as recipient and provider).

• To consider the concept of ‘continuity of care’ from the perspectives of participants (as recipient and provider).

• To develop a grounded theory of how transitional care can be enhanced through transitional intensive case management (TICM), Critical Time Intervention (CTI) to inform health policy.

• To explore the support networks of arrestees and remand prisoners and implications for provision of TICM, Critical Time Intervention (CTI)

The secondary research questions addressed are:

• What constitutes appropriate support for arrestees and remand prisoners with mental illness leaving short term custody?

• Could continuity of care for arrestees and remand prisoners with mental illness be improved through TICM?
• How can CTI improve the transitions of arrestees and remand prisoners leaving custody?

• How do individual support networks facilitate or hinder the provision of CTI for arrestees and remand prisoners with mental illness?
Chapter 2

This chapter explores the high prevalence and limited recognition of health and social needs in mentally disordered offenders; including mental health problems at various points of transition, namely arrest, remand and release into the community. Transitions, within and across service boundaries are particularly problematic for people with mental illness involved in the criminal justice system (CJS), with disruption to continuity of care. The literature emphasises the inter-relationship between service user outcomes and consistent engagement in mental health care, and how established interventions and supports, such as case management may optimise co-ordination of care.

Within this chapter, the literature on case management is presented. The review explores how interactions and relationships, between health and criminal justice professionals and service users ultimately shape care provision. The support available within service users’ support networks and how these influence service engagement is highlighted. The chapter concludes by situating transitional case management, within the existing framework of the Care Programme Approach (CPA) for delivery of health and social support. Suitability of interventions in meeting the needs of offenders are examined. Finally, service limitations and deficiencies are identified in the extant literature.

2.1 The NHS Policy Context

Historically, the NHS has assumed responsibility for improving patients’ health, by ensuring access to health care, through various Department of Health (DH) strategies, including the
White Paper: The New NHS Modern, Dependable (DH, 1997), the Green Paper Our Healthier Nation: a contract for health (DH, 1998a), and A First Class Service: Quality in the new NHS (DH, 1998). Improvements in quality of care for specific populations are highlighted within the National Service Framework (NSF) and the specific needs and vulnerabilities of prisoners to ill-health was recognised (DH, 1999). In the same year, the Joint Prison Service and National Health Service Executive Working Group’s report (1999) promoted access to equitable health care for prisoners. Other publications of relevance were: Saving Lives: Our healthier nation (DH, 1999b); Reducing health inequalities: an action report (DH, 1999a); The NHS Plan: A plan for investment, a plan for reform (DH, 2000a); Our health, Our Care, Our Say: A new direction for community services (DH, 2006a); High Quality Care for all: Final Report (DH, 2008b). These documents challenged NHS commissioners, patients and providers to maintain health by adopting healthier lifestyles. Consideration of measures to address inequitable health for some groups, such as Black and ethnic minorities, young people and prisoners, was largely absent.

Similarities exist between the criminal justice and mental health systems in that both incorporate elements of state control (Lurigio & Harris, 2007). Recent developments within public health and social care have advanced personal responsibility, by optimising patient choice and control through personal budgets (DH, 2007). However, the introduction of patients’ choice within the CJS has been limited, as a result of the overarching principle of risk management (Ward & Maruna, 2007). The public health agenda prioritises illness prevention, self-management and personal responsibility approaches which promote personal accountability for health and recovery (Fox, 2013). Securing offenders engagement in health and social care may be straightforward in prison populations, due to regimes and inherent behavioural controls.
(Brooker et al, 2008), but more difficult when applied to other settings. The Care Bill (DH, 2013) sets out responsibilities for maintenance of health and well-being and outlines the rights of prisoners to be assessed for social support. This highlights how health, criminal justice and social care services need to provide a more coordinated approach particularly for those with complex health and social needs (Bradley, 2009).

2.2. Mental Health Policy and the Criminal Justice System

The formation of NHS England with responsibility for both generalist health and offender health services aimed to streamline and increase standardisation of clinical practice, care provision and commissioning of services. However, one of the main difficulties for securing a health and criminal justice infrastructure is that NHS England has transferred commissioning responsibilities to Trust’s and local authority providers that also have competing demands such as A&E, diabetes and cardiac care targets.

Offenders were identified as a priority in the National Service Framework (NSF) and NHS Plan and more recently within the government’s Health and Criminal Justice Programme, but there has been limited establishment of evidence-based mental health service provision within the CJS (Fazel et al, 2002; Centre for Public Innovation Review, 2005; Nacro, 2007). Service delivery has been hindered by poor communication across agencies (HMI Probation, 1993; Ritchie et al 1994).

‘Breaking the Cycle’ emphasised the need for effective rehabilitation (MoJ, 2010a), to link individuals to community services (CfMH, 2010). The Offender Rehabilitation Act, (2014)
described rehabilitative supervision for 12 months after release for all offenders serving less than twelve months, in order to engage offenders in community support. Despite these proposals difficulties remain in arranging sufficient support for release, rehabilitation and community re-integration. There are concerns at all stages of the criminal justice pathway, including in relation to prevalence, identification, access and engagement in mental health treatment. Prevalence is examined at the various stages of the criminal justice pathway and the main literature summarised below. The first area in the literature included an overview of the prevalence of mental illness throughout the offender health pathway. The first group to be examined is prisoners, who are the most studied group within the offender population.

2.3. Prevalence of Mental Illness in the Criminal Justice System

The highly publicised Reed Review identified the prevalence of mental illness and the variable quality of care in prison establishments (Reed & Lyne, 1997). Whilst the Reed Review was instrumental in bringing about improvements to the health care expectations of prisoners, inconsistent provision remains throughout prison establishments (Rickford et al, 2005). The literature consistently reports high levels of mental disorder among prisoners, particularly those on remand. Studies are presented below with a summary of the main findings and relevance to the PhD study as Table 1:
### Table 1: Prevalence of mental illness among prisoners, including those on remand

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Type of Study</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusions &amp; limitations</th>
<th>How relates to PhD study</th>
</tr>
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<tbody>
<tr>
<td>Gunn et al (1991)</td>
<td>Prevalence study</td>
<td>16 adult prisons, 9 YOs male young offenders, representative of all Prisons, England &amp; Wales over one year 1988/9. 406 young offenders (YO) &amp; 1478 adult men. 404 (YO) &amp; 1365 adults participants</td>
<td>37% of sentenced prisoners with mental disorders. 10% personality disorder (PD), 5.9% neurotic disorder, 23% substance misuse, 2% psychosis including 1.2% schizophrenia &amp; 0.4% affective psychosis</td>
<td>High response rate, particularly among YOs. No data collected on remand population however, rates of mental illness higher than general population.</td>
<td>High incidences of mental illness in remand and sentenced prisoners.</td>
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<tr>
<td>Mitchison et al (1994)</td>
<td>Prevalence study, point prevalence on one ‘census’ day at HMP Leeds</td>
<td>Prison medical notes of 834 out of 864 prisoners examined. 23% assessed, 15% used drugs, 16% history of depression or self-harm. 43 were interviewed, 18 poor mental health records, 6 former long-stay forensic patients. 36 reside in health care; 33 had disorders, 10 requiring inpatient transfer.</td>
<td>High prevalence among total prison population. Limited psychiatric histories available. Insufficient screening for psychiatric disorders and suicide risk. No comparison on need among remand and sentenced groups. Non-generalised findings of a single prison population.</td>
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<tr>
<td>Maden et al (1995)</td>
<td>Point Prevalence via Survey</td>
<td>Male &amp; female &amp; YOI remand prisoners: From a range of remand prisons during 1993/4. Stratified random sample of 544 (9.2%) of total adult male remand population, 206 male YO &amp; 245 women</td>
<td>9.9% remanded men, 8.7% YOs, 13.5% females with PD. 15% neurosis remanded men, 8.7% male youths &amp; 27.7% women with neuroses. 28.1% substance misuse remanded men, 21.8% male youths, 26.1% females Psychoses among 5.9% remanded men, 1.9% male youths, 4.5% females</td>
<td>Almost 30% with a history of one or more episodes of self-harm, not recorded in other prevalence studies. High levels of inaccuracy and bias was found within surveys; thus less reliability</td>
<td>Higher rates of psychoses among remand prisoners. 1/3 of sample had two or more disorders demonstrating complexity of needs including co-existing substance misuse.</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Type</td>
<td>Methodology</td>
<td>Findings</td>
<td>Highlights</td>
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<td>Davidson et al (1995)</td>
<td>Prevalence study</td>
<td>9 institutions – 7 prisons for adult males, 1 for women, and 1 for males YOI, during 1993. 371 men, &amp; 18 women (389 in total) – 50% random sample in Scottish prisons</td>
<td>10.8% anxiety, 22.4% with alcohol-related problems - 73.2% used illicit drugs previously, 14.1% depression, 2.3% schizophrenia</td>
<td>Personality disorder was omitted making comparison with similar studies difficult. Drug use was high but was lifetime use rather than dependent or problematic usage Refers to Scottish health and prison system which is different to England.</td>
<td></td>
</tr>
<tr>
<td>Birmingham et al (1996)</td>
<td>Prevalence and treatment need study</td>
<td>569 men aged 21+ on remand between 1 October 1995 to 30 April 1996. Consecutive male remand cases at reception using semi-structured interview</td>
<td>95% were white, mean age 28. 452 were unemployed 4% with schizophrenia, 1% affective psychosis, 21% with non-psychotic disorders. 148 (26%) co-morbid conditions, 24 acutely psychotic. 168 men require psychiatric treatment, 17 placed in prison healthcare, 16 require inpatient treatment</td>
<td>26% of new remand prisoners with a current disorder, 1/3 serious. Most undetected and so untreated. No records about substance misuse despite links to mental illness. Findings were based on inmates of a single prison with a large catchment area and therefore not generalisable to the entire remand population</td>
<td>High prevalence in remand, including serious mental illness. Limited identification and poor management and treatment for mentally ill prisoners.</td>
</tr>
<tr>
<td>Brooke et al (1996)</td>
<td>Prevalence study</td>
<td>Male remand prisoners, 3 YOI and 13 adult prisons (N=750), (544 adult men, 206 YOs), randomised. Semi-structured interviews &amp; case note analysis</td>
<td>469 (63%) with a mental disorder, including psychosis among 36 (5%), 84 (11%) personality disorder, 192 (26%) neurotic disorder, 285 (38%) substance misuse</td>
<td>They concluded levels of psychosis in the study group suggested occurrence was 4-5 times more likely than in the general population The time frame for data collection was absent there were no references to the matching of skills and experience between interviewers. Data was not separated between remand prisoners and YOs making it difficult to differentiate needs. Prisoners self-report combined with potential reporting bias generated by staff effect, and an 18% refusal rate highlights methodological flaws.</td>
<td>Highlights high level of mental illness and complex needs among remand population of adult men and young offenders</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Setting</td>
<td>Prevalence</td>
<td>Findings</td>
<td>Conclusions</td>
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<tr>
<td>Grubin et al. (1997)</td>
<td>Prevalence via Survey</td>
<td>Local male remand and Short-sentence prison HMP Durham, during 1996-569 from reception throughout remand Semi-structured interviews - 549 (97%) with 528 (96%) completion rate</td>
<td>312 (57%) illicit drug use (33% current); 116 (21%) (current), 354 (62%) current psychiatric disorder, 103 (19%) had co-morbid illness and substance misuse</td>
<td>19 (3%) refused. No data is collected to identify illnesses e.g. schizophrenia or personality disorder making comparison with other studies more limited. No information as to usual screening for detecting illness.</td>
<td>High levels of current mental illness among remand prisoners showing active symptoms.</td>
</tr>
<tr>
<td>Singleton et al (1998)</td>
<td>Survey, point prevalence study</td>
<td>Representative sample from all prisons in England &amp; Wales. Interviews with 3000 prisoners</td>
<td>7% of male sentenced and 10% remand psychosis; 40% sentenced &amp; 59% remand neurosis (higher in women); 64% sentenced &amp; 78% remand with alcohol (lower in women) &amp; 43% sentenced &amp; 51% remand drug problems (similar to women)</td>
<td>The results reveal higher prevalence, specifically remand prisoners compared to sentenced. Remand prisoners ranked highest for having co-existing mental disorders. No conclusions reached regarding treatments</td>
<td>Remand prisoners found to have more complex needs than sentenced prisoners.</td>
</tr>
<tr>
<td>Fazel et al (2002)</td>
<td>Systematic review (worldwide – western countries)</td>
<td>62 studies, countries 22, 790 individual prisoners</td>
<td>Mean age was 29 years and 81% were men. 2568 (26%) violent offenders, 3.7% psychosis, 65% personality disorder (47% antisocial personality disorder)</td>
<td>No examination of the treatment needs in the population. No discussion of context &amp; alternative explanations for findings e.g. anxiety higher in remand due to ongoing court matters &amp; uncertainty.</td>
<td>High rates of disorder including anxiety &amp; substance misuse among remand population, demonstrating increased and complex needs in remand population.</td>
</tr>
</tbody>
</table>

The studies included in the above table have highlighted the higher rates of mental illness in prisoners (Birmingham et al, 1996; Brooke et al, 1996; Fazel and Danesh, 2002; Fazel and Seewald, 2012; Gunn et al, 1991; Singleton et al, 1998). Similarly, Fazel and Seewald (2012) updated the worldwide systematic review (Western Countries) of 2002 (Fazel and Danesh) confirming similar findings. The review contributed to a wide body of evidence, indicating prisoners have elevated rates of mental disorders, including depression and schizophrenia. The Offender Health Research Network’s (OHRN) national evaluation of mental health in-reach services corroborated prevalence findings, reporting 23% with serious mental illness, including
4% with psychoses, 19% major depression and 66% substance misuse problems. Overall 71% of the prison population were reported with mental illness, substance misuse problems, or both.

Blauuw et al (2007) conducted a study of sixty-one prisoners with psychosis, over a three month period. Prisoners were screened by a psychiatrist. 64% were diagnosed with schizophrenia and 42% with dual diagnosis, including substance misuse. Positive symptoms varied among participants, with 21% of prisoners showed a decrease in symptoms, 13% fluctuating symptoms, 8% deteriorating during imprisonment and 5% initially improving, but deteriorating before release from prison. 79% of the sample received at least one visit from a prison doctor or nurse. The authors concluded that psychosis remained stable and was not exacerbated by prison. Methodological and analytical flaws in the study included incomplete statistical analysis and small sample size.

Shaw et al (2009), conducted an evaluation of reception screening processes in prisons across England and Wales. Findings showed 18% of the sample recorded as experiencing symptoms at reception were engaged with community mental health services, before imprisonment. Over half of prisons were found to have modified the standard screening tool and few reported it as effective in identifying mental health problems. The main issues at the reception screening, included limited access to collateral information, such as confirmation of mental health status, diagnosis and treatment summaries.

High levels of mental illness were reported in a study by Forrester et al (2010) investigating a prison health care wing of a remand prison in London, over a twenty-week period in 2006/7.
Data from inmate medical records (IMRs) within the prison were examined for descriptions of psychiatric diagnosis, behaviour, discipline and progress. High rates of mental disorder and co-morbid conditions were reported and delays in accessing hospital-based treatment. They reported 88 prisoners, 4.4 per week with mental disorder, primarily psychosis, with one-third not previously known to mental health services and 25% requiring transfer to hospital for assessment. A further eleven were noted to need emergency psychiatric treatment administered under common law. The authors concluded prison health care wings operated as front-line services for highly complex individuals displaying behavioural disturbance. However, the findings may not be generalisable and only relevant to inner city prisons.

2.3i. Remand Prisoners

Further to the aforementioned studies it is important to note the higher prevalence and increased incidence of co-morbidity among remand prisoners (Birmingham, 1996; Brooke et al, 1996; Singleton et al, 1998). Reasons for this may include anxiety about facing the future (appearing in court, giving evidence, being found guilty), the effect of imprisonment (first experience of prison) and the stress on the family (fear of reprisals, loneliness, stigmatisation, financial pressures), (Nurse et al, 2003).

Brooke et al’s (1996), prevalence study of male remand prisoners at three young offender and thirteen adult prisons (n=750), investigated the prevalence of ICD-10 diagnoses and treatment needs among the remand population. The authors reported an acceptable refusal rate. Findings included 469 (63%), had mental disorder, with neurotic illness affecting 192 (26%), personality disorder among 84 (11%), psychosis in 36 (5%), with 36 classed as uncertain. They concluded
the levels of psychosis among the study group as 4-5 times higher than the general population. The results of one study, albeit across a number of prison sites cannot be applied representatively across the whole remand population. However, these findings are supported by the studies above highlighting the significant levels of unmet need among the remand prison population, which remains relevant to service planning and developments.

2.3.ii. Community Offenders

Research on prevalence is more limited in community offenders, but rates of mental illness are still disproportionately high (Shaw et al, 1999; Robertson et al, 1996; Greenhalgh et al, 1996; Mair et al, 1997; Hatfield et al, 2004). Brooker reported high levels of non-psychotic disorder, which may fall under the remit of primary care services in prison and the community (Brooker et al, 2008). Common mental health problems were reported as three times higher in prisoners than the general community (Brooker et al, 2008).

2.4. Summary of Prevalence Literature

The literature reveals higher rates of mental illness in prisoners, especially those on remand. Of further concern are the levels of co-morbidity, highlighting the multiple and complex needs among this client group. Entry into and release from police custody and prison are recognised as vulnerable points in offender care pathways (Birmingham et al, 1997; Bradley, 2009, Shaw et al, 2010). However, limited identification at these critical points, results in missed opportunities to engage offenders, in appropriate mental health services. Mental illness not identified at the reception stage may remain undetected during imprisonment resulting in individuals released into the community with inadequate health and social support (Birmingham et al, 1998; Coid,
1988; 1991; Dell et al, 1993). Consequently, the early stages of the CJS are critical to the effectiveness of the offender health pathway.

The next sub-sections report the literature in relation to identification issues presented in the sequence of the offender pathway; arrest, court, remand and release. The first section is ‘arrest’, which is the earliest stage of the criminal justice pathway.

2.5 Identification of Mental Illness in Police Custody - Arrestees

All individuals enter the criminal justice system at the same point i.e. arrest. Progress through the various stages of the criminal justice system depends on a number of factors including the charge, evidence, fitness to interview, detain and the public interest. People can be arrested for many reasons, including the committal of both serious and minor offences. Arrests can be precipitated by concerning or intimidating behaviour committed in a public place, which may be indicative of mental illness and the appropriateness of diversion should be considered.

2.5.i. Diversion

Diverting the mentally ill from the criminal justice system (CJS) at the earliest opportunity is a Department of Health (DH) priority (DH & NIMHE, 2005; DH, 2007), highlighted by Lord Bradley;

“Interventions as early as possible in the criminal justice system would provide the best opportunities for improving how people with mental health problems or learning disabilities are managed” (Bradley Report, 2009, p.29).
The Bradley report (England & Wales), stated that more comprehensive triage and assessment could generate significant cost savings (Bradley, 2009). Similarly, the Centre for Mental Health (CfMH), Rethink and the Royal College of Psychiatrists (2010), reported on the costs of prison beds, crime and how these could be reduced by at least 30%, through well-designed interventions (CfMH, Rethink and the Royal College of Psychiatrists, 2010).

Diversion schemes have been recognised as being of variable quality with little outcome evidence (Dyer, 2011; Lovell et al, 2002). However, the potential of CJL to assess and divert where appropriate has been recognised though national evaluations (Bradley, 2009; OHRN, 2011). In response, in 2014, funding was allocated to conduct a national pilot study of existing CJL provision, using 10 trial schemes, to investigate service specifications. The business case will support national roll out of CJL by 2017/18.

The Centre for Mental Health’s (CfMH) (2009), diversion model succinctly describes the various stages of the criminal justice system. The model is divided into three broad sections, with a total of seven stages and is illustrated in Figure 1 below:
**Diversion Model CfMH (2009)**

**Early intervention:**

1. Prevention (interventions designed to prevent offences e.g. social inclusion and housing advice)
2. Pre-arrest (neighbourhood policing and identification of people at potential risk of crisis and offending)
3. Point of arrest (information sharing with other agencies e.g. health and social services)

**Criminal justice decision-making:**

4. Arrest / pre-court (consideration of other options e.g. caution and referral to other agencies e.g. health and social services)
5. Bail, remand and sentencing (appropriate disposal options determined by psychiatric reports e.g. Guardianship Orders, Hospital Orders, voluntary hospitalisation)

**Through-care and recovery:**

6. custody or detention (multi-agency meetings, assessment for treatment and/or transfer to hospital)
7. release and resettlement (multi-agency management, social inclusion and support lifestyle change)

The CfMH model was designed to optimise the identification of mental illness among individuals who enter (or are at risk of entering), the CJS to provide better links with mental health services. It highlights opportunities to divert into more appropriate care, such as mental health treatment and at any stage of the CJS. Mental health diversion (also termed CJL) has been established at the interface between mental health and criminal justice services to identify and refer individuals into mental health treatment.
The Rethink and CfMH report ‘The Diversion Dividend’ (2010), stressed the importance of early interventions at the ‘entry points’ to the CJS. Other studies have highlighted the lack of consistent evidence but nevertheless acknowledged the benefits of CJL services (Kane et al, 2012; Scott et al, 2013). There has been progress in meeting the recommendations made by Lord Bradley, through the coordinated efforts of NHS England, Ministry of Justice and Public Health England to develop the national all-ages liaison and diversion programme. The Offender Health Collaborative (OHC) produced a standardised Operating Model for CJL services (NHS England, 2014), however, no standard model of intervention was recommended.

Research is more limited around the identification of mental illness among arrestees. However, the relevant literature is presented below in Table 2:
Table 2: Identification of mental illness among arrestees

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Type of Study</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusions &amp; limitations</th>
<th>How relates to PhD study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown et al (1992)</td>
<td>Evaluation</td>
<td>Examination of 167 custody records from 2 police stations over 2x2 week periods (4) before changes to Police and Criminal Evidence Act (PACE) and 2x2 weeks periods (4 weeks) after implementation</td>
<td>106 people identified with mental illness, 60 in phase 1 &amp; 46 in phase 2. Representing 1% of all arrests during the study period. Limited referral to mental health services is achieved.</td>
<td>The reduction in mental illness found between phase 1&amp;2 may not have related to procedures, but be as resist if less mentally ill people being arrested. Mental illness was identified by police officers only and therefore may be less accurate.</td>
<td>Arreestees with mental illness are not identified particularly non-psychotic, non-aggressive presentations.</td>
</tr>
<tr>
<td>Gudjonsson et al (1993)</td>
<td>Case study</td>
<td>Arrestees assessed on mental health state, intellectual functioning and fitness to be detainted. N=163, the sample drawn from arrestees waiting to be questioned by police. Assessments are undertaken by psychiatrists. Inclusion 18-65 yrs</td>
<td>Use of a range of mental health assessments and questionnaires. 7% of the sample is found to have mental illness, 3% learning disabled and a further 5% as having language problems.</td>
<td>Improve accuracy by assessments undertaken and scored by experienced clinicians. Insufficient time to complete some assessments due to detention limitations. No personal or social information was gathered. Sampling method is not disclosed. Localised study findings not be generalisable across the country.</td>
<td>Higher detection of mental illness by psychiatrists than police officers demonstrating need for specialist staff to assess and refer to mental services.</td>
</tr>
<tr>
<td>Robertson et al (1996)</td>
<td>Case study</td>
<td>2617 individuals generating 2947 custody records were included from 7 police stations in London, over a 6 month period</td>
<td>Structured assessments were administered by psychiatrists</td>
<td>26% of individuals with mental disorder including 1.2% with serious mental illness, e.g. schizophrenia were undetected by police officers.</td>
<td>Limited identification of mental illness by police officers at time of arrest</td>
</tr>
<tr>
<td>Study</td>
<td>Type</td>
<td>Key Findings</td>
<td>Limitations</td>
<td>Notes</td>
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<tr>
<td>Phillips and Brown (1998)</td>
<td>Prospective cohort study</td>
<td>Ten police stations were included. The sample comprising of 4,250 arrestees, 85% men (n = 3,610) and 15% women (n = 639). 79% were white, 13% black, 6% Asian and 2% of other ethnic origin.</td>
<td>The study found that 2% of arrestees (n = 67) were identified as mentally disordered, with a further 13 regarded as ‘behaving bizarrely’.</td>
<td>Limitations were identification solely by police personnel. Illness is identified among twice as many arrestees as the earlier Brown (1992) study. The reasons for this were not discussed such as if related to greater occurrence or improved detection. Mental illness among arrestees was missed and poorly managed at the point of arrest.</td>
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<tr>
<td>Steadman et al (2000)</td>
<td>Multi-site case control study</td>
<td>The study measured outcomes at 3 &amp; 12 month intervals. Sample N=635 with mental illness diverted from the CJS and 625 with mental illness that were not diverted.</td>
<td>Findings showed people spent more days in the community, had fewer re-arrests, used community mental health services and scored higher on mental health symptom measures during the 12-month follow up period than their non-diverted counterparts.</td>
<td>Characteristic differences such as diagnosis, previous convictions, social functioning and existing family relationships were not explicated between the cases and controls represented within the findings. Demonstrates diversion from CJS to mental health care at the arrest and court stages may provide positive outcomes in the longer term.</td>
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</table>
2.5.ii. Discussion of the Literature

Studies have attempted to establish identification of mental illness in people who are in contact with the police (Brown et al, 1992; Gudjonsson et al, 1993; Philips et al, 1998; Keyes et al, 1998). However, due to sample selection and methodological flaws, such as reliance on police officers to identify mental illness; it is difficult to interpret study findings (Gudjonsson et al, 1993; Philips et al, 1998). Teplin (1984), conducted a study of two police stations, using trained observers to examine police discretion and arrest decisions. Findings revealed poor identification and higher arrest rates for people with mental illness. Limitations centred around appropriately factoring environmental and organisational factors into the analysis and reporting of results (Engel & Silver, 2001).

McKinnon and Grubin (2010) found poor police screening procedures failed to systematically identify mental health problems, substance misuse and other social issues. Brown suggested the
consequences of poor detection was the police, assumed greater responsibility and ‘duty of care’ (Brown et al, 1992, Robertson et al, 1996).

2.5.iii. Summary

The criminal justice process may provide opportunities, through the use of ‘diversion’ to link into services potentially vulnerable individuals with complex health and social care needs. The aims of diversion are not for individuals to avoid prosecution or reduce personal responsibility, but to ensure appropriate access to mental health services. However, the effectiveness of interventions is incumbent upon other parts of the mental health system committing to the principles of diversion by supporting offenders’ engagement with a range of health and social services. Limitations in identification of mental illness at the arrest stage and the relevance of CJL and diversion have been highlighted.

2.6. Identification of Mental Illness in Court Settings

Court liaison schemes were expanded following the recommendations of the Reed Report (DH, 1992) and the more recently Bradley Report (Bradley, 2009) to increase specialist input within court settings and processes. Despite these developments many people with mental illness fail to be identified at the court stage (Shaw, 1999). Poor identification has been associated with offenders’ not perceiving any benefits in revealing mental health concerns (Karras et al, 2006). Poor identification results in mental health difficulties not factored into the offence analysis or sentencing decisions. Reduced opportunities to identify mental illness have been attributed to poor availability of mental health services, within court settings (Birmingham et al, 2001). Despite recognition of mental health related needs among offenders Shaw (1999), reported poor
identification and failure to link to services (Joseph and Potter, 1993). Table 3 displays studies about the identification of mental illness within court settings.

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Type of Study</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusions &amp; limitations</th>
<th>How relates to PhD study</th>
</tr>
</thead>
<tbody>
<tr>
<td>James et al (1991)</td>
<td>Prospective case control study</td>
<td>Investigation of psychiatric liaison schemes in Magistrates’ Courts in London. 80 remand cases receiving psychiatric assessment through a liaison scheme comparing them to 50 placed on hospital orders by Magistrates’ Courts after being remanded for psychiatric reports.</td>
<td>Average number of days between arrest and receipt of a psychiatric report in court was 33.7 days. Arrest to admission to hospital was 50.8 days. Reduced by liaison scheme to 5.4 days (arrest-report) and 8.7 days (arrest-admission) respectively.</td>
<td>Reduction in time offenders were in custody, generating cost savings. No controls included to enable cross-comparison of variables such as therapeutic interventions.</td>
<td>Demonstrated the effectiveness of mental health assessment and diversion at court stage</td>
</tr>
<tr>
<td>Joseph et al (1993)</td>
<td>Evaluation case study of court diversion scheme</td>
<td>Eighteen month study period; 201 referrals received for 185 individuals. Referrals predominantly male, single &amp; homeless.</td>
<td>High rates of previous mental health service contact including former hospital detainments. Over 1/3 (n = 79; 39%) had schizophrenia. Most committed repetitive low level offending, only 6% with previous imprisonment of 1 year. Following assessment, 25% hospitalised, 25% return to custody and 50% released. 29% of cases with no further action.</td>
<td>Individuals accessed hospital quicker via the court psychiatric service than prison based assessments averaging 5.8 days (SD=6.8 days). The study was limited by being London based not generalisable to different populations or geographical areas. Largely descriptive case series with no control group to compare, contract and test findings.</td>
<td>Demonstrated the value of mental health assessment at court stage for referral to appropriate mental health services.</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Type</td>
<td>Overview</td>
<td>Findings</td>
<td>Conclusion</td>
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<td>Babbins et al (1994)</td>
<td>Case study</td>
<td>Investigated whether high numbers of individuals with mental illness were missed by an established court diversion scheme at Liverpool Magistrates’ Court</td>
<td>Sample 136 arrestees, male (87.5%), white/Caucasian (90.4%), average age of 26 yrs. 1/3 are stable, 7.5% homeless. Previous convictions (91.9%) &amp; 83.8% unemployed. 93% have a GP, significantly higher than reported by Bruton et al (2006).</td>
<td>High levels of substance misuse and low levels of undetected mental illness. Likelihood of remand if homeless was an important factor not discussed within the study. Conclude CJL operates for mental illness and inequitable provision exists for individuals with substance misuse problems. Demonstrates high levels of undetected mental illness among defendants at court due to police and court staff not having appropriate training. Confirms difficulties for dual diagnosis clients.</td>
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<tr>
<td>Greenalgh et al (1996)</td>
<td>Conducted a three-month pilot study</td>
<td>Identification of mental illness among court attendees in Leeds. N=57 assessed by psychiatrists. Most were male (89%), unemployed (82%) and average age 26 yrs. Diagnoses - personality disorder (12%), schizophrenia (7%), bipolar disorder (7%). Almost 50% substance misuse problems</td>
<td>Referral to MH outpatient most common outcome. Lack of mental health beds and specialist approved premises for the mentally ill. 43% not guilty and 30% remanded or convicted. A greater number may have been considered for bail if appropriate accommodation was available in the community.</td>
<td>Small pilot study needs to be replicated on a larger scale involving more court sites to validate the findings. Highlights the lack of options for mental health and specialist hostel support.</td>
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<tr>
<td>James et al (2000)</td>
<td>Case study</td>
<td>264 consecutive referrals over 12 months were examined, custody records, Court recordings, remand data and hospital admission reports were concurrently reviewed from a psychiatric diversion scheme based at a Magistrates Court in London.</td>
<td>The seriousness of the charge did not markedly influence rates of admission. Findings suggested CJL was successful but may be more suitable for court settings, with psychiatric assessments completed complementing existing police station based arrest and referral diversion schemes.</td>
<td>Demonstrates how high quality mental health assessment can divert people from court into appropriate mental health treatment.</td>
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<tr>
<td>Study (Year)</td>
<td>Study Design</td>
<td>Focus</td>
<td>Findings</td>
<td>Highlights</td>
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<td>Kingham et al (2005)</td>
<td>Retrospective case analysis</td>
<td>Examination of the identification of mental illness and the short-term outcomes for defendants. 1830 defendants were included. Three year study period from 1 January 2000 to 31 December 2002. CJL scheme in East Sussex.</td>
<td>79% referred for diversion at arrest stage. 541 (30%) no formal mental health diagnosis, 567 (31%) drug or alcohol problems, 200 (1%) schizophrenia, 134 (7%) depression and the remaining had personality disorder, learning disabilities and other mental disorders. Diversion recommended for 858 individuals.</td>
<td>Highlights the usefulness of diversion to a range of mental health and substance misuse services.</td>
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<tr>
<td>Shaw et al (2009)</td>
<td>Case study</td>
<td>Investigation of prevalence of mental illness, rates of detection by non-mental health staff and the proportion of defendants requiring diversion at Manchester Magistrates’ Court. Serious mental illness was detected in 99 individuals, 1.31% of defendants. 6.57% in custody overnight. 34 (34%) with schizophrenia/other psychoses; 55 (55%) depression. Only 14 (14.5%), of (N=99) mental illness detected by police or court staff.</td>
<td>Limited detection by police or court staff. Comprehensive data but short study period. Recommended the use of standardised screening and training for court staff. No discussion of implications of mental illness not being factored into court justice proceedings.</td>
<td>Highlights poor detection of mental illness by police and court staff, emphasising the importance of standardised assessment and training.</td>
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<tr>
<td>Magill et al (2010)</td>
<td>Evaluation study</td>
<td>Evaluation of Crown Prosecution Services’ (CPS) role in decision making regarding mental health defendants. Also process of information sharing. Use of focus groups in four selected CPS areas during 1&lt;sup&gt;st&lt;/sup&gt; January &amp; 30&lt;sup&gt;th&lt;/sup&gt; June 2009. 65 CPS case files in sample, 51 male, 37 white, 12 Black, 4 Asian and one mixed racial background. 48 cases charging decision progressed to prosecution. Of the remaining 9 cases; 6 showed mental disorder was not factored into the charging decision. The final three cases suggested failure to clarify the offender's mental disorder.</td>
<td>Information on defendants’ mental health was often sparse. Application of data protection and confidentiality was a barrier to effective information sharing. Limitations - the reliability of CPS electronic data systems to select representative or randomised cases</td>
<td>Demonstrates effective working relationships between CPS, police and mental health staff can generate positive outcomes in court settings.</td>
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</table>
2.6.i. Summary

The court process is important within the offender pathway to support the identification of mental illness to enable diversion and/or appropriate sentencing decisions to be made. Chung et al’s (1999) study highlighted that despite identification of mental illness and diversion to mental health care, there are difficulties maintaining engagement. The researchers investigated living patterns, quality of life, types of after-care and psychological well-being following court diversion of offenders at one court diversion scheme in England. Sixty-five offenders were followed up for a six-month period and 22 for twelve months. Information was documented on transient living patterns at two designated study intervals. At 12 months only 22 offenders were registered with a GP and significantly fewer attended hospital outpatient care. Hedge’s (2000) evaluation of court diversion in the Thames Valley area highlighted the limited engagement by individuals in mental health services following diversion. Both statutory and non-statutory services excluded or worked ineffectively, particularly over the longer-term, with offenders with multiple health and needs, arguably one of the most potentially vulnerable client groups.

The lack of psychiatric reports and effective mental health interventions may result in courts remanding rather than releasing potentially vulnerable individuals with complex needs (CCJS, 2007). The remand experience provides an opportunity to identify and refer people into mental health services. However, mental health needs are often missed among remand prisoners, which is the next stage of the offender pathway and is discussed in the next sub-section.
2.7. Identification of Mental Illness in Prison Settings and Implications for Remand Prisoners

The literature reveals higher rates of mental illness among prisoners, especially those on remand, than in the general population, including significant levels of co-morbid disorders. Evidence indicates symptoms, if not detected early, may continue untreated throughout incarceration and following release into the community (Birmingham et al, 1998; 2006, Coid, 1988; 1991; Dell et al, 1993).

Most prisons use the standardised health screening tool for identifying the health needs of prisoners (Birmingham and Mullee, 2005). Birmingham et al (1996) conducted a large prevalence study of mental disorder among remand prisoners at HMP Durham, utilising a case study approach. Sample size of 669 men of 21 years and above. Data collection included levels of accuracy of identification of mental illness and resultant outcomes such as number requiring hospital admission. Findings were that reception screening identified that 168 (25%) of the sample required psychiatric treatment, 148 (22%) having more than one disorder, with a further twenty-four showing acute symptoms of psychosis. Fifty of the sample required urgent intervention, but only seventeen of those were placed on the hospital wing, after identification of mental illness. Sixteen of the sample needed urgent transfer to hospital. This study demonstrated the high prevalence and limited recognition of mental disorder among remand populations. The case study approach has limitations, which were not fully discussed, such as limited clinical entries and inaccurate inmate health records. The use of self-report methods also reduced validity and reliability.
Recognition and management of mental health conditions among prisoners, specifically those on remand could be improved through policy, procedures and communication between mental health and criminal justice agencies. The Data Sharing Review (Clark and Dugdale, 2008) stressed the importance of effective multi-agency working for optimal care pathways and continuity of care within the CJS. After diversion from police stations, courts and remand prison there are further problems in maintaining engagement after release, which is discussed in the following section. The stages of the criminal justice pathway; of arrest, court, remand and prison have been discussed in relation to both prevalence and identification of mental illness. The literature has highlighted poor identification at all stages. If undetected at these earlier stages mental illness can go unrecognised through to an individual’s return to the community.

2.8. Release into the Community

Release from the police station or prison are vulnerable points in offender care pathways (Birmingham et al, 1997; Bradley, 2009, Shaw et al, 2009). NACRO (2005) and Revolving Doors (2006) raised concern about the lack of continuity of care for released prisoners with mental health problems. Most offender health studies were related to serving prisoners’ experiences of mental illness with relatively few examining care after release. The Prison Reform Trust reported 30% of people released from prison as homeless; despite research estimating stable accommodation reduced re-offending by 20%. Forty-nine percent of prisoners with mental health problems are released from prison without an address. Release can exacerbate symptoms and potentially elevate the risk of suicide (Appleby et al, 1999; Farhall et al 2003; Pratt et al, 2006 and Binswanger et al, 2007).
The importance of improving offender health after release from prison as a service development priority is well illustrated by Verger et al, (2003). The study examined the mortality rates of 1305 released prisoners during 1997, using a sample of 86.4%. Compared with the general population, ex-prisoners mortality rates were substantially higher in both the 15-34 and 35-54 age groups (3.5-fold and 10.6-fold). They noted the elevated risk of death by overdose as being 124 and 274 times higher in the same age groups respectively. The key findings and recommendations were for preventative and follow up care in the pre-release period to encourage prisoners’ on-going engagement in health care in the community.

A number of studies have highlighted increased levels of mental health need among offenders and poor access to community mental health services (Hatfield et al, 2004, Rennie et al, 2009; Sirdifield, 2012). In practice, many people with mental health problems ‘fall through the net’ in the community as they become the responsibility of neither mental health or criminal justice services (Harris, 1999), resulting in inconsistent interventions from both sectors, poor communication and limited outcomes. Many individuals resort to using health services in a crisis-driven way, with high use of non-routine services such as Accident and Emergency (A&E), (Frank et al, 2013; McGilloway 2004; Jackson, 2005). These individuals may have complex health and social needs, high rates of unemployment, substance misuse, violence, self-harm and risk of death from all causes (Cox et al, 1995; Sattar, 2001; Pratt et al, 2006; NCI, 2006; Draine & Herman, 2007), yet have inconsistent patterns of engagement in services, with fewer than 50% of prisoners registered with a general practitioner (Bruton et al, 2006).
2.9. Continuity of Care and Transitions

Continuity of care between prison and the community is limited. Meltzer et al (2002), identified 140 prisoners with psychosis during imprisonment; after release only 23% were in contact with mental health services, highlighting problems in accessing support for community offenders (CfMH, 2008). Lennox et al’s (2012), prospective longitudinal cohort study of prisoners assigned to Mental Health Inreach Team caseloads, across five UK prisons, examined the management of released prisoners. Information from inmate medical records and accompanying in-reach files were used to determine the level of contact with mental health services prior to sentence, during and post sentence. Prior to sentence 95% of the 137 sample had prior contact with mental health services. 54 (40%) had no contact with mental health services during custody. During the 6 month study period 53 (39%) of the 137 sample were released from prison, but only 4 (20%) maintained contact with a Community Mental Health Team (CMHT). Findings highlighted the need for continuity of care at the points of transition, including transfer and release. The study strengthened the need for care following release, among remand and convicted groups incorporating housing, benefits and accommodation assistance. The importance of community support for remand prisoners released without further charges was highlighted for the first time. The study limitations were that prisoners’ medical records were largely based on self-report introducing responder bias. Furthermore, the insufficient sample size in contact with community mental health teams (n=4) limited further analysis of service contact. Follow up after release was difficult to sustain due to the level of mobility of the study group.
Re-offending rates among the mentally ill are high, with seven out of ten offenders re-convicted within two years of leaving prison (Lennox et al, 2012). Community sentences evaluate more positively with re-offending rates being closer to five in ten (Lennox et al, 2012). However, this means between half and three quarters of convicted individuals re-offend within two years (Cloyes et al, 2010). The cycle of revolving door prisoners is apparent; consideration about how to intervene to stabilise mental health, improve engagement and reduce re-offending rates is required (Revolving Doors, 2002). Ross & Jang (2000) and Yanos et al (2007) emphasised the benefits of consistency of support, particularly during service transitions as essential to successful community reintegration.

2.9i: Transitions

Transfer and discharge remain the most vulnerable parts of service user care pathways (Royal Pharmaceutical Society, 2011). Anxiety, uncertainty and inadequate preparation may exacerbate deterioration and relapse (Kripalani, 2007). Poorly executed transitions could result in significant problems including relapse, errors, omissions or duplications in services that elevate physical, psychological and social concerns for service users.

The concepts, complexities and consequences of care transitions and specifically for people with mental health problems in the criminal justice system are discussed in Paper 1 ‘Mind the Gap: Improving Transitional Care for Mentally Disordered Offenders Leaving Custodial Environments’, published in the International Journal of Psychosocial Rehabilitation, Vol 18(2) pp.101-112. This paper highlighted effective transitional case management strategies, successfully implemented in other health sectors such as cardiac care, paediatric diabetes and
orthopaedics and how transitional case management programmes may be beneficial for people with mental health problems transferred or released from custodial settings. Careful consideration of care transfer processes is important for continuity of care.

Evidence about service users’ increased vulnerability following discharge from services has been reported, showing increased risk of suicide during the immediate post-discharge period (Appleby et al., 1999; Crawford, 2004; King et al., 2001). Associations between suicide and ‘unplanned’ discharge, short admissions and the length of time between discharge and follow-up emphasise the importance of preparation to reduce the negative impact of discharge. Discharge from secondary to primary care is also a significant point in a person’s treatment. As well as ensuring that service users and their families have information about medication and other treatments, details about how they access secondary care services in the future is required. Problems can arise in relation to inadequate information sharing between primary and secondary care services, highlighting the need for continuity of care to be assured. Breakdown in continuity of care can hinder individuals’ interest and willingness to access services, therefore affecting future engagement. In recognition of these difficulties, national policy in the form of the Care Programme Approach (CPA), was established to improve co-ordination of mental health care, which is discussed in the next subsection below.
The Care Programme Approach (CPA) was introduced to services in 1991 (DoH, 1990) to provide a framework for delivery of mental health care, comprising of four main components:

1. Systematic assessment of health and social needs of people eligible for specialist mental health services
2. Formation of a care plan that identifies the health and social needs and relevant care providers
3. Nomination of a key worker to maintain contact with the person and monitor all aspects of care delivery
4. Regular review and agreed changes to the care plan

Revisions were made to the CPA in 1999 to integrate with local authority arrangements for care management and to form a single approach for adults (18-65 years old) applied in all settings for use by health and social care staff (NHSE & SSI, 1999). Following review, CPA support packages were condensed into one level to cater for service users with multiple care needs, requiring inter-agency co-ordination and intensive interventions to reduce risk of harm to self or others and avoid disengagement from services.

The CPA is intended to enable a ‘seamless service’ for hospital and community, and between different community teams. Fundamental to the CPA is the role of the care co-ordinator in building therapeutic relationships with service users and supporting access to assessment, planning, treatment and review of the care plan. Historically the role of the care co-ordinator has not been clearly defined and consequently has been subject to local interpretations and practice.
Furthermore, although the CPA has been integrated within a case management function this has been tailored to the allocation of resources rather than the provision of a therapeutic model of care. Consequently local delivery of CPA may not include effective case management for service users requiring intensive interventions, from a variety of professionals and agencies, resulting in service users remaining on the fringes of service provision.

2.11: Intensive Case Management in Mental Health Services

Intensive case management (ICM), originated in the USA and has been the subject of many policy discussions and developments across health and social care sectors in the UK and USA for over a decade (Applebaum and White, 2000). A system of case management was introduced within the NHS in UK to manage the care needs of people with long term health conditions, including mental health problems. There are a number of terms used to describe similar types of approaches including ‘case management’, ‘care management’, ‘intensive case management’, ‘assertive case management’ and ‘active case management’. A wide range of literature exists on case management, all of which cannot be comprehensively examined and discussed within the parameters of this thesis. Three case management approaches (Assertive Community Treatment/Outreach, Intensive/Case Management and Critical Time Interventions) and potential application to ‘offenders’ with ‘complex mental health needs’ are discussed within this section.

The importance of case management approaches were highlighted by a number of studies in the UK, USA, Australia and New Zealand (Ventura et al, 1998; Lovell et al, 2002). Burns et al (1998), conducted a systematic review of the efficacy of intensive case management (ICM), in reducing re-hospitalisation among people with serious mental illness with previous increased
hospital usage. The authors reviewed randomised controlled trials, involving meta-analysis and meta-regression. After performing a review of the literature the authors included 29 studies meeting the inclusion criteria. They identified factors that may affect efficacy of intensive case management in reducing rates of hospital admission among a group of patients with severe mental illness. Random effect meta-regression was used to examine relationships between hospital stay and co-variants. ICM was reported to reduce hospital stay with a sample requiring a high level of hospital care. They reported using an ICM model such as the UK equivalent Assertive Outreach Teams (AOT), as potentially successful in managing this group of patients. Assertive Outreach reduced in popularity after Marshall et al’s (1998), study demonstrated AOTs as no more successful than ‘treatment as usual’ available from Community Mental Health Teams (CMHT), and costing considerably more to provide. This led to AOTs being disbanded, however, AOTs may have been beneficial in meeting the needs of a group of patients with serious mental illness requiring frequent or lengthy periods of inpatient care. Gaps have emerged in service provision for this client group. Burns et al (2001) reported practitioner competencies, fidelity and consistency of approach as the most important aspects to the model. Burns et al’s (2001) review did not include any criminal justice or substance misuse studies to examine the AOT approach for individuals with such complex needs.

Burns et al (2007) updated the systematic review of intensive case management (ICM). They investigated why previous clinical trials of ICM with people with severe mental illness reported inconsistent effects on levels of hospital care. They reviewed 1335 abstracts with a total of 5961 participants. Of these, 49 randomised controlled trials were eligible for inclusion and 29 provided comprehensive data sets. They included comparison of high or low intensity
programmes, including assertive community treatment approaches. They separated multi-centre trial data into site specific results. Using multivariate meta-regression, mean days per month spent in hospital was the dependent variable. They reported reduction in hospital bed usage and suggested that ICM may decrease the need for inpatient care, in patients with a history of re-hospitalisations.

Marshall et al’s (1998), meta-analysis examined models of case management effectiveness, reporting individuals receiving ICM as more likely to remain in contact with community mental health services. Limitations were the inclusion of studies with participants randomly assigned to one treatment model or another, which resulted in only six being included. Whilst this criterion ensured the inclusion of high ranking studies of substantial rigour it was restrictive. Marshall and colleagues could have compared domains of care within a wider sample as opposed to each model as an entirety. Furthermore, Marshall et al’s findings of ICM increasing admission rates were strongly refuted in a later study by Ziguras et al (2000), replicating Marshall’s original review adopting wider inclusion criteria to include non-randomised studies for analysis of case management approaches versus standard care. Ziguras and Stuart included more studies spanning the years 1980 to 1998. Overall forty-four studies of which thirty-five compare assertive community treatment or case management with usual care and a further nine compared assertive community treatment with clinical case management. The results were quantitatively combined and compared to the results of mental health care without case management. Positive ratings for case management in relation to the domains of ‘family burden’, ‘service user and family satisfaction’ and ‘cost of care’ are found. They reported increased rates of hospitalisation among the ‘clinical case management’ group, but lower in the assertive case management and
ICM groups, contradicting Marshall et al’s earlier assertions. Ziguras and Stuart reported the frequency of admission rates as higher but actual time spent in hospital was lower. Ziguras and Stuart concluded that all forms of case management produce positive effects in relation to actual bed nights spent in hospital. Increased rates of admission could be due to serious symptoms, limited social support networks or staff taking preventative action before serious relapse. Ziguras and Stuart reported improved rates of service engagement, mental health symptoms and social functioning in studies investigating ICM and assertive community treatment. Importantly, the two reviews negated to examine the needs and differences among participants in the reviews, for example, the presence of ‘homelessness’ and ‘co-morbid substance misuse’ which had an effect on items such as rates of hospitalisation, engagement and treatment effectiveness. Without such examination it was difficult to determine which approach was useful for what type of service user presentation. Ziguras and Stuart concluded both forms of case management were more effective than standard care and assertive case management as positive.

In 2005, Udechuku et al investigated effectiveness of Assertive Community Treatment (ACT) model for a mentally ill sample group. They provided descriptions of ACT and examined its effectiveness in reducing rates of hospital admission. Forty-three clinical case notes were examined on a single census day in September 2001 and admission episodes, including length of stay were extrapolated. Participants comprised 79% diagnosed with schizophrenia and 76% with co-morbid substance misuse. Outcome measures were recorded at baseline and post introduction of ACT. Improvements in service engagement following ACT were not verified by standard measures. Udechuku et al concluded ACT applied in a clinical environment was effective in reducing re-admission rates in a group with persistent mental illness.
Dieterich et al (2010) conducted a systematic review concluding ICM as more effective for individuals with severe mental illness with a high rate of hospital use at baseline. The authors examined thirty-eight randomised controlled trials involving 7328 participants with the aim of comparing ICM with standard care and case management versus ICM. They included studies for adults with severe mental illness aged between 18-65 years. In twenty-four randomised controlled trials (n=3595 participants) ICM generated minimal effect on reducing rates of hospital admission, engagement and personal functioning. They noted weakness in the data making it difficult to measure ‘quality of life’ characteristics. The authors found no compelling evidence that ICM was better than standard care.

The above studies have not examined ‘criminality’ as a demographic but clearly there are similarities in ‘frequent hospitalisation’ and ‘repeated imprisonment’ and therefore ICM may be beneficial to offender populations.

2.12: Intensive Case Management (ICM) for Offenders with Mental Health Problems

The risk of people with mental health problems who have offended ending up in a continuous cycle of relapse, hospitalisation, offending and imprisonment is a feature of available research in this field. This is examined further in *Paper 2 Slipping through the Net: A Critical Analysis of ICM for Offenders, submitted to Journal of Offender Rehabilitation and currently in review*. The paper summarises the literature contained in this chapter, exploring prevalence and identification in relation to remand and sentenced prisoners and the implications following release.
Hartwell (2003) in Boston USA, collected data from 247 offenders with mental health problems released from prison, to identify and distinguish characteristics. Outcomes included return to prison, admission to psychiatric hospitals and remaining in the community. Mental health, socio-demographic, criminal history and service variables were compared across a range of outcome categories with a focus on those admitted to hospital and re-sentenced to prison. They reported different levels of mental health and criminal justice agency contact in the hospitalised and re-sentenced in comparison to the engaged, community group. They concluded that those released from prison after committing less serious acquisitive offences were more likely to return to prison, whilst those released after more serious offences such as violence were more likely to be admitted to psychiatric hospital after release from prison. The study did not include possible explanations for this assertion i.e. those who commit acquisitive crimes may abuse substances after release increasing rates of re-conviction; whereas the serious offending group may be susceptible to mental illness due to factors such as remorse or incarceration, resulting in admission to hospital. Another consideration is when services and supports are developed for offenders with mental health problems these invariably increase supervision. Risk factors for repeat offending following offences such as murder are considerably lower than acquisitive offending, which are not discussed within the paper. They conclude implications for the cumulative effects of engagement with the criminal justice system and progress through institutions.

McCoy et al (2004) revealed the importance of ICM for released prisoners with mental health problems. The authors stated people with mental illnesses released from prison were high risk of
psychiatric de-compensation and associated re-arrest. The authors described an Assertive Community Team (ACT) prison linkage scheme that won an American Psychiatric Association Gold Award in 2001. Based on semi-structured interviews with the first 24 participants, including pre and post programme data they illustrated how released prisoners experience factors that contribute to recidivism and de-compensation. They studied the first twenty-four people during the infancy stage of the programme within the prison which may have generated different results than participants randomly assigned to a longer running programme. Results suggested it was possible to identify, engage, and retain people in treatment. They concluded the programme should be expanded and replicated across all prison sites. However, the programme had no independently evaluated results.

Another form of case management for offenders is the Re-entry Programmes, originating in the US to support individuals leaving prison. The challenges for offenders reintegrating into society are noteworthy (Baer et al. 2006; Mallik-Kane & Visher 2008), particularly in relation to accessing appropriate health and social support (Kouyoumdjian et al, 2015; Theurer & Lovell 2008). Young et al (2015), highlighted the general practitioner’s role as gateway to link released prisoners, with complex needs into services. Unmet health and social needs, over the longer term, produced a detrimental effect on individuals’ well-being, stability and associated re-offending (Mears et al, 2012; Pager 2003; Weiman 2007; Western 2002). The greater the frequency and duration of incarceration experienced by individuals the more difficulties encountered, particularly in relation to housing, education and employment opportunities (Travis 2000). Theurer & Lovell (2008) and Skeem & Louden (2006) purported that a multi-disciplinary approach, comprising of both criminal justice and health staff was most effective in
addressing complex mental health needs and reducing recidivism.

Re-entry schemes were established to optimise continuity of care for prisoners with mental illness (Baillargeon et al. 2009; Cloyes et al. 2010). Re-entry programmes aim to engage with individuals in advance of release and provide intensive, multi-disciplinary support to reintegrate prisoners into the community (Arnold-Williams et al, 2008; Baer et al. 2006; Mallik-Kane & Visher 2008). Evidence of efficacy in re-entry programmes, was highlighted by the Burke & Heaton (2004) randomised control trial of effectiveness of a nine-month re-entry programme. Of the 548 sample; cases included male 55%, female 45% and controls male 63% and female 36%. Cases and controls were matched on demographic, criminogenic and diagnostic variables. During the 12-month trial phase 46% of the controls re-offended, in comparison to 35% of the cases (p < .05). Cases spent less time in custody than the control group. Significantly, positive results did not diminish after withdrawal of the programme. Whilst the study highlighted potential benefits in re-entry programmes, evaluation of effect on mental health stability and recidivism over the longer term is required.

Baillargeon et al’s (2009) conducted a retrospective cohort study of 79, 211 prisoners incarcerated between 1st September, 2006 and 31st August, 2007. Demographics, medical information and committal history for the preceding 6 years was collected. The results implicated serious mental disorders such as psychotic illnesses as contributory to an increased risk of multiple incarceration. Bipolar disorder was associated with 3.3 times greater likelihood of four or more incarcerations. However, the relevance of substance misuse and lifestyle factors within the bi-polar population was not fully explicated. The importance of comprehensive re-
entry programmes, including pre and post release support was conveyed. Cutcher et al’s (2014) study of 1,324 prisoners examined health-related outcomes over a six-month post-release period. Like Baillargeon’s study they emphasised the importance of transitional re-entry programmes, but stressed the need for flexibility within programmes commensurate with need.

Farabee et al (2006), conducted a large quasi-experimental evaluation of a 90 day re-entry programme for released prisoners with mental illness. The sample size of 60,912 included cases (N = 32,322) and controls (N = 28,590) with mental health problems. Controls did not receive pre-release assessments and support. Findings demonstrated offender contract prior to release positively impacted on engagement with community mental health services and reduced re-offending rates over 12-months post-release. The value of relationship building pre-release was not fully explicated within the study; rather benefits were attributed to improvements in referral systems.

Similarly, Critical Time Intervention (CTI), another form of ICM, is supported by a consistent body of evidence spanning over ten years, associated with improving continuity of care and community assimilation among ‘hard to engage’ populations.

2.13: Critical Time Intervention (CTI)

Critical Time Intervention (CTI), was developed through collaboration of mental health clinicians and researchers, working at the Franklin Avenue and Fort Washington Armoury mens shelters in New York City during the mid-1980s and early 1990s. CTI is an adaptation of ICM emphasising time-limited, intensive support at times of transition, such as release from prison or
hospital. The purpose of CTI is to establish a stable support network in the community, forging effective links with local services, including housing and mental health services for people with additional vulnerabilities because of limited networks of family and friends.

Susser et al (1997), investigated men discharged from an on-site psychiatric programme at a mens shelter in New York between 1991 and 1993. The study duration was eighteen months. The study sample was ninety-six men, all with severe mental illness. Participants were randomly assigned to receive treatment as usual (TAU) or CTI. CTI was provided for a period of nine months, after which the group return to TAU for the remaining nine months of the study. Staff were trained to deliver CTI in a systematic way through a specially designed training manual. Complete follow-up data on homelessness was obtained on 98% of the sample. Susser et al reported the average number of homeless nights over the 18 month study as 30 for the CTI and 91 for the TAU group. During the last month of follow-up, four (8%), of the CTI and 11 (23%), of the TAU group were homeless. Extended homelessness (more than 54 nights) occurred in 10 (21%), of the CTI and 19 (40%), of the TAU group. Following the nine months CTI period and reverting back to TAU the differences between the groups did not diminish. This was a significant finding as the effects of programmes rarely exist after the end of the intervention term (Muijen et al 1992). Risk of homelessness was three times higher in the TAU than the CTI population. However, the standard of services provided to people in the area of study was considerably better since the ‘New York/New York’ agreement in 1990, which expanded housing for homeless persons with severe mental illness. Therefore, the homelessness nights for both groups could arguably be much higher in another area. To have run this trial across more than one site would have provided a more accurate interpretation of the comparative results for
both interventions.

Susser identified ‘discharge’ as the weakest part of the health pathway and stressed the importance of this being addressed to ensure continuity of care between hospital and the community (Susser et al, 1997). Similarly prisoners with mental health problems demonstrated substantial improvements whilst in prison and these benefits were lost by failure to engage with service after release (Lennox et al, 2012; Shaw et al, 2009). The importance of the relationship between the CTI practitioner and the patient was emphasised. The main strength of the evidence in support of CTI was that it supports development of social networks and is relatively inexpensive compared to TAU. The study was designed to meet the needs of a group of psychiatric patients: homeless men, over half of whom had substance misuse problems and complex needs. Traditionally this group of patients have been excluded from mainstream services due to limited help-seeking, poor attendance and inconsistent medication adherence. This study group reveals similarities with mentally ill offenders, in terms of the problems and chaotic lifestyles present during initial community resettlement after release from prison.

Jones et al (2003) conducted a cost-comparison of CTI with TAU, building on the preliminary cost analysis conducted in 1994. Costs of service care, (including acute care, outpatient, housing and shelter and criminal justice services) provided to participants over the duration of study (18 months) were calculated for the CTI and TAU groups totalling mean costs of 52,374 for the CTI group and 51,649 dollars for the TAU group. The CTI group spent significantly fewer homeless nights than the TAU group (32 nights versus 90 nights) and the potential savings to the state of not having to pay to reduce homelessness, which was calculated to be 152 dollars or more per
night. They concluded the CTI group exhibited greater net housing stability benefit than the TAU. The significant difference over the long-term is the CTI group, whilst having spent less homeless nights, has been empowered to move away from perpetual homelessness and reliance on emergency services at critical times.

Herman et al (2000), examined the impact of CTI on the symptoms of schizophrenia, namely positive, negative and general psychopathology. The sample comprised 76 participants with a complete data set. Symptom severity at baseline and at 6 months was assessed using the Positive and Negative Syndrome Scale (PANSS). Results suggested CTI was associated with a statistically significant decrease in negative symptoms at the 6-month follow-up, but insignificant effect on positive or general psychopathology symptoms. This demonstrated CTI impacts on self-perception and relationship with the world. The authors suggested ‘CTI may contribute to cognitive re-mediation, by assisting the reactivation of pre-frontal cortical functions involved in these cognitive activities’ (Herman et al, 2000), although this concept requires further investigation.

Further studies have been undertaken with homeless women in 2007 and homeless veterans with mental illness leaving inpatient care (Kasprow and Rosenheck, 2007). The project was based at eight veteran assisted medical centres, applying a non-randomised, pre-post cohort design, with follow-up at three monthly intervals for a one-year period. Sites selected on the basis of historical risk of homelessness and local medical centre managers interest in supporting the project. Inclusion criteria included diagnosis of mental disorder (schizophrenia or other psychotic disorder), recent homelessness or imminent risk of homelessness (based on client self-
report), intention to remain in the geographical area for at least a year, and agreement to participate in follow-up interviews. A total of 278 participants were recruited during phase 1 (TAU), and 206 in phase 2 (CTI); n= 484 participants. Baseline interviews were conducted shortly after recruitment and averaged 1.0–1.5 hours. Case managers conducted interviews in both phases, following instruction and training on interview style and recording, provided by the CTI originators.

Participants provided written, informed consent and were paid $10 for each interview. Demographic characteristics including age, ethnic origin, civil status, education, and military service history were collected. Housing status measured by the number of days in the past 90 that clients were homeless (living in shelters or on the streets), living in an institution (hospital, prison), or housed (living in their own home or staying with others). Recent alcohol and drug use and co-existing mental health symptoms were assessed using the Addiction Severity Index (ASI). CTI case managers completed monthly reports recording each participant’s service use including type of service, duration of contact, reporting at quarterly intervals.

Participants in phase 1 and phase 2 were compared on baseline characteristics. Follow-up rates for duration of the study in phase 1 averaged 56% (625 of 1,112 possible interviews) and in phase 2 - 56% (459 of 824 possible interviews). The duration of CTI programme for the CTI group (phase 2) was six months, shorter than the nine month time-frame of the original model. The average duration of CTI services was reported as approximately seven months (212 days), with 53% involved for 180 days or less. Visits averaged five contacts during the first month and less thereafter. The most common activities during the first month were referring the client to
other agencies, for example, benefits and treatment services (71%), providing housing assistance (49%). More specialist interventions such as substance misuse counselling (35%) or psychotherapy (22%) were less frequently undertaken.

Findings were consistent with the original study by Susser et al (1997) generating substantial reductions in homeless nights sustained beyond the provision of CTI. However, potential limitations were not acknowledged, such as reports completed by the CTI manager with no independent reviewer based at site. Furthermore, participants were not randomised introducing potential selection bias. The two study groups showed differences in significant areas such as dependent drug taking as more prominent in the TAU group. Substance abuse and mental health was assessed by self-report with no standard instruments or qualitative guidance which was a flaw in the study. The case manager conducting interviews introduced potential reporting bias. The authors asserted bias was minimised by stringently evaluating all aspects of the model consistently using mixed-model regression analysis to retain as much statistical power as possible.

CTI was reported to improve frequency of family contact and relationships in a study involving an 18-month follow-up period (Tomita, Lukens, & Herman, 2014). This provided support for the hypothesis that CTI may strengthen clients’ social networks, including support provided by family members. A further analysis of data from this trial examined the impact of CTI on community integration. Findings did not demonstrate a significant association of improvement in social integration through CTI (Baumgartner & Herman, 2012). The study was limited by the statistical measures employed.
Two studies have examined the use of CTI with released prisoners (Jarrett et al, 2012) and (Lennox et al 2012). Jarrett conducted a feasibility study to determine whether CTI during the post-release period may support offenders’ access to health, housing and welfare services in the community (Jarrett et al, 2012). The study took place in 2007 and involved prisons in London and Manchester. Sixty prisoners were randomised, with outcome measures completed on 23. The findings demonstrated improved engagement in services among the CTI group; however, the study was limited by the small sample size. Lennox et al’s prospective, longitudinal, cohort study examined the proportion of the prisoners (N=137) from the mental health inreach team involved with the community mental health team (CMHT) following release from prison. The findings at six months follow-up showed that out of the 53 (39%) released, only four individuals were in contact with the CMHT. The need for robust discharge planning and more active through-care support was purported. Study findings were limited by the small sample size, particularly at the six-month interval. Findings highlighted the complexities of engagement with this population in community mental health support at a critical, transitional point.

In summary, CTI promotes continuity of care during transitions, by effectively linking service users to community services (Draine & Herman, 2007). Whilst CTI establishes community links, the programme does not specifically include a social network approach. This inclusion would identify the composition, strength and functionality of ties in networks, highlighting gaps within individuals’ support networks. Thus enabling improved targeting of transitional interventions, also involving service users and family, in both care planning and service delivery. The next section provides an overview of social networks and their relevance to people with mental illness and offending populations.
2.14. Social Networks

A body of evidence exists about the social networks of people with mental illness, demonstrating impact on access and engagement with mental health services (Pinto, 2006). Individuals are influenced by relationships with family and friends, which in turn affects the relationships formed with others, including professionals and ultimately recovery from mental illness (Falloon, 2003). Studies demonstrate that network structures including size, strength of ties, density, reciprocity and functionality influence pathology and rates of hospitalisation (Holmes-Eber & Riger, 1990; Maulik et al, 2009; Pinto, 2006). The networks of people with acute mental illness tend to be dominated by family members and non-reciprocal relationships (Rosenfield & Wenzel, 1997). Social support networks comprising largely of family members may foster intense and familiar forms of support, which may be crucial to those involved in the criminal justice system.

Holmes-Eber & Riger (1990) found that those with long-term mental illness and frequent or lengthy hospital admissions had fewer friends and relatives remaining within support networks. Friends and family are replaced either temporarily or permanently by people met through the mental health system that essentially offer short-term relationships (Breier & Strauss, 1984). This suggests people with mental illness have more dynamic and compromised social networks, which is associated with increased isolation and loneliness (Perese & Wolf, 2005). This was apparent in Hamilton’s study of men diagnosed with schizophrenia, who had smaller social networks which showed more dysfunctional relationships than those with less severe symptoms (Hamilton et al, 1989).
Social network structures provide understanding about sharing information and support within networks. Low density networks comprising of weak ties, where people are less involved with one another can facilitate linkage to high-density networks of strong-tie members who are close or kin-related (Granovetter, 1983). Such associations with weak ties can prove to be highly effective in bridging between both dense and sparsely populated networks that are beneficial for network members (Granovetter, 1983). Close knit networks may be less effective in sourcing information providing highly effective and desirable support likely formed through similar attributes, activities, trust and group identity (Kalish, 2008). Close knit groups are homogeneous, but function through the connectivity of weak ties. Burt purported the disconnection between individuals generates structural holes but bridging enables greater support than available within closed networks (Burt, 2000a; 2005).

Research on the social networks of people with mental illness has substantial limitations. The main problem is that research focuses on structural characteristics such as size, density and composition which does not explain the type, quality and value of support provided by network members. Furthermore, much of the research evidence is based on self-report with assessments undertaken during acute illness and hospitalisation phases. Most of the research evidence reflects analysis of a specific time interval which cannot be generalised across different populations and time periods because people (and their networks), are individual, dynamic and subject to change throughout the process of recovery.

The importance of social networks to offenders with mental health problems has been stated to provide access to important social support, including practical advice and assistance. However,
the main area of relevance to this study is that network members can access a range of resources to support development of social capital, which is essential to health and well-being and community resettlement.

The concept of social capital has been extensively debated and contested within the literature. The main debate centres on whether social capital is a characteristic of individuals or a feature of social structures. Lin (2001) posits that individuals can benefit from transactions in social relations within four mechanisms of social capital, which may improve mental health, well-being and reduce offending behaviour.

Firstly, individuals can benefit from network membership, through access to information, expertise or guidance from network members perceived to be prominent, knowledgeable or helpful. An example, is a trusted network member (mother) raising health concerns that may prompt an individual to modify behaviour or seek professional support, and improve mental health and well-being (Zambon et al, 2010). However, this is reliant on the choice of and trust in the network member, as to whether advice is acted upon. Offenders may receive pro-social or anti-social guidance, due to selection of a particular member. For example, how to avoid high-risk people or situations, or conversely how to avoid detection and offend more successfully.

The second aspect is the power, influence and dominance of network members and the impact this can have upon an individual’s health vulnerabilities or offending-related risks (Song, 2007). Also, the material resources possessed by individuals occupying the network could perhaps support access by another member during ‘hard times’, such as unemployment or illness. This
may afford opportunities to optimise alternative or improved prospects, such as a new job or home (Lin 2001). However, at certain times, offenders may occupy less favourable positions within networks by upsetting a prominent network member potentially limiting access to resources/opportunities. The third element is the social credentials possessed by members of the network. Social credentials can improve trust between members, thus facilitating improved mental health and non-offending lifestyles. The final feature concerns the emotional impact of membership which can reinforce individuals’ self-identity and social status within groups or network settings (Song 2007), which may promote mental health and well-being or conversely reinforce status as an offender.

Relationships and bonds connect people to one another and facilitate standard-setting for all community members (Hirschi, 2004) which can lead to offenders being more disconnected, particularly during imprisonment. Relationships with significant others may become increasingly strained the further the individual becomes enmeshed within the criminal justice system. Transitions, such as leaving custody are a time when the quality of relationships with others is crucial to an individuals’ ability to resettle into the community (Maruna, 2001), and avoid further offending (Laub & Sampson, 2003; Maguire & Raynor, 2006).

2.15: Overall Summary of Literature

Recognition, diagnosis, treatment and arrangements for follow-up care are crucial to engaging service users into services during contact with the CJS. The literature highlights difficulties in identification of mental illness throughout the criminal justice pathway, and importantly at critical transition points including arrest, court, remand and release from prison. The
identification of mental illness within police stations and court settings has improved by the establishment of criminal justice liaison and court diversion services. Whilst this may improve access to mental health assessment at the earliest opportunity, there is still an absence of intensive support after release from short-term custody. Consequently, many opportunities to engage individuals in a more pro-active manner, before the development of refractory symptoms and more serious offending, are lost. The literature highlights the specific issues for those involved in the CJS, accessing and importantly remaining in contact with mental health services (Birmingham et al, 2006; McGilloway, 2004).

The literature suggests mental illness that is not identified at the early stages before reception into prison remains undetected throughout sentence and following release (Birmingham et al, 2005). This has implications for individuals’ future mental health stability, community assimilation and associated re-offending. Efforts have been made to improve the recognition of mental illness within prison settings, through the standardisation of reception screening tools, although many individuals are still missed (Birmingham et al, 2006; Shaw et al, 2009). Even those identified with mental illness in prison, experience difficulties in accessing appropriate care after release (Lennox et al, 2012). Without effective diagnosis and targeted interventions the risk of relapse and further offending remains high.

Evidence demonstrates people do not successfully access and sustain engagement with mental health services in the community as support is not delivered in an appropriate way and at the critical times (Brun and Rapp, 2001). The focus may not be on the issues that matter to people such as obtaining decent housing or appropriate benefits but instead is about completing
assessments, monitoring medication and attending offending behaviour programmes. More emphasis is required on the resources available within social networks, such as practical support, emotional well-being, information and self-identity (Vassilev et al, 2014). The importance of social networks is often disregarded by mental health and criminal justice agencies. There may be scope to include this approach within routine practice and service delivery to enhance understanding of the composition and functionality of networks and facilitate more effective targeting of interventions.

Effective engagement in mental health services involves the interplay of health and social factors and the negotiation of roles and responsibilities between service users, family, friends and mental health staff. The Care Programme Approach (CPA) was designed to orchestrate and support mental health care packages, by ensuring all eligible individuals that were assessed had a care plan reviewed regularly. However, the CPA does not proffer a clinical model resulting in a ‘one-size fits all’ approach to mental health management in the community. Service users with complex health and social needs often fail to meet the stringent, locally determined eligibility criteria, particularly for secondary mental health services.

The CPA supports the ethos of case management, however, there is little focus on care planning at critical time points when service users and their families may require and appreciate additional support. Specific transitional points such as moving into, within and from services, are times when service users are most vulnerable. More individualised and holistic care planning is required within a structured, formulated programme of care to meet the dynamic and varied needs of offenders with mental health problems.
Case management programmes benefit service users that are more vulnerable to disengagement and subsequent periods of hospitalisation. Case management could potentially be of value to service users involved in the criminal justice system as there are no care pathways to facilitate seamless transition from custodial establishments. CTI has shown promise when applied in both offender and non-offender populations. Furthermore, it provides intensive support at critical time periods when individuals are at their most vulnerable. The programme promotes relationship development, linkage to local communities and the enhancement of social capital.

Family, carers and friends can positively or negatively influence service users involvement in networks (DeFriese & Woolmart, 1992). Treatment of service users in isolation from family can impact on relationships, including with professionals. This PhD study extends this position, by considering the importance of social network influences within case management programmes. By adopting a broader health and social care approach, emphasising support at critical times, it is easier to create a contextually relevant approach for offenders in the community.

2.16: Situating the PHD Study

Many individuals become ‘revolving door’ patients or prisoners and end up being incarcerated or hospitalised for long periods of time (Morin, 1986; Howerton, 2009). This is not helpful for the individual and also causes distress and frustration to those who encounter and work with them. Diverting people with mental illness from the criminal justice system may generate a positive reduction in the number of arrests, court appearances and rates of incarceration. Recognition, diagnosis, treatment and arrangements for follow-up care are crucial to engaging
service users with mental illness into services. Without effective diagnosis and targeted interventions the risk of relapse and further offending is high. There is a need to provide mental health support and interventions in a structured and intensive way to address the wide-ranging health and social needs among this client group, particularly at transitional points such as release from custody. The existing literature does not include service users’ perspectives on mental health interventions including intensive case management. However, the PhD study design addresses this gap, by incorporating the perspectives of service users, family and staff as central to the grounded theory.

Transitional care comprising intensive, but short-term interventions aimed at improving engagement, stability, social functioning and community assimilation are required to address needs and link people into mental health services. A transitional intensive case management approach (TICM) such as Critical Time Interventions (CTI), enables all agencies to work together within a common, shared framework to provide health and social support, particularly at the arrest and remand stage to avoid repetitive offending and prolonged imprisonment. Therefore, this PhD study investigates the adaptation of CTI as a potential intervention for use by Criminal Justice Liaison and Mental Health In-reach Teams at the entry points of the CJS.

CTI provides a comprehensive programme of care for people with mental illness to support the appropriate and effective diversion and release into the community which currently does not exist. Moreover, CTI provides personalised interventions at vulnerable transitional points of the criminal justice pathway, to improve engagement in services and optimise community assimilation. The CTI literature does not currently include a qualitative exploration, nor an
emphasis on support networks, which demonstrates the contribution of this thesis to the body of
CTI literature and offender health policy and practice.
Paper I


Published
Mind the Gap: improving transitional care for mentally disordered offenders leaving custodial environments

Abstract

Topic:
Review of transitional care programmes in various health settings to determine the relevance of transitional case management for individuals with severe enduring mental illness released from custodial environments.

Purpose:
Transitions, such as discharge or transfer from one service to another or between levels of care can be problematic. In some health and social care sectors such as obstetrics, cardiology, and older age services; transitional care programmes have been introduced to improve continuity of care. Examination of the various forms of transitional care, availability of programmes and associated outcomes in a range of health contexts, could provide important lessons for improving services for mental health service users leaving custodial settings.

Sources Used:
Published health, social care and criminal justice literature

Conclusion and Implications for Practice:
Poor transitional care is evident across health sectors and service domains. The consequences for service users can be far reaching such as interrupted, duplicated or omitted interventions, which may have a detrimental or damaging impact on their health and wellbeing. The resultant
effects include increased use of emergency care, readmission to hospital and in extreme cases, death. Recent health policies have substantiated the importance of transitional care programmes. However, these are yet to be fully realised within mental health settings. Transitional case management may optimise offenders’ engagement with mental health services and provide more effective and sustainable strategies for managing their complex health and social care needs in the community.

Keywords

Introduction
Recent healthcare policy recommended integrated working between health and social services to ensure the safe transfer of service users within and between services (DH 2009). The benefits of effective transitional care are improvements to individuals’ health, care and support alongside efficient use of resources (Humphries & Curry, 2011). However, despite movement between care providers being customary, limited transitional care programmes exist. Consequently, transfer remains the most vulnerable part of the service user care pathway (Royal Pharmaceutical Society, 2010).

This paper introduces the concept of transitional care, before highlighting the availability and the consequences of its absence, particularly for those with complex needs. The relevance for individuals leaving custodial environments who require continued mental health support is discussed. Finally, a case management programme designed to improve transitional care is
described along with its implications for national health policy.

The nature of the problem

Individuals requiring health and social care frequently receive care in diverse locations and from a variety of health professionals within primary, secondary and tertiary services. Each service user has unique personal circumstances, specific symptoms and care objectives. Therefore effective communication between health professionals in each setting is essential to meet care expectations. Each health professional, service or care provider represents a unit of care and a boundary or barrier for the service user to gain access. Without effective information exchange between professionals, the flow and overall quality of care can be interrupted or jeopardised.

Defining transitional care

Kralik et al (2005) highlighted the lack of consensus about definition, nature and components of transitional care. They described widespread disagreement about whether transitional care was linear or cyclical and whether there was an obvious beginning and end point. Chick and Meleis (1986) seminal work defined care transitions as; ‘passage from one life phase, condition, or status to another’. Concurring with this, Currie and Watterson said transitions were ‘the purposeful planned movement of patients with chronic physical or medical conditions from one health service to another, or from hospital to residential care’, (Currie & Watterson, 2008, p.8).

Transitional care involves a set of actions or services designed to promote safe, timely and co-ordinated transfer from one level of care to another (in the same location) or to more than one location involving continuity and coordination (Honsleman, 2008, p.13). Coleman contends
transitional care is complicated involving several key stages including hospital care, discharge, follow up and support services (Coleman, 2003). Coleman proposed transitional care should cover admission, transfer and discharge procedures (Coleman & Boult, 2003).

Despite the availability of professionals at different stages of transitional care, gaps remain that adversely affect the health and safety of service users. Naylor suggests gaps are due to incomplete information transfer, poor communication and limited access to appropriate aftercare (Naylor, 2003).

**Consequences of gaps in transitional care**

The consequences of poor transitional care can be extreme. Lafasco reported one in ten seriously ill service users die as a result of inadequate transitional care (Lafasco, 2013). During transitions, service users are at increased risk of medical error, with nearly one quarter experiencing adverse events, most commonly medication related, half of which are preventable (Kripalani, 2007).

Honsleman (2008) found poor transitional care led to serious complications for service users including re-admission and increased emergency treatment. Poor outcomes may be attributable to duplicated, omitted or incomplete care provision (Honsleman, 2008, p.53). Similarly, Fulmer articulated increased physical, psychological and functional problems for service users as a result of inadequate transitional care (Fulmer et al, 2007).
Despite these risks, health care policy does not promote practitioners to provide care to individuals throughout the care pathway. A conventional approach is favoured where practitioners remain situated in clinical areas and people attend for pre-arranged appointments. Arguably, this facilitates the development of specialist knowledge but expertise is department rather than pathway based. Consequently information does not follow the person leading to multiple and disparate case note recordings within various clinical settings.

**Improved transitional care**

Progress in transitional care is evident in health services but more limited within mental health settings (Reynolds et al, 2004). In other clinical areas, enhanced service user outcomes have been reported. For example, in pain management, rehabilitative programmes eased transitions between hospital and community which generated improved outcomes (Brook et al, 2011). Similarly, Naylor et al (2004) revealed positive health outcomes in cardiac care with reduced hospitalisation occurring in those receiving transitional care (Naylor et al, 2004). In cancer care, transitional care programmes increased the support provided to care givers improving relationships and family functioning (Pinquart et al, 2003, p. 112).

Advanced communication and information sharing is the foundation of transitional care programmes. Effective information sharing in paediatric diabetes services during transitions positively impacted on individuals’ glycaemic control (Orr et al, 1996). Similarly, in orthopaedic care the introduction of a checklist for transitional care planning improved communication between service users and staff (Hadjistavropoulos et al, 2009, p. 183).
Checklists may be beneficial in some specialties but for service users with complex needs like older adults, a ‘transitional manager’ or dedicated discharge planner may be required to prevent re-admission and excessive use of emergency services (Rich et al, 1995). The extent and consequences of poor transitions for older people are some of the most extreme (Naylor & Keating, 2008) including temporary disability, psychological stress, and sometimes death (The National Transitions of Care Coalition, 2008). Crotty (2005) emphasised the importance of effective discharge planning (Crotty et al, 2005, p 1110, Petersson et al, 2009) and continuity of care in the community (Thraen et al, 2011).

People with mental illness released from custodial environments have similar issues to older people leaving hospital, in terms of the complexity of health and social care needs limiting successful community resettlement. To improve care transitions, a shift in emphasis from provider to service user centred care is required. Often service users, families and informal care-givers are the only link between providers and care settings indicating that transitional care planning must centre on the individual (Gibson et al, 2012).

**Transitional care within mental health settings**

In spite of continuity of care being defined as essential (Crawford et al, 2004) transitional care is inadequate following discharge from inpatient treatment (Dorwat et al, 1994) elevating service users’ vulnerability to relapse, suicide and violence (Appleby et al, 2006; DH, 2009; Doyle et al, 2012; Goldacre, 1993). Many individuals struggle to cope with reduced levels of support, isolation and resumed self-care (Miguel et al, 2011). Rose found discontinuity of care on discharge led to unmet service user needs in the community (Rose et al, 2007).
Developing awareness of the consequences of poor transitional care has improved discharge management, for example, through assertive outreach or case management (Burns et al, 2007). Assertive outreach was established to promote engagement in people with mental illness (Marshall & Lockwood, 2004) and was found to reduce the likelihood of relapse and rehospitalisation (Marshall & Lockwood, 1998). Similarly, other studies have demonstrated benefits by case management (Burns et al, 1999; Mueser et al, 1998; Rosen et al, 2007), particularly for people with complex mental health problems and significant health and social needs.

The New Horizons mental health strategy document outlined effective discharge planning to facilitate safe and timely discharge. In the UK, Crisis Resolution Home Treatment (CRHT) services support people following discharge from acute inpatient care by providing rapid follow up in the community. The remit also provides home support, alternatives to hospital and assessment for inpatient treatment (Sainsbury Centre for Mental Health, 2006). Thus, support during transitions to and from hospital is available for individuals eligible for CRHT.

**Transitional care for people with mental health problems in the criminal justice system**

Offenders with mental health problems are socially disadvantaged with complex needs (Durcan & Corner, 2012; Farrell & Marsden, 2005). Factors related to offending including poor education, unemployment, housing, debts, substance misuse and limited family networks (Social Exclusion Unit, 2002) are also synonymous with mental ill-health (Bonta, et al, 1998; Murali & Oyebode, 2004). Despite recognition of health and social needs, critical information is often not conveyed to community mental health teams prior to prison release (Miguel et al, 2011),
limiting effective community care (Caldas, 2011, p. 5).

Mental illness is prevalent throughout the offender care pathway including at arrest, court, remand, during sentence and on release from prison (Ogloff et al, 2007). McKinnon and Grubin (2010) reported high levels of morbidity among arrestees in police custody with systematic failures in detection of mental health problems, substance misuse and social problems. Other studies have similarly reported high prevalence and low detection of mental illness (Gudjonsson et al, 1993; Phillips & Brown, 1998; Steadman et al, 2000). Significant levels of mental illness exists among defendants at court (Joseph & Potter, 1993; Shaw, 1999), but limited identification means limited opportunities for early engagement into services, increasing relapse and likelihood of imprisonment or hospital admission (Durcan, 2008).

Studies report higher rates of mental illness in prisoners compared to the general public (Birmingham et al, 1996; Singleton et al 1998; Fazel & Danesh, 2002) especially among remand prisoners (Birmingham, 1996; Brooke et al, 1996; Gavin et al, 2003; Prins, 1995). Nurse et al (2003) hypothesised that higher rates in remand prisoners could be due to anxiety about facing the future (for example, appearing in court, being found guilty), the effect of imprisonment (such as, first experience of prison), and stresses on the family (including fear of reprisals, financial pressures).

Communication of mental illness between police, court and prison settings is hindered by separate systems and procedures (The Sentencing Project, 2002). National Association of Care and Resettlement of Offenders (NACRO, 2007) and Revolving Doors (2006) raised concern
about poor continuity of care for individuals with mental health problems leaving prison. Programmes to link released prisoners with appropriate health and social care are impeded by limited integrated working, widespread geographical locations and absences of inter-agency policy directives (Gaes et al, 2002; Raynor, 2007). Repper (2008) argues for the provision of appropriate transitional care (Repper, 2008, p.110) that is comprehensive and commences prior to release (Petersilia, 2003, p.173). Similarly, Lord Bradley proposed “wherever discharge or release occurs, it is important to ensure that responsibility for care is passed on to the relevant services, and that they are engaged well in advance of discharge (Bradley, 2009, p.114).

The implications of inadequate transition planning are significant including increased risk of suicide, relapse, hospitalisation, re-arrest and imprisonment (Draine & Solomon, 1994; Keil et al, 2008). Many individuals come from disadvantaged communities and similarly return (Lynch, 2006) with multiple problems including mental health, substance misuse, poor educational attainment and limited employment skills making resettlement more difficult. High numbers of people with mental health problems ‘fall through the gaps’ in the community and become neither the responsibility of mental health or criminal justice services (Harris, 1999) resulting in inconsistent interventions, poor communication and limited clinical outcomes. Consequently, many resort to using health services in a crisis-driven way, with high use of emergency services (McGilloway 2004; Jackson, 2005). Such contact is uneconomic, provides poorer long term outcomes, limited health promotion and inadequate community support (Singleton, 1998).
Osher proposed an integrated framework may reduce duplication, maximise resource availability, information sharing, care co-ordination and opportunities for therapeutic or restorative community work (Osher et al, 2003). They highlight the need for intensive, time-limited interventions that take account of specific vulnerabilities during initial release, provide consistent support which is reduced as the person forges links in the community (Pickup, 2011, Travis et al, 2005). However, most support programmes focus on reducing reoffending without incorporation of social support such as housing, finance, employment, education and training and improved links with families. Yet each of these factors can have a significant impact on reoffending (SEU, 2002). Blackburn (2004) highlighted the dichotomy of ‘offence focused’ versus ‘offender focused’ support and suggested amalgamation of both approaches was most effective in treating offenders with mental illness (SEU, 2002).

A range of re-entry programmes exist around drug rehabilitation (Friedmann, 2009; Knight et al, 1999), education and employment (Adams et al, 1994; Turner and Petersilia, 1996), specialised housing (Lowenkamp & Latessa 2004), mentoring schemes (Jucovy, 2006) and building family ties (Shanahan & Villalobo Agundelo, 2011). Theurer highlighted the importance of support programmes combining mental health and substance misuse treatment, crisis support, housing and active case management with frequent contact in home settings (Theurer and Lovell, 2008). One such programme which incorporates all these elements is Critical Time Intervention (CTI).

Critical Time Intervention (CTI) is a variant of Assertive Community Treatment emphasising time-limited, intensive case management at critical points, such as release from prison or
hospital. The purpose of CTI is to establish a stable support network in the community, forging effective links with local services including housing and health intentions for people who are additionally vulnerable due to limited informal networks. CTI was developed collaboratively by mental health clinicians and researchers to support homeless people with severe mental illness (SMI) released from hospital. CTI promotes continuity of care during transitions, by effectively linking service users to community services. The aim is to expand supportive networks in the community, including family, friends and services (Draine & Herman, 2007).

There are similarities between the original study population and offenders with mental health problems in respect of levels of disengagement with services (Susser et al, 1997; Durcan & Knowles, 2006). In 2007, CTI was adapted for mentally ill prisoners due to be released (Lennox et al, 2012). The feasibility study aimed to see if CTI effectively connected prisoners with social, clinical, housing and welfare services in the first few weeks after leaving prison. The pilot randomised controlled trial was conducted at three prison sites. Sixty prisoners were randomised to either CTI or treatment as usual (TAU) and 23 were followed up. At follow up, a higher proportion of the CTI group were involved with services in comparison to the TAU group. CTI prisoners were significantly more likely to be receiving medication, and be registered with a GP than those receiving TAU. Results suggest continuity of care for prisoners with SMI can be improved through identification of needs prior to release, and by assisting effective engagement with appropriate community agencies.

Effective transitional care is needed to facilitate service users moving in and between services to avoid discontinuity of care and adverse events. Transitional care is needed particularly for
individuals with complex health problems requiring co-ordinated input from one or more service providers to ensure consistent delivery of care. CTI has demonstrated improved engagement, reduction in psychotic symptoms (Herman et al, 2000) and high levels of service user and staff satisfaction (Lennox et al, 2012) and may have potential to improve transitional care for client groups with complex needs. CTI is not designed to be a permanent support system, therefore discouraging the formation of service dependency. Significantly, CTI supports the principles of recovery as the intensity of support reduces gradually (to exit) as the person regains independence, generating considerable longer term cost savings (Jones et al, 2003). The development of evidence based interventions such as CTI for offenders should have a significant public health impact, directly influencing service use and possibly reducing re-offending rates (NACRO, 2007).

Conclusion

Transitional care has become an important focus for health policy with calls for generic, cross-specialty developments, since discontinuity of care represents common challenges in all services and specialities (McDonagh & Viner, 2006). Transitional care is particularly important for people experiencing serious or chronic illness including mental illness; however, useful initiatives such as CTI have not been integrated within routine care systems.

People in the criminal justice system with mental health problems need transitional care before release to ensure receipt of a range of health and social support to optimise resettlement. Offenders with mental health problems may be vulnerable to many issues including recidivism, instability, poor health and well-being outcomes, without intensive intervention (Loveland &
Boyle, 2007). Yet many have difficulty accessing and maintaining engagement with mental health and criminal justice agencies (McGilloway et al, 2004).

Critical time intervention (CTI) has generated positive results when applied to pre-release prisoners (Lennox et al, 2012), and homeless populations with SMI (Susser et al, 1997), demonstrating its potential transferability among complex service user groups. This paper has illuminated various aspects of discontinuity of care and emphasised the need for better transitional services for people released from custodial care. Future research should consider the benefits in terms of financial and societal costs, as CTI could be beneficial by engaging people at an earlier stage to reduce risk of relapse and recidivism, while preventing unnecessary waste in health, police and prison resources.

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Paper II


In Review
Slipping through the net: A Critical Review Paper on Intensive Case Management Programmes for Mentally Ill Offenders Released from Prison

[Alison Pearsall\textsuperscript{ab}, Dr Mike Doyle\textsuperscript{ac} Dr Dawn Edge\textsuperscript{a} and Professor Jenny Shaw\textsuperscript{ab}]

\textsuperscript{a}The University of Manchester
Manchester Academic Health Science Centre
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Email: alison.pearsall@postgrad.manchester.ac.uk

\textsuperscript{b}Lancashire Care NHS Foundation Trust

\textsuperscript{c}South West Yorkshire Partnership NHS Foundation Trust

**Corresponding author:** Alison Pearsall
Offender Health Research Network
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Tel: +44 0161 275 0723
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ABSTRACT

Individuals involved in the criminal justice system may encounter difficulties in accessing and maintaining engagement with mental health and criminal justice agencies on release from custodial environments. Failure to successfully engage this population can have serious implications for individuals, victims, families and the general public. High profile inquiries including the Clunis Inquiry, over 20 years ago, highlighted the importance of engaging offenders with mental health support services. More recent inquiries, research and guidance including the National Framework for Mental Health have made similar recommendations. Despite this, appropriate mental health programmes for offenders returning to the community remain elusive and opportunities to intervene early, divert and refer into appropriate health and social support are lost. This paper examines the literature on the prevalence of mental health problems at service transition points and identifies case management programmes that might be applicable. A particular variant Critical Time Intervention is proposed as potentially beneficial in meeting the complex health and social needs of this client group.

Research highlights

• Mentally disordered offenders are ‘slipping through the net’ of mental health care

• High levels of need accompany high rates of service disengagement
• Mental illness is often missed in custodial settings like prisons

• Service transitions are particular points of vulnerability for offenders

• Critical Time Intervention (CTI), a variant of case management may be beneficial in improving service engagement

**Keywords**

‘Offender’; ‘Mental Health’; ‘Criminal Justice System’; ‘Case Management’; ‘Critical Time Intervention’; ‘Community’; ‘Transition’

**INTRODUCTION**

The consequences of poor engagement with mental health services can be severe and far-reaching for service users with mental health problems, their families and potentially the general public. For individuals, poor engagement is associated with relapse (Mitchell and Selmes, 2007), reduced well-being (Naylor et al, 2012) social isolation (Parle, 2012) self-harm and suicide (Pratt et al, 2006). Whilst homicides by people with mental health problems are rare events, approximately seventy-four such homicides occur each year in the UK (National Confidential Inquiry, 2011; 2013; Appleby et al, 2006). In 2011, The National Confidential Inquiry into Suicides and Homicides highlighted the need to improve engagement in mental health care for people whose complex needs place them at risk of criminal justice involvement (NCI, 2011). Yet recent cases, suggest service limitations and engagement difficulties first highlighted by the Clunis Inquiry over 20 years ago, persist in current services (Ritchie et al., 1994).
Recent research has revealed that most prisoners with mental illness disengage from mental health services following release into the community and are therefore at risk of relapse and recidivism (Lennox et al, 2012). Serious concerns about follow-up from prison were highlighted recently in England following the homicide of a teenager, perpetrated by a mentally ill man recently released from prison (The Guardian, 2nd October 2013). This case revealed inherent complications of retaining contact with prisoners particularly at vulnerable points of transition such as arrest, imprisonment and perhaps most importantly release into the community. This review examines these transitional points and the potential for the use of ‘bridging interventions’, including case management to provide support to people after release.

**PURPOSE OF THE LITERATURE REVIEW**

This review forms part of a larger study exploring mental health care provision for offenders at various points on the offender health care pathway, specifically arrest, remand and release from custodial environments. This literature review pertains to the release of offenders from prison, access to mental health care and whether transitional case management may enhance engagement with community mental health services.

**Aim:** To explore existing literature on case management for with mental health problem in the criminal justice system to determine applicability and acceptability for service users, families and staff. This will support the development of model for transitional support for remand prisoners leaving custody.
Objectives:

- To identify research studies that highlight the needs of people with mental illness involved in the criminal justice system, particularly on the point of release into the community.
- To examine literature on the outcomes and interventions for people with mental illness within criminal justice settings, specifically on release from prisons.
- To examine case management models used for people with mental health problems.
- To propose a model for transitional case management for remand prisoners leaving custody.

BACKGROUND AND RATIONALE FOR THE REVIEW

There are more people in prison with mental illness than ever before (Bradley, 2009). Consistently high prevalence of mental illness (between 45-90%) has been reported amongst prisoners in the UK and internationally (Gunn et al, 1991a; 1991b; Brooke et al, 1996; Brugha et al, 2005; James and Glaze, 2006; Parsons et al, 2001; Singleton et al 1998; Torrey et al 2010). The Office for National Statistics seminal report and the Social Exclusion Unit reports (SEU, 2004 & 2010) asserted that over seventy percent of prisoners in England and Wales have one or more psychiatric disorders (Singleton et al, 1998). Similarly, Fazel and Danesh (2002) reported high levels of psychotic illness and major depression, which is consistent with findings in all Western countries over four decades (Fazel and Seewald, 2012). Disproportionally high rates of mental illness have been found (Epperson et al, 2011; Lamb et al, 2004), for example, 14.5% in males and 31.0% in females (Steadman et al, 2009). Higher prevalence rates were found in
remand prisoners with 76% of women and 59% of men experiencing mental health problems (Meltzer et al 1994). Several studies indicated high rates of co-morbidity, particularly in remand prisoners (Brooke et al, 1996; Gunter et al, 2008).

People in contact with the criminal justice system are also known to be disadvantaged and vulnerable with higher rates of poor physical health (Brooker et al, 2008), dependent drug and alcohol misuse (Weaver et al, 2002), homelessness (Draine and Herman, 2007), limited or absent social support (SEU, 2002) and increased mortality and morbidity (Birmingham 2005; Draine et al, 2002; Jackson, 2005), including from suicide (Biswanger et al, 2007; Pratt et al, 2006). Increased anxiety, distress and risk of self-harm, including suicide have been found after initial imprisonment (Hunt et al, Webb et al, 2011). Similarly, such symptoms can return with the prospect and process of release from custody (Lennox et al, 2012; National Association for Care Resettlement of Offenders (Nacro), 2005).

Despite the high prevalence of mental disorder, including major mental illnesses complicated by substance misuse, identification is inconsistent both prior to and during imprisonment (Epperson et al, 2011; Forrester et al, 2010; OHRN, 2009; Prison Reform Trust, 2014; Steel et al, 2007). Indeed concerns about inadequacies of care provision were raised through the Reed Reports (1997; 2002; 2003) and the Chief Inspector of Prisons (HM Inspector of Prisons, 1996). In response, the Department of Health strategy ‘Changing the Outlook’ (Department of Health (DoH), 2001) extended the National Health Service Plan (2000) to include prisoners and proposed an expansion of mental health staff, more comprehensive treatment and linkage to community mental health services for released prisoners. In April 2006, commissioning
responsibility for healthcare services was transferred from the prison service to the NHS. The aim was to provide offenders with access to NHS services equivalent to those received for the general public. This is yet to be achieved nationally with inconsistencies particularly evident in relation to care after release (Lennox et al, 2012; Tamburello and Selhi, 2013).

Evidence suggests if not detected early, symptoms continue untreated throughout incarceration and following release (Birmingham et al, 1998; 2006; Coid, 1988; Dell et al, 1993). The combination of variable provision and limited identification of mental illness make it difficult for offenders to access assessment, treatment and ongoing support after release; the absence of which can contribute to the cycle of repeated offending, relapse and imprisonment (Baillargeon et al, 2010; Keil et al, 2008). This paper reviews the literature on the use of case management in people with mental health problems in contact with the criminal justice system, with a view to proposing models of care that may enhance service engagement and consistency of care.

**Literature Search Strategy**

A comprehensive search of all case management studies and interventions meeting the eligibility criteria. Broad search techniques were used in an attempt to identify and include studies that were poorly indexed. The electronic databases PsycINFO, MEDLINE, CINAHL, EMBASE and Sociological Abstracts were consulted, together with the Cochrane Collaboration registers of randomised controlled trials and the Campbell Collaboration library of systematic reviews (between Jan.1970 - Jan.2010). Search terms included intensive case management, case management, assertive community treatment, assertive outreach, offender health care, prison after-care, transitional care, transitional case management, community care, follow up, release
programmes, jail diversion, ex-prisoner, community offender and community treatment.

**Inclusion Criteria**

Search terms and literature selection inclusion criteria were deliberately broad. These included:

i) people with severe mental illness

ii) people with mental illness who also exhibit offending behaviour

iii) relevance to mental health and criminal justice systems

iv) restricted to countries with similar health care services to the UK, e.g. Canada, Australia

v) English language papers only

vi) any study design.

This was then synthesised using narrative analysis, including a description of all included studies (Dixon-Woods et al, 2004).

Reports were excluded if they were superseded by subsequent work and their inclusion would involve duplication of data. A standardised format was used to extract the data, using ‘levels of evidence’ typology (Ontario Ministry of Health, 2003; Novo Scotia Department of Health, 2003) Mental Health Accountability Framework including information on study design, inclusion and exclusion criteria, geographical location, sample size, characteristics of the participants including gender, age, diagnoses, type of after-care or diversion programme, primary and secondary outcomes and outcomes. Intervention content, development, fidelity and sustainability were recorded. An assessment of the quality of study findings and relevance were also documented. Recipients’ perceptions and experiences of interventions contained in the studies were noted where available.
Narrative summaries of the publications explaining the findings from each of the included studies were completed. This included extensive descriptions of the interventions being evaluated, target populations, outcomes and results. Limitations at the study and outcome level (e.g. risk of bias) and review level (e.g. reporting bias) were recorded. Publications were ordered, synthesised and summarised as described below:

**Figure 2 – organising, synthesising and summarising the literature:**

**Figure 2:** Review existing or on-going reviews (using Database of Abstracts of Reviews of Effects/DARE & Cochrane Database of Systematic Reviews/CDSR)

Applying predetermined inclusion criteria (IC) generated from research question:

- Pilot – apply IC to sample papers
- Comprehensive search of the literature
- Titles & abstracts screened
- Accepted = obtain full paper, Rejected = why? – reasons recorded i.e. not relevant, or topic relevant, but fails other criteria
- Data extracted using predetermined format e.g. author, conflict of interests, study type, population/numbers included, aims, hypothesis, interventions, outcome, conclusions, costs
- Critical appraisal check list - assess quality, strengths & weaknesses referring to ‘levels of evidence’ typology (Ontario Ministry of Health, 2003; Novo Scotia Department of Health, 2003)

Key questions for the purposes of the literature review were: a) what is the available literature describing forms of transitional, intensive case management provided to offenders with mental illness?, b) what point on the offender pathway are interventions provided? c) what gaps exist in the literature? Grey literature and policy documents were searched using relevant websites.
INTENSIVE CASE MANAGEMENT (ICM)

Case management has been established within the USA and UK for several decades as a service modality to co-ordinate and integrate mental health and social care resources (Marshall, 1996; Onyett, 1992; Thornicroft, 1991; Ziguras, 2002). Case management is defined as the co-ordination of community mental health care through the allocation of a mental health key-worker assuming responsibility for the assessment of need, implementation and evaluation of care plans (Kantor, 1989). Intensive case management (ICM) is usually required for individuals who have serious mental illness and need on-going support for their mental health, but also more broadly in areas such as housing, employment, social relationships, and community participation (Kantor, 1989).
Intensive case management (ICM) aims to link and co-ordinate a wide range of health and social services. Holloway reported a positive impact for people with mental illness as a result of engagement in case management programmes (Holloway et al, 1995; 1998). Similar results were reported by Johnston (1998) comparing intensive case management to routine case management (Johnston et al, 1998). Improved attendance for mental health outpatient appointments was found by Quinlivan et al (1995) as a result of ICM. A meta-analysis of a variant of case management, Assertive Community Treatment (ACT) concluded that those on ACT demonstrated improved service engagement, but with limited benefits to health and social outcomes and was more costly than standard care (Marshall et al, 1996; 1998). The review was criticised for selection of outcome variables and inclusion of randomised health samples only, therefore potentially limiting positive findings (Ziguras et al, 2002). In contrast, Ziguras reported ICM was relevant to people with serious mental illness and poor compliance with aftercare (Ziguras et al, 2002).

A follow-up study reported ICM as valuable for people with severe mental illnesses and repeated or prolonged hospitalisation, by increasing engagement and reducing hospitalisation (Dieterich, 2010); however, studies relating to criminal justice populations were not included. Holloway and Carson concluded case management, by any definition, improves mental health after-care (Holloway and Carson, 2001) and could be relevant for people involved in the criminal justice system. Derivatives of ICM including hybrid models have been developed, aimed at matching interventions to the specific needs of different populations at different time points (Mueser et al, 1998), for example supporting young people using substances (Cameron et al, 2012), in long-term conditions (Challis et al, 2011), women with disabilities at risk of
violence (Women’s Health West, 2013), and for older people leaving hospital (Chiu et al, 2007).

CRITICAL TIME INTERVENTION AT THE POINTS OF TRANSITION IN MENTAL HEALTH SETTINGS

One adaptation of traditional ICM is Critical Time Intervention (CTI), which emphasises time-limited, intensive case management at times of transition, such as release from prison or hospital. The purpose of CTI is to establish a stable support network in the community, forging effective links with local services including housing and mental health services for people additionally vulnerable due to limited informal social networks.

Susser et al (1997) conducted a randomised controlled trial in previously homeless men discharged from psychiatric care between 1991 and 1993 in New York. Participants were ninety-six homeless men with mental illness; over 50% had substance misuse problems. Participants were randomly assigned to receive treatment as usual (TAU) or CTI. Critical Time Intervention was provided for a period of nine months, after which the group participants returned to TAU for the remaining nine months of the study. Susser et al (1997) found a significant reduction in the number of homeless nights at the nine month stage of an eighteen month study. Following the nine months CTI period and reverting back to TAU the differences between the groups were maintained.

Herman examined the impact of CTI on symptoms of schizophrenia (Herman et al, 2000) and found a statistically significant decrease in negative symptoms at six-month follow-up,
reflecting modest clinical improvement. There was no impact on positive symptoms. Herman and colleagues concluded that CTI impacted on how people see themselves and relate to others (Herman et al, 2000). Jones et al, (2003) published another arm of the study comparing costs of CTI with TAU and found that the CTI group exhibited significantly greater net housing stability than for TAU and suggested financial benefits could improve further over the longer term.

Dixon et al (2009) examined after-care for homeless veterans using an experimental randomised control trial design. The sample included 135 veterans with complex needs. The original CTI programme was merged into two phases with a nine-month duration. Findings demonstrated benefits in promoting post-discharge continuity of care and improved client satisfaction. Study limitations were the small sample size, one site geographical location and limited power calculations.

Further studies have been undertaken with homeless women and homeless veterans with mental illness leaving inpatient care (Kasprow and Rosenheck, 2007). The study used a non-randomised pre and post-cohort design with follow-up at three monthly intervals over one year. Findings were generally consistent with Susser et al (1997) generating reductions in homeless nights, sustained beyond the provision of CTI. Limitations were non-randomisation, and selection and reporting bias by CTI managers conducting follow-up interviews.
CRITICAL TIME INTERVENTION IN CRIMINAL JUSTICE SETTINGS

Wilson and Draine (2006) highlighted CTI’s potential relevance for released prisoners with mental illness claiming it focused on individuals’ health as opposed to community safety, unlike other case management programmes for mentally disordered offenders. It also provides holistic interventions and bespoke support that can be tailored to meet individuals’ needs (Jarrett, 2012). In a feasibility study by Shaw et al (2011), the CTI programme was adapted for relevance to offenders and also shortened from nine to six months for practical purposes, in a feasibility randomised controlled trial. CTI was found to be acceptable and feasible to deliver to offenders and revealed that there was improved community mental health service engagement in the CTI in comparison with TAU groups at 6 weeks post release. CTI was effective in connecting individuals with welfare, housing, health and social services following initial release (Jarrett et al, 2012). Whilst the study establishes CTI as effective in supporting offenders assimilation to community living, it does not mention the component of timing and longevity following introduction.

Tomita and Herman (2012) conducted a randomised controlled trial of 150 psychiatric inpatients being released into the community. The sample comprised of a individuals with serious mental illness and substance misuse. The study reported improved stability and reductions in re-hospitalisations. Limitations of the study were around the sampling and allocation of treatment groups. The data was further analysed to assess the extent to which CTI improved the quality of family relationships at two interaction points (9 month and 18 month), using a range of quality of life measurements. Findings demonstrated CTI can strengthen individuals’ ties with the community and support families (Tomita et al, 2014). There is a need for an effectiveness trial to
establish efficacy of community engagement and cost effectiveness over a longer period of follow-up, including the use of qualitative methods.

**DISCUSSION**

The findings of this review confirm the high prevalence of mental illness in sentenced and remand prisoners. The literature suggests that mental illness not identified before or during reception into prison can remain undetected throughout sentence and following release (Birmingham et al, 2005). Efforts have been made to improve the recognition of mental illness within prison settings through standardisation of screening, although improved, many individuals with mental illness are still missed (Birmingham et al, 2006; Shaw et al, 2009). Furthermore, even those identified, experience difficulties in accessing mental health care after release. Consequently, opportunities to engage individuals in a more pro-active manner to maintain the stability gained in prison are lost (Birmingham et al, 2006; Lennox et al, 2012; McGilloway, 2004).

Generalist mental health services often consider their services inappropriate to meet the multiple and complex needs of offenders (Lamb and Weinberger, 1998). Individuals can be perceived as ‘disturbed’, ‘dangerous’, ‘unsuitable’ or ‘unresponsive’ to treatment, presenting without formal diagnosis and treatment being provided (Coid, 1988). Being declined services results in offenders having insufficient support for mental health, social and integration issues which escalates risk of relapse and associated re-offending (Hatfield et al, 2004). Difficulties have been found in organising the delivery of continuous care between custodial and community mental health services leading to fragmented support packages offered to released prisoners (Telfer,
Fewer than 50% of released prisoners are registered with a General Practitioner (GP), (Bruton et al, 2006; Lennox, 2012), restricting their access to appropriate care in the community (Meltzer et al, 2002). Many struggle to secure accommodation with nearly half homeless on release into the community (Williamson, 2006). Lack of stability and limited access to support enhances the risk of re-offending (Centre for Mental Health, 2008; Kesten et al, 2011). Offenders lacking stable support are twice as likely to have community orders and licences revoked (Prins & Draper, 2009). Disproportionally high re-offending rates and increased likelihood of re-arrest within 18 months of release were found in a study by Lovell et al (2002). Similarly, Cloyes et al found that up to 70% were charged with new offences during a thirty-nine month follow-up study (Cloyes et al, 2010).

Release from prison is a vulnerable transition point (Haney, 2001); instability and poor engagement in services can increase the likelihood of arrest and incarceration for public protection and to access appropriate treatment (Hartford et al, 2006; Lamb et al, 2004; Lurigio, 2001; Soderstrom, 2007; Teplin, 2000). Repeat offenders have been described as the ‘revolving door’ (Revolving Doors, 2012; 2013) or on the ‘merry-go-round’ (McCacken and Perry, 2009) of relapse and arrest. There have been multiple models for ‘Through the Gate’ care, aiming to provide contact between custody and community to provide support on release to reduce the proportion of repeat offenders (Ministry of Justice, 2013). The New Economics Foundation reported significant benefits, including reductions in re-offending, better links with family and improvements in housing employment and health care among offenders linked into schemes
(New Economics Foundation, 2008; 2011). However, studies have also highlighted the difficulties in designing and delivery re-entry programmes to meet the specific needs of offenders with complex needs including physical, mental health and substance misuse (Hammett et al, 2001; Baillargeon et al, 2010). Transitional case management may enhance traditional re-entry programmes with coordinated and holistic mental health care, to more consistently engage offenders with complex mental health needs in the community.

Calsyn’s outcome study highlights inadequacies in meeting the needs of offenders (Calsyn et al, 2005). McCoy et al, 2004 demonstrated a reduction of approximately 90% in the number of arrests and days spent in hospital. The sample was small (n=24) and lacked a control group. The beneficial factors were noted as being the availability of support and collaborative working between mental health and criminal justice staff. Comparable findings were noted by Lamberti in a pre-post cohort evaluation study of offenders referred by police, hospitals and prisons into an intensive residential community treatment programme (Lamberti et al, 2001). A national review of re-entry programmes found that limited effectiveness in the improvement of mental health status, quality of life or reduction in offending (Wilson and Draine, 2006).

The engagement of offenders in case management prior to release was reported as important in studies by Ventura et al, (1998), Buck et al (2011) and Lennox (2012). Fundamental is the transitional care planning prior to release, for people with mental health problems, particularly severe enduring mental illness (Baillargeon et al, 2010; Lurigio et al, 2004). As an intervention CTI focuses on the transitional points and there is growing evidence of application within criminal justice populations.
CTI is an effective bridging intervention, providing a range of health and social support to individuals transiting from institutional settings, including hospitals and prisons (Draine and Herman, 2007). Lurigio highlights the need to “build lasting bridges between mental health and criminal justice systems, leading to co-ordinated and continual health care” (Lurigio, 2001, p. 458). CTI enhances linkage and social inclusion and appears superior to other forms of ICM that show diminishing benefits after termination (Olfson 1990; Burns et al, 1999). Engagement in services prior to release from custody is an important pre-requisite. Sustenance, specifically in relation to offenders at the earlier stages of the criminal justice pathway including arrest and diversion remains inexplicit and in need of further investigation.

Additionally, CTI can potentially overcome the difficulties other re-entry programmes have identified (Hammet et al, 2001; Baillargeon et al, 2010), by incorporating structured mental health treatment and support, tailored to the complex needs of mentally disordered offenders (Lennox et al, 2012, Jarrett et al, 2012)

CONCLUSION

Offenders with mental health problems are vulnerable at transition points to many issues including recidivism, relapse, instability, poor health and well-being outcomes. In order to reduce mortality and morbidity at times of transition, health and criminal justice agencies need to provide sufficient levels of support for individuals identified as being at risk (Pratt et al, 2006).
CTI is one form of intensive case management that has generated positive results reducing risk and meeting health and social needs when applied to offender and non-offender populations alike, demonstrating its potential transferability among service user groups. Benefits associated with CTI have been retained long after the intervention was withdrawn and sustainability should be explored within other service user groups. Future research should consider issues of timing, sustainability and longevity; also incorporating qualitative approaches to explore service user, family and staff acceptability. Further research is required to assess clinical and cost effectiveness of CTI in varied client populations and settings including for women, young offenders, those serving community sentences; and specifically more preventively in police custody and court for people with mental illness.

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3.1 Introduction

The aim of this chapter is to describe the Constructivist Grounded Theory (CGT) approach, developed by Charmaz (2006), applied to investigate the provision of mental health care to offenders at the entry points to the criminal justice system of arrest and remand. The interpretive nature of this theoretical perspective is consistent with exploring mental health care, understanding service users’ perspectives and multi-agency working (Tweed and Charmaz, 2012). Interpretive research uses the interactive and social process of creating meaning that is linked to experience (Lincoln & Guba, 1985). Social capital, particularly Lin’s (1999) network theory of social capital, was used as the theoretical framework to guide the study. Social capital incorporates the norms, relations and resources embedded in social networks, which can be accessed or mobilised through ties in the networks (Lin, 2001).

Using Grounded Theory methodology, this study describes stakeholders’ experiences, understanding and interpretations of the characteristics of effective mental health care for offenders and develops a substantive theory about the usefulness of transitional case management, applied at the entry and transitional points of arrest, remand and release from short-term custody. This chapter explains the rationale for adopting a qualitative approach and the epistemological position of constructivism underpinning the grounded theory design selected for the study. The background and principles common to grounded theory methodology (GTM), and Constructive Grounded Theory (CGT), are explained. The methods, ethics, participant
sample, data generation and data analysis are discussed. The chapter concludes by explicating the analytical approach for the empirical data. The chapter opens with the research questions and objectives and an overview of grounded theories, including the CGT selected for the PhD study.

3.2 Research Question

“What are stakeholders’ experiences of mental health care provision and could continuity of care at entry and transition points in the CJS be enhanced through CTI?”

Objectives:

• To explore participants’ experiences of health and social support (as recipient and provider).

• To consider the concept of ‘continuity of care’ from the perspectives of participants (as recipient and provider).

• To develop a grounded theory of how transitional care can be enhanced through transitional intensive case management (TICM), Critical Time Intervention (CTI) to inform health policy.

• To explore the support networks of arrestees and remand prisoners and implications for provision of TICM, Critical Time Intervention (CTI)

The secondary research questions addressed are:

• What constitutes appropriate support for arrestees and remand prisoners with mental illness leaving short term custody?
• Could continuity of care for arrestees and remand prisoners with mental illness be improved through TICM?

• How can CTI improve the transitions of arrestees and remand prisoners leaving custody?

• How do individual support networks facilitate or hinder the provision of CTI for arrestees and remand prisoners with mental illness?

3.3. Situating the Research and Methodology

A qualitative approach to the PhD study was appropriate given the following characteristics about the subject area:

- the limited research available around the health and social support needs of offenders released from short-term custody
- the particular research questions (‘what’ and ‘how’ terms)
- the need for theory development to promote understanding of the complexity of care provision for the study population, contextually and systematically
- the ability to access unique, personalised data from the perspectives of recipients and providers of care

Qualitative studies attempt to contribute to knowledge-gathering in areas which have not been studied before or where substantial gaps in understanding exist. Limited information exists about arrestees’ and remand prisoners’ needs, and qualitative inquiry is most appropriate to
explore perspectives of mental health care. Qualitative research facilitates investigation in naturalised settings and provides opportunities for data collection and analysis based on individual interpretation of the world (Denzin & Lincoln, 2003). Qualitative data is typically descriptive, providing entry and insights into the social world of participants (Neuman, 2003). People interpret things individually, which can vary with exposure to different people, places and at different times (Denzin and Lincoln, 1998).

Qualitative research methodologies are particularly appropriate to make sense of complex situations, understand phenomena and develop theoretical frameworks (Morse & Richards, 2002). To date, there is limited understanding of the health and social needs of arrestees and remand prisoners and no available care programmes following release from short-term custody. There is therefore a need to gain participants’ views of mental health care to consider if CTI could improve continuity of transitional support for arrestees and remand prisoners. For these reasons, this research employed a Grounded Theory (GT) methodology (Charmaz, 2000, 2006; Glaser & Strauss, 1967, 1999; Strauss & Corbin, 1998) within a constructivist paradigm (Guba & Lincoln, 1994, 2001). However, before the Grounded theory methods are discussed it is important to disclose other research methods considered for the study including ethnography, case study, phenomenological and narrative methods.

Ethnography involves the researcher immersing him/herself within a cultural group over a prolonged time period to collect primarily observational data. This would be less achievable in the author’s PhD study as arrestees and remand prisoners can be released or moved swiftly to other establishments making access challenging. Case studies aim to obtain an in-depth...
understanding of a programme, person or event using multiple data sources including documents, interviews and observations. This approach was considered inappropriate because of the range of stakeholder views and the generally poor records and documents available within criminal justice environments. Phenomenological research aims to understand human experiences of a phenomenon e.g. an event or relationship, using long interviews with a limited number of participants to identify patterns and relationships of meanings. However, it is not as effective at examining processes and care experiences of a range of participants. The strength is the detailed examination of the data from each participant which would not be possible across five stakeholder groups. Narrative research involves the researcher studying the lives of individuals by compiling life stories by interview. It can provide a detailed picture of an individual’s life but is not appropriate to study a range of stakeholders perspectives about mental health care provision.

3.4 Grounded Theory Methods - GTM

GTM embraces the following principles that pertain to other qualitative methods but are applicable to this study:

- Enquiry as a co-operative process between researcher and participants
- Focus on everyday life experiences
- Valuing participants' perspectives and experiences
- Primarily descriptive reporting of people’s own words

(Marshall and Rossman, 1999)
Grounded Theory (GTM), provides a methodological framework, tools and techniques to gain an understanding of individuals’ perspectives about a specific subject area. The data collection generally utilises in-depth interviews but can include other sources such as quantitative data, research literature and related documents. GTM provides a framework to guide data collection and analysis comprising of coding, memo-writing, data comparison and theoretical sampling.

Grounded theory (GT), was originally developed by Glaser and Strauss from their published work 'The Discovery of Grounded Theory: Strategies for Qualitative Research (1967). The original report describes the study of the care of terminally ill patients in hospital settings (Glaser and Strauss, 1967). Subsequent published work highlights the further development of GT emphasising the methodological basis and procedures of the approach. Through continued clinical research, particularly in social sciences, three main trajectories have emerged within GT. Firstly, ‘Glaserian’ (Glaser and Strauss, 1965; 1967; Glaser 1978; 1992; 1998), secondly ‘Straussian’ (Strauss and Corbin, 1987; 1990; 1994; 1998), and thirdly ‘Constructivist’ (Charmaz, 1995; 2000; 2004; 2006).

The use of grounded theory and specifically constructivist grounded theory (CGT) was selected for this study because it is a suitable methodology for generating new theories and the exploration of clinical practice. Traditional GTM is informed by symbolic interactionism, which is a sociological theory that emphasises meaning in human interactions and behaviours (Denzin & Lincoln, 2003), while CGT is guided by constructivism, which supports the co-construction of meaning through participant voices and experiences. The main philosophical difference is instead of assuming theory emerges from the data, adopting a constructivist perspective, the
researcher and participant co-construct categories and meaning from the data. CGT embeds social constructivism, which is directly relevant to exploring participants’ perspectives of historical, cultural and social issues related to mental health care for arrestees and remand prisoners (Charmaz, 2006; Mills et al, 2006).

Social constructivism understands reality as “truth, or meaning, which comes into existence in and out of our engagement with the realities in our world” (Crotty 1998, p.8). Crotty described reality in a constructive way positing;

“all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and transmitted with an essentially social context” (Crotty, 1998, p.42)

CGT is applicable to the exploration of an original idea or theme, such as the provision of mental health care to arrestees and remand prisoners. It is also applicable to investigating situational or process issues associated with individual or group behaviour (Locke, 2001). Furthermore, where there is limited available literature and the perspectives of participants are highly important to the construction of meaning, theory and related practice. The Constructivist Grounded Theory research approach for this study was informed by Kathy Charmaz’s work; primarily the texts “Constructing Grounded Theory – A practical guide through qualitative analysis” (2006), and Tweed & Charmaz’s (2012), chapter entitled ‘Grounded Theory Methods for Mental Health Practitioners’ in a book of the same title edited by Harper and Thompson.
Constructivist Grounded Theory (CGT), differs from earlier Glaserian and Straussian traditions because of the emphasis on "how data, analysis, and methodological strategies become constructed, and takes into account the research contexts and researchers' positions, perspectives, priorities and interactions" (Bryant and Charmaz, 2007, pp.10). The constructivist approach emphasises the role of researcher in the construction or interpretation of meaning, in addition to the context created by participants. Critics of this adaptation to the original GT methodology including one of the founders Glaser considers this adaptation to be deviating from the original methodology resulting in the ‘forcing’ of the data (1978; 1998) and suggests that the co-constructor relationship is likely to generate researcher bias. Glaser posits that the original theory should be followed and variants should be regarded as the fusing or mixing of methods. The objectivist stance assumes each researcher will collect data, make the same observations and draw replicable conclusions (Bryant, 2003). Conversely, the constructivist or interpretivist view within CGT is that data is interpreted through the shared interaction between the researcher and participant (Charmaz, 2006). Participants are considered to equally ‘make sense’ of experiences to assist with the development of theory. The researcher can then use this data to develop theoretical abstraction, through categorisation and linkage to construct an informed interpretation and comprehensive theory. The research process is depicted diagrammatically in Figure 4 below:
Figure 4: Relationship between epistemology, theoretical perspectives, methodology and research methods

Figure 4 [above] illustrates the various components of the research process. The researcher’s epistemological, theoretical and methodological [terms defined below] considerations determine the version of Grounded Theory selected, which in turn influences and guides the research inquiry process (Jeon, 2004; Mills et al, 2006).
3.5. Ontological and Philosophical Positions within CGT

Grounded theory incorporates a range of epistemological positions located on the “methodological spiral” (Mills et al, 2006, pp.13), influenced by the underlying ontological stance of the researcher (Mills et al, 2006). The researcher’s ontological position influences his/her epistemological and methodological choices and ultimately the research design (Urquhart, 2013).

Ontology is a philosophical belief system about the nature of social reality (Denzin & Lincoln, 2005). The researcher’s ontological assumptions impact on the research subject, development of questions and strategies for conducting the research. Epistemology refers to a philosophical belief system about the nature and origins of knowledge and the limitations of human understanding (Guba & Lincoln, 2001). The researcher’s ontological and epistemological positions form the philosophical basis of a research project. Denzin and Lincoln (2005), state that ontology “raises basic questions about the nature of reality and the nature and relative position of human beings in the world” (p.138).

The ontological perspective of this study was informed by an interpretivist philosophy proposing that the relationships, interactions, activities and experiences of stakeholders (detailed below) influence the ‘social worlds’ of service users and their mental health provision (Schutz, 1973), which is contextually positioned within a specific time, place and culture (Charmaz, 2006).
In CGT there is emphasis on gaining an interpretive and contextual understanding of the subject and prioritising participants’ perspectives within the analysis. “The constructionist version of grounded theory redirects the method from its objectivist, mid-20th-century past and aligns it with 21st-century epistemologies” (Charmaz, 2008, pp.402). Constructivist’s enquire how meanings are formed and reflected “on to and into” the individual’s world (Harding and Palfrey, 1997, pp.11). Applicability of the CGT approach is discussed in the next sub-section below.

3.6. Applicability of Constructivist Grounded Theory to the PhD Study

The CGT approach was considered most appropriate for this study based on a number of relevant factors. Firstly, a review of literature highlighted the high prevalence and limited identification of mental health problems among offenders at the entry points to the criminal justice system. Secondly, there was a lack of information about the health and social needs of arrestees and remand prisoners leaving short-term custody. Specifically, ‘if little is known about a topic and few adequate theories exist to explain or predict a group’s behaviour, the grounded theory method is especially useful’ (Hutchinson, 1986, p. 112). Thirdly, the main interest in this thesis was to explore the availability, access to and engagement with mental health services for individuals transiting within the criminal justice system. The CGT approach examines the connections between the ‘before’, ‘during’ and ‘after’ processes between participants and the research environment.

In order to develop an understanding of CGT I read a range of GT research, such as Jones, 2002; Jones and Hill, 2003; from the educational sector and health-related publications including Annells, 1997; Corbet-Owen and Kruger, 2001; Gustafsson et al, 2003 and McCann & Clark,
2003. Grounded theory has been used within mental health settings and among marginalized groups (Boyd & Gumley, 2007; Charmaz, 2008; Chiovitti, 2008; Frankel & Levitt, 2009). Commonly, health related publications draw on the work of Charmaz (1995, 2000), as justification for the use of CGT. This demonstrates the applicability of CGT to mental health related research, particularly when limited understanding of the phenomenon exists. Charmaz argues ‘reality’ i.e. understanding of a phenomenon or situation is constructed through an interactive process that has ‘dynamic, structural, cultural and behavioural contexts’ (Charmaz, 2000, pp. 524), which are appropriate to explore the complex contexts of mental health provision within criminal justice settings.

A further strength of CGT methodology is that participants are central to the entire research process and their ‘voices’ feature throughout analysis, construction of theory and outcome. Constructivism makes the distinction between the social, outward “person” and the “inner self”. Each individual has a unique perspective and history embedded within the inner self which dictates and influences a person’s capacity for autonomy and self-determination. This component is useful to understand how people perceive their interactions and relationships with others and is therefore appropriate to inform the CGT methods employed within this thesis. Specifically, participants’ perspectives of mental health care for people following arrest, remand and release was emphasised.

CGT acknowledges the researcher’s position as a ‘co-constructor’ of experience and meaning (Charmaz, 2000; 2006). Therefore, my clinical experience was relevant to the research process rather than a hindrance to objectivity within the data, context or setting of the research.
Knowledge of the research area in traditional GT is termed ‘theoretical sensitivity’ and includes insight into the environment and sample population (Strauss and Corbin, 1990, pp.44). In CGT, researchers must be cautious as past experiences can lead to routine or obvious elements being overlooked or dismissed.

Charmaz (2005; 2006) purported CGT as particularly useful to social justice research, which suggests further suitability for the PhD study. Realities are influenced by context; the construction of power, equality and discrimination are examined, highlighting the power differentials between participants and potential influence on data and construction of theory. CGT provides the opportunity to identify, generate and substantiate theory that may contribute to policy and practice within health and criminal justice settings. The next sub-section sets out the theoretical position of relevance to this PhD study - Social Capital Theory (Lin, 1999, 2001).

3.7. Network theory of social capital

The notion of social capital being network-based is acknowledged by a range of researchers (Bourdieu, 1983, 1986; Burt, 1992; Coleman, 1988, 1990; Erickson, 1995, 1996; Lin, 1982; Putnam, 1993, 2000). Through the social relations of networks, a network member may access and utilise another’s resources such as expertise, knowledge, power, influence and wealth. There are various definitions of social capital (Bourdieu, 1986; Burt, 2001, 2005; Coleman, 1990; Putnam, 1993; Lin, 1999; 2001 and Wellman 2001). This PhD study embraces a theoretical framework of social capital network theory incorporating Lin’s (1999) definition of social capital as the “investment in social relations by individuals through which they gain access to embedded resources to enhance expected returns of instrumental or expressive actions” (Lin,
1999, p. 39). Lin posits social capital as having three main characteristics, which are described in the Table 4 below:

**Table 4: Characteristics of network theory of social capital (Lin, 1999)**

<table>
<thead>
<tr>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Resources are embedded in a social structure;</td>
</tr>
<tr>
<td>● The Accessibility of resources by individuals</td>
</tr>
<tr>
<td>● The purposeful use of the social resources by individuals</td>
</tr>
</tbody>
</table>

**And, three further key elements**

<table>
<thead>
<tr>
<th>Key elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Inequalities - individuals possess varying levels of social capital; hence inequalities exist within networks</td>
</tr>
<tr>
<td>● Capitalisation - individuals’ access to and capitalisation of social capital within networks.</td>
</tr>
<tr>
<td>● Effects/returns - the returns or benefits to individuals associated with the social capital gained</td>
</tr>
</tbody>
</table>

These returns/benefits referred to above in Box 1 are divided into two outcomes:

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Returns of instrumental action (which is the resources gained not originally possessed by the individual)</td>
</tr>
<tr>
<td>● Returns of expressive action (which is the maintenance of resources already possessed by the individual)</td>
</tr>
</tbody>
</table>

Pescosolido, 2015). Lochner posits that social capital consists of social networks and specifically the quantity of relationships, characterised by the reciprocity of ties (quality of relationships), (Lochner et al. 1999). Stone (2001) suggests that quality and quantity aspects of relationships should be viewed by examining individuals’ activities or behaviours (structural social capital) and separately analysing how people think, feel and ultimately trust others (cognitive social capital), (Bain and Hicks 1998). Structural and cognitive social capital incorporates the ties that link individuals such as religion, hobbies, socio-economic groups, drug cultures and living circumstances, for example prisoners that have common bonds around culture or sub-cultures (bonding social capital).

Other descriptors of social capital are ‘bridging social capital’, which relates to individuals or groups developing relationships based on shared beliefs or views such as, for example, religious groups. Social capital can also be facilitated by shared experiences within formal institutions such as prisons, community centres or government agencies, termed ‘linking social capital’ (Szreter and Woolcock, 2004). These characteristics of relationships - ‘bonding, bridging and linking’ (described above) explain the location, context and type of relationship. This is relevant to offenders with mental health problems whose symptoms, offences or associated behaviours have resulted in the breaking of ties with key family, friends or former geographical areas thus affecting the availability of resources and supports. This thesis applies the network theory of social capital (Lin, 1999; 2000) as the theoretical framework for the CGT study of mental health care and the influences of social capital and social networks on engagement with mental health programmes.
3.8. Study Settings

There are six police divisions with seven regularly used custody suites within Lancashire at Blackpool, Blackburn, Burnley, Lancaster, Leyland, Preston and Skelmersdale. In 2011, there were 64,192 arrestees detained in the custody suites across the county.

Two police stations, Leyland and Preston were included in the study, both containing large custody suites as suitable venues to conduct interviews with police, criminal justice liaison and arrestees. These specific police stations were put forward by the relevant police Inspector due to being the two busiest custody suites in Lancashire and therefore more suitable to contacting potential participants. Another interview was conducted with a police sergeant in Lancaster, due to a change of work-base during the study period.

Remand prison - HMP Preston was included in the study, as the only remand prison serving adult men within Lancashire during the study period. The prison capacity is 842 and during 2014 remand prisoners accounted for 14.5% and awaiting sentence prisoners 21% of the population. This indicates that prisoners waiting for court decisions/disposals make up approximately 1/3 of the prison population. The average length of stay was between 1-3 months for those on remand; however, a small number wait over one year.

3.9. The Study Participants

Individual interviews were conducted with stakeholder representatives involved in care experiences within police custody and remand prison settings between September, 2011 and March, 2013.
Stakeholder participants comprise of five cluster groups:

Cluster 1: Mental health staff (criminal justice liaison and mental health in-reach, community mental health teams)

Cluster 2: Criminal justice staff (police and prison officers)

Cluster 3: Service Users (arrestees and remand prisoners)

Cluster 4: Family/Carers

Cluster 5: Mental health commissioners

Participants were recruited using a purposive approach, which means specifically targeting a wide range of views for example participants of different ages, custody experiences, variance of offences (Bryman and Bell, 2007). A purposeful research sample focuses on arranging for people with the most knowledge of the phenomena to engage in the study.

Participants received a written information sheet, designed specifically for each stakeholder group involved in the study and is located in the Appendices Section as Appendix 4. Informed consent was obtained prior to interviews taking place and capacity issues are assured for service user participants by local mental health teams. Consent forms are situated in the Appendices Section as Appendix 6. Interviews were conducted with consented participants in five clusters using a semi-structured interview schedule designed for each participant group (Appendices Section as Appendix 5).
### Table 5 - Participant Descriptors:

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Interviews</th>
<th>Descriptors 1</th>
<th>Descriptors 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster 1:</strong> Mental health - Mental Health Inreach</td>
<td>5</td>
<td>3 nurses, 1 social worker, 1 occupational therapist</td>
<td>1 male 4 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Criminal Justice Liaison</td>
<td>6</td>
<td>5 nurses, 1 social worker</td>
<td>2 male 4 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Primary Care</td>
<td>2</td>
<td>2 nurses with a range of therapy qualifications</td>
<td>1 male 1 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Secondary Care</td>
<td>3</td>
<td>3 nurses</td>
<td>2 female 1 male</td>
</tr>
<tr>
<td><strong>Cluster 2:</strong> Criminal Justice – Police Officers</td>
<td>5</td>
<td>Custody, first response and offender management</td>
<td>5 male</td>
</tr>
<tr>
<td><strong>Cluster 2:</strong> Criminal Justice – Prison Officers</td>
<td>5</td>
<td>Safer custody, induction, visits and resettlement</td>
<td>3 male 2 female</td>
</tr>
<tr>
<td><strong>Cluster 3:</strong> Service Users - Arrestees</td>
<td>5</td>
<td>1 employed 4 unemployed</td>
<td>3 male 2 female</td>
</tr>
<tr>
<td><strong>Cluster 3:</strong> Service Users - Remand Prisoners</td>
<td>6</td>
<td>1 prior employment 5 unemployed</td>
<td>6 male</td>
</tr>
<tr>
<td><strong>Cluster 4:</strong> Family/Carer</td>
<td>3</td>
<td>1 employed, 1 retired, 1 full-time carer</td>
<td>1 male 2 female</td>
</tr>
<tr>
<td><strong>Cluster 5:</strong> Mental Health Commissioners</td>
<td>2</td>
<td>CCG and Specialist services</td>
<td>1 male 1 female</td>
</tr>
</tbody>
</table>

| **Total**                                              |            |               | 42            |

Each stakeholder cluster group is outlined below with a description of the sample, inclusion and exclusion criteria and recruitment strategy.
3.9.i: CLUSTER ONE - MENTAL HEALTH STAFF

SAMPLE:

The sample was drawn from staff working in Criminal Justice Liaison Teams in Burnley and Preston. The In-reach Team included in the study was based at HMP Preston.

INCLUSION CRITERIA

Mental health staff based within police custody suites (Burnley and Preston) or remand prison (HMP Preston) were eligible as their normal working practices involve working with offenders with mental health problems.

Mental health staff at Preston, Lancaster and Morecambe, working in primary and secondary care teams with former experience of working with people in contact with the criminal justice system were eligible. The latter participants were included following approval from the Research Ethics Committee of a substantial amendment (see Research Ethics subsection 3.21) to capture the views of staff that may have more limited experience and training of working with criminal justice service users.

EXCLUSION CRITERIA:

Mental health staff with no prior experience of working with people in the criminal justice system were excluded.
RECRUITMENT:

Mental health practitioners were recruited following meetings with team managers and presentations about the study to staff groups. Managers provided the names of key and interested staff members, which were then followed up by the researcher in the form of emails and introductory appointments to discuss the project, including the study aims, objectives and structure of the interviews (Information sheets are contained in Appendices Section as Appendix 3).

3.9.ii.a): CLUSTER TWO - CRIMINAL JUSTICE STAFF – POLICE

SAMPLE:

Police officers were based at Lancaster and Preston stations. The police sample included officers working in custody suites, offender management and emergency response teams, in order to gain wider perspectives of police involvement with mental health problems.

INCLUSION CRITERIA:

Criminal justice staff currently working in relevant areas of the police and prison system that routinely came into contact with arrestees and remand prisoners with mental health problems were eligible for inclusion.

EXCLUSION CRITERIA:

Criminal justice staff with no experience of working with mental health problems were excluded.
RECRUITMENT OF POLICE OFFICERS:

Police were recruited following meetings with senior officers to gain approval to circulate information within the police station. This was followed up by directly approaching police staff working in critical areas such as custody and critical response teams to confirm interest.

3.9.ii b) CRIMINAL JUSTICE STAFF - PRISON OFFICERS

SAMPLE:

Prison officers working at HMP Preston with differing lengths and types of experience and working in key areas of routine contact with remand prisoners formed the sample.

INCLUSION CRITERIA:

Prison officers working in relevant areas that routinely come into contact with remand prisoners with mental health problems were eligible for inclusion. This included officers working in the induction, visits, safer custody and the re-engagement sections.

EXCLUSION CRITERIA:

Prison officers with no experience of working with people with mental health problems were excluded.

RECRUITMENT:

Prison officers were recruited following approval from the main Governor to approach staff working directly with remand prisoners. Initial approaches were made through the In-reach team manager to email a range of staff working in the prison. This produced a list of potential
participants for the researcher to contact about the study.

3.9.iii: CLUSTER THREE - SERVICE USERS – ARRESTEES AND REMAND PRISONERS

SAMPLE:

Arrestees and remand prisoners with mental illness confirmed by criminal justice mental health staff in police custody at Preston, and Leyland, as well as HMP Preston formed the sample.

INCLUSION CRITERIA:

Arrestees and remand prisoners with mental illness aged between 18 and 65 years, considered stable and with capacity to consent (judged by qualified mental health practitioners) were eligible for inclusion in the study. There were no restrictions on gender in police custody; however, remand prisoners were males due to the host prison serving male prisoners. Consideration was given to the inclusion of female arrestees rather than have the study as male only given there was no female remand prison in the area. The decision to include female arrestees was taken as there was no logical reason for exclusion. Furthermore, there was useful insights to be gained about the perspectives of female arrestees, although the specific item of gender and its impact on care provision at arrest or remand stages was not explored.
There were no universally agreed definitions of Mental Illness (Ruggeri et al, 2000). However, the National Institute of Mental Health definition is applied within this study:

- A mental, behavioural, or emotional disorder (excluding organic, developmental and substance use disorders)
- Diagnosable currently or within the past year
- Of sufficient duration to meet diagnostic criteria specified within the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V)
- Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

**EXCLUSION CRITERIA:**

- Individuals lacking capacity to consent or who decline to participate, determined by CJL/MHI practitioners
- Individuals deemed to be too violent or a risk to the researcher, judged by CJL/MHI practitioners
- Immigration detainees
- Language issues – those that do not speak English proficiently are excluded for practical reasons

**RECRUITMENT OF ARRESTEES:**

Arrestees were recruited by criminal justice liaison staff who approached the individual in the first instance to explain the study and ensure appropriate timing in relation to legal proceedings.
This was because the interview schedule could elicit information relevant to the criminal proceedings so legal interviews were completed in advance.

**RECRUITMENT OF REMAND PRISONERS:**

Service users on remand in HMP Preston were recruited from the In-reach Team caseload. The researcher contacted the relevant In-reach Team staff member to discuss potential eligibility and confirm the stable mental health state of potential service users. Service users were then approached initially by their nominated mental health practitioner to obtain consent to discuss the study.

3.9.iv: **CLUSTER FOUR - FAMILY MEMBERS/CARERS**

**SAMPLE:**

The sample was gained by attendance at Lancashire police stations, HMP Preston and the Carers’ Support Group within the host Trust.

**INCLUSION CRITERIA:**

Family members/Carers providing support to individuals with mental health problems and with experience of the criminal justice system were eligible for inclusion.

**EXCLUSION CRITERIA:**

Family members/Carers without any relevant knowledge or experience of the criminal justice system were excluded.
RECRUITMENT:

One family member/carer was recruited on request of a service user participant and was a mother of a remand prisoner. She was very supportive of her son and was actively campaigning for services to be developed to support young people with mental health and substance misuse problems within the local area. Another family member was recruited via meeting with family at Family Days at the prison and was seen after the session ended over a cup of coffee in the prison visits area and was a partner of a remand prisoner, with school age children and struggled financially during her partner’s incarceration. The third family member was recruited through attendance at the Carers’ Group, facilitated by the local host Trust and was a retired father supporting his son diagnosed with mental illness. His son had served several prison sentences for violence and drug related offences and had also been through the secure mental health system and was living in supported accommodation in the community. Two other family members were sampled but then declined to participate due to personal issues.

3.9.v: CLUSTER FIVE - MENTAL HEALTH COMMISSIONERS:

Mental health commissioners were the fifth cluster stakeholder group included.

INCLUSION CRITERIA:

Individuals with direct responsibility for commissioning mental health care within criminal justice environments or for specific community teams were eligible for inclusion.
EXCLUSION CRITERIA:
Commissioners without knowledge, experience or current responsibility for commissioning secure, specialist criminal justice or community mental health services were excluded.

RECRUITMENT:
Commissioners were approached by email. However, due to recent NHS restructuring individuals that have initially agreed to participate either no longer had responsibility for mental health or were not in post. Following further unsuccessful attempts the researcher managed to gain agreement for two other commissioning managers to take part.

3.10. AIMS OF RECRUITMENT AND SAMPLING STRATEGY FOR PARTICIPANT CLUSTER GROUPS
The study included participants of different ages, experiences and locations within the field sites, to optimise the range of perspectives, through communication with mental health and criminal justice team managers. The inclusion of service user perspectives (Noble et al. 1999; Rose, 2001) and equally families and carers (Brand, 2001) were central to the study. Wide stakeholder representation was important to the study to co-construct a Grounded Theory of transitional support and CTI for individuals at the entry points of the CJS.

3.11. RATIONALE FOR SAMPLE SIZES:
Sample sizes were difficult to gauge as this was the first qualitative study of CTI with offenders at the entry points of the CJS. However, in accordance with GTM sampling continued until
saturation was achieved within participant Cluster groups 1-3. Inbuilt flexibility ‘theoretical sampling’ (discussed in next sub-section below) within GTM facilitated the addition of participants from primary and secondary care mental health teams, which were included within Cluster Group 1. Preliminary themes within the data exposed gaps in care pathways for offenders referred to community mental health teams and further sampling intended to explore this through participant interviews. Saturation may not have been achieved for cluster groups 4 and 5; however, no further participants could be recruited within the time frame. There are inherent challenges in recruiting participants within criminal justice settings such as the time intervals within the arrest period. The person has to be clerked by the custody sergeant and interviewed in relation to the charges within permissible detention timeframes before Criminal Justice Liaison staff could interview to confirm suitability and seek initial consent. This resulted in a number of potential participants not being recruited that may have been suitable.

Two remand prisoners did not attend for pre-arranged interviews due to prison officer shortages on the day and they declined further appointments. Two recruited carers also withdrew consent due to personal reasons. One member of the community mental health team was unable to participate due to sickness absence from work. Despite the challenges inherent in engaging service users and families within the study the individuals who participated providing rich data which was fundamental to the co-construction of the grounded theory.

3.12. THEORETICAL SAMPLING:

As the study progressed and categories constructed, participants were selected according to points requiring clarification from the data. This is also known as theoretical sampling, which is
selection based on the conceived concepts found during constant comparison of the data. The co-constructed concepts are described by Corbin and Strauss (2008) as the ‘building blocks of theory’ (p.102) and direct further data collection. As possible theories are generated, theoretical sampling guides final data collection to confirm and consolidate categories (Charmaz, 2006; Glaser & Strauss, 1967). This enables the grounded theorist to collect less data than in other qualitative methodologies because data collection ‘is controlled and directed to relevance and workability by theoretically sampling for the emerging theory’ (Glaser, 1978, p. 47).

In this study, semi-structured individual and group interviews were conducted of varied duration between 37 minutes and 2 hours and 23 minutes. The variance between participants’ interviews is discussed in sub-section 3.18 under the heading of ‘Transcription’. Other data collection methods were employed, including discussion with supervisors and attending mental health team meetings to clarify aspects of the developing theory. The researcher recruited participants from primary and secondary care community teams, as part of the theoretical sampling process to verify that developing concepts were relevant to the transitional care process. This approach was defined by Glaser as ‘theoretical sensitivity’ and involved the recruitment of participants external to the core research area to support theoretical development (Glaser, 1978). Participants were also theoretically sampled by the length of health or criminal justice experience and by gender to optimise variation of perspectives.

The researcher aimed to ensure the direction of the sampling and developing concepts remained grounded in the data (Corbin & Strauss, 2008). The researcher was flexible to changing interviewing styles and questions, by following up on recurring patterns in participant data to
ask key participants for more information on categories that seem central to theory generation (Charmaz, 2006; Draucker et al, 2007). Saturation of data was achieved after interview with 42 participants; themes were confirmed and existing results verified by previous participants.

3.13. DATA COLLECTION:

Data can be drawn from a variety of sources to develop a GT. In GT methodology, sources may range from interviews, written documents, field notes and the researcher’s own reflections on the content or methods used within the study (Charmaz, 2006; Corbin & Strauss, 2008). In this study, arrestees, remand prisoners, health and criminal justice staff were the key sources of data obtained through interviews, supported by field notes, reflections and discussions with supervisors and clinicians external to the project.

3.14. PROCEDURE FOR CONDUCTING INTERVIEWS WITH ALL PARTICIPANTS IN CLUSTER GROUPS:

The study objectives, confidentiality and consent issues were discussed with participants by the researcher. Participants were provided with 24-48 hours reconsideration time, before interviews took place, with the exception of arrestees due to inherent difficulties of contacting individuals after release from police custody. Financial remuneration was provided for remand prisoners in the form of £3.00 of telephone pin credit.

3.15: INSTRUMENTATION:

The semi-structured interview schedules for the five participant groups (Appendices Section - Appendix 5) were developed by the researcher then reviewed by supervisors and peer
colleagues. The interview schedule was piloted with the recovery network for ease of language, terminology, content and flow and amended accordingly. The schedules were refined following feedback from the Research and Ethics Committee and Service User and Carer Committee including an additional statement emphasising the exploratory nature of the study to ensure that participants do not expect such services to be available at the current time.

The interview schedule involved gathering basic demographic information and asking a series of open-ended questions, using appropriate prompts and probes. The questions explored current mental health service provision, access, engagement and the relevance of the CTI programme. The researcher’s intention was to capture the participants’ perspectives of the ‘care in custody’ episodes to co-construct a grounded theory of how best to meet individuals’ needs.

Semi-structured interviews were flexible and valued participants’ own words detailing experiences, events and beliefs, within a basic structure. The design aimed to elicit similar or diverse views and variance of opinion about the subject. CGT methods allowed the researcher to ask supplementary questions and change the format in response to data arising from earlier interviews to clarify potential themes (Bryman and Bell, 2007; Charmaz, 2006).

The researcher attempted to put people at ease by opening the interview with an informal exchange for example ‘how they were feeling’. Interviews were held at a venue of the participants’ choice with the exception of remand prisoners who were seen within the healthcare department of HMP Preston. This was because permissions for use of the Dictaphone was restricted to the healthcare department for security reasons. Interviews were held in private
interview rooms to protect participants’ confidentiality and booked in advance. Staff members chose to be interviewed in offices within the workplace and carers were interviewed at home environments or prison visits department to simplify travel arrangements.

Before describing the transcription process the Social Network Method is detailed (sub-section 3.16 below). Sociograms were developed with service users in both prisons and police custody suites to ensure the availability, level and functionality of social support was included. The inclusion of this method supported the interview data and specifically ensured service users’ perspectives were represented.

3.16. SOCIAL NETWORK METHOD

Within the semi-structured interviews with service users personal (ego-centric) social network data was collected to establish the existence and types of support available to individuals in the community, following release from custody. Social network methods produce a range of data that can be analysed using narrative, content and thematic approaches to aid understanding of the content, meaning and motivations of relationships within the network (Valente, 2010). Relationships can be uniquely individual and the strength and depth of relationships can vary over time or in response to life changing situations. This was significant for arrestees and remand prisoners as becoming involved in the criminal justice system can be a critical, life changing event affecting the individual and the relationships within their personal network. Therefore it is important that the type, quality and significance of ties between network members are explored rather than assumed (Phillips et al, 2001).
Qualitative Social Network Analysis (SNA), applied in this study, incorporated the examination of smaller scale personal networks termed ‘egocentric networks’ (Prell, 2012, p.118). Egocentric networks site the ‘ego’ (the individual) at the centre of data collection with the network being constructed from this central perspective and source of information (Wellman, 1983). This is appropriate to accentuate a service user qualitatively and is suitable for the confines of a PhD study. SNA has the potential to amplify the service user’s voice and opinions by the diagram being structured from their perspective. Within the egocentric approach ‘alters’ names and network position are provided by the ‘ego’ and as such may not necessarily be known to others within the network. Alters are other people identified as members of the network by service user ‘ego’ (Wellman, 1989).

Distinct SNA maps or ‘sociograms’ were produced during data collection rather than within the analytical process. A sociogram is a visual representation of the interpersonal relationships an individual has within a group (network) situation. Within egocentric, qualitative studies, sociograms are generated with the service user. Sociograms aid exploration and understanding of structural characteristics specific to an individual’s network, for example, the strength of relationships, frequency of contact between the ‘ego’ who is the subject, and other members in the network (Freeman, 2000).

The method facilitated the inclusion of qualitative data by allowing clarifying questions during network development, for example, about where and why participants placed ‘actors’ in relation to the centre on the map (Pahl and Spencer, 2004). Emmel and Clark concur that participants are encouraged to ‘move from descriptions of social practices, to elaboration and
theorisation’ (Emmel and Clark, 2009, p.16), which is important to aid understanding of the impact of social relationships.

SAMPLE

Social networks were constructed with eleven service users within the semi-structured interview as detailed in Table 6.

Table 6: Sample of Service Users with Sociograms Completed

<table>
<thead>
<tr>
<th>Research ID</th>
<th>Pseudonym</th>
<th>Arrest</th>
<th>Remand</th>
<th>Sociogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID:1023</td>
<td>Stephen</td>
<td>Arrestee</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1024</td>
<td>Paul</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1025</td>
<td>Mark</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1026</td>
<td>Frank</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1027</td>
<td>David</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1028</td>
<td>James</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1029</td>
<td>Philip</td>
<td>Remand</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1030</td>
<td>Jill</td>
<td>Arrestee</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1035</td>
<td>John</td>
<td>Arrestee</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1036</td>
<td>Sue</td>
<td>Arrestee</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>ID:1039</td>
<td>Peter</td>
<td>Arrestee</td>
<td></td>
<td>Completed</td>
</tr>
</tbody>
</table>

RECRUITMENT:

The researcher combined the development of social networks within the qualitative interviews conducted with service users, therefore separate recruitment strategies were not employed. Social network data was not compiled about staff members’ professional networks as this would not aid the understanding of service users’ egocentric networks. Furthermore, it was not
practical due to the timescales available to obtain network data from individual staff working with the service user participants for whom egocentric network data was compiled. This would have provided an alter-perspective that could have enhanced the service user generated networks. However, questions were asked of carers and staff participants around availability and quality of support for arrestees and remand prisoners. Furthermore, questions were asked about the type of support available to service users in the community, particularly during crises, to understand how support is activated or compromised within social networks.

**DATA COLLECTION**

Egocentric network maps, termed sociograms, were constructed using the ‘name generator technique’ (Marin, 2006). Egocentric refers to networks being generated with the individual termed ‘ego’ being at the centre. Other people identified as part of the network, by the service user, were referred to as ‘alters’. Alters were people, with whom the service user had a connection or relationship. Alters were included using an adaptation of Antonucci’s hierarchical mapping technique of concentric circles (Antonucci, 1986) and included five support layers to distinguish ‘closeness’ to the ego. The adaptation of adding two further layers provided additional flexibility for participants in determining closeness of alters. Expansion of the support layers has similarly been applied in other egocentric network studies (Boase et al, 2006; Wellman et al, 2001). The concentric circle technique was developed in 1979, by Antonucci and colleagues to support the first national study of the social networks of older adults in America (Antonucci & Akiyama, 1987) and has been widely applied within social networks studies.
PROCEDURE

Antonucci’s technique was applied by creating concentric circles on large, A3 sized paper, with the central circle labelled as ‘you’. The respondents were asked to identify people for the immediate inner circles as people who are ‘most important’ or ‘very important’ that life would be hard to contemplate without those individuals (such as spouse, close family and friends, with ties that were noted to be long term). The middle circle was about people who were ‘important’ but not as close as those in the inner circle (family, friends and peers, which were described as changeable over time). Finally, the outer circles was for people who were ‘less important’ or ‘not important’ at all, but were considered to have a place within the network (such as distant family, professionals and neighbours described as role dependant and short term), (Antonucci, 1986). Participants were asked to write the first initials of the person the relationships (for example M- sister, P- brother, K- partner) on post it notes to allow movement of the connection during discussion. Participants were asked to place the name on the sociogram as to the current position of ‘importance’ in relation to ‘closeness’ on an everyday basis.

Participants were asked five questions in relation to their visualised network:

Who is in your network?

What is your relationship with the person named?

Who is important to you, and why?

Who would you contact in a crisis?

Has your network changed, and why?
Participants were asked to describe the differences in relationship ‘closeness’ between people placed in the inner, middle and outer circles to understand the importance and value attributed to these relationships. Characteristics including numbers of alters, relationships between ego and alters (for example; parent, partners, relative, friend), gender, age, frequency of contact and geographical distance between ego and alters were obtained. Descriptors about how often people were in contact, accessed support and potential changes as a result of mental illness, offending and imprisonment were incorporated within the sociograms. Finally, participants were asked to position the name (post it note) on one of the five segments (using the five descriptors of importance above). This provided an opportunity to identify ‘who’ within the network participants could access at challenging or distressing times. Antonucci’s technique was applied by creating concentric circles illustrated in Figure 5:

Figure 5: Example of Concentric Circles adapted for use within the study
The method was considered appropriate for use within the study argues it is collaborative and easy to understand for a client group known to have lower levels of literacy, numeracy and high potential for disengagement (Clark, 2008). The circle diagram provides respondents with a flexible framework to aid description of social support networks (Rogers et al, 2011). The concentric circle diagram does not make assumptions about ‘actors’ the ego should include in his/her network; moreover, it facilitates service users to construct social support networks based on their perspectives of closeness. The researcher routinely uses this type of approach within clinical work as it facilitates discussion around how the person sees themselves in relation to others and the type of support available in the community through social networks.

The technique promotes discussion around who is placed where and why (Spencer and Pahl, 2006) and the quality of relationships and ties between those placed on the diagram (McCarty et al, 2007). According to Antonucci, the technique introduces minimal bias due to supplementary questions that are posed (Antonucci, 1986) as described in sub-section 3.16 titled ‘Procedure’. However, Antonucci’s methods are not without the potential for ‘social desirability bias’ in that participants could present themselves in a certain way, for example, to convey popularity, strength or isolation (Cabanac, 2008). Ideally, it would have been useful to counterbalance these effects by revisiting network diagrams to capture ‘real time’ changes to enhance data reliability (Wright & Pescosolido, 2002), but this was not possible within the study time-frame.

Descriptors indicating for example gender, relationship and geographical proximity are visualised by different colours or shapes. Data illustrating frequency of contact and potential relationship changes, as a result of relapse or incarceration, were incorporated and are highlighted in Paper 4: Tying Up Loose Ends - expanding the social networks of offenders.
released from short-term custody and within Chapter Five the second of the Chapters presenting 'Findings’ from the study.

3.17. TRANSCRIPTION

All interviews were recorded and transcribed; however, one respondent declined recording (due to a stated dislike of recording, which generally occurred within police interviews) requiring the researcher to make contemporaneous notes. Technical failures were noted in another interview (problems with the Dictaphone). Another interview contains substantial background noise, making accurate transcription time consuming.

In total, 42 interviews were conducted of varied duration of between 37 minutes and 2 hours and 23 minutes. The shortest was a remand prisoner and the longest the parents of a prisoner in their home setting. 11 Sociograms (Appendices Section - Appendix 10) were compiled with service users in remand prisons and police custody suites. These were developed within the interview as a method of enhancing interpretation of service users’ perspectives on availability of social support.

Glaser (1978; 1998) does not advocate transcription or the use of a computer because manual handling of the data allows the researcher to remain immersed in the data. However, Charmaz (2006) is not as prescriptive and recommends the researcher listens to the recordings several times as replaying reveals new items of interest. Field notes of participant observations and attributable insights and reflections about the data were also transcribed. The researcher completed all the transcriptions as soon as possible after leaving the research setting. This
facilitated immersion in the data, enabling the experiences and voices of participants to be
gathered immediately, reducing the potential for error. The transcripts and memos were printed,
processed and coded manually. Transcripts were then transferred to Dedoose (Dedoose - Version
6.1.18, 2015) for systematic analysis. Dedoose software facilitated effective exploration of the
data, specifically links, relationships and categorisation, which enhanced the analytical process.
Dedoose is a web application for mixed methods research developed by academics from UCLA,
with support from the William T. Grant Foundation and is the successor to EthnoNotes. Dedoose
is designed, developed and operated by SocioCultural Research Consultants (SCRC), whose
majority of ownership consists of academics from University of California, Los Angeles
(UCLA). Sociograms were transferred into the software VennMaker version 1.03 (VennMaker,
Cologne, Germany), to support the analysis. VennMaker is a software-based instrument used for
data collection, analysis of personal networks and for visualising the functionality of
relationships in social groups.

3.18. DATA ANALYSIS

The CGT method for analysis includes ‘coding’, ‘memo-writing’, ‘theoretical sampling’,
‘saturation’ and ‘sorting’. The difference between the CGT and more traditional social sciences
research approaches are evident in the analytical procedures. CGT requires researchers to ensure
the narrative of participants remains embedded in the findings, outcome and published reports.
CGT confirms the researcher’s ethical obligation to “describe the experiences of others in the
most faithful way possible” (Munhall, 2001, pp. 540).
Charmaz stresses the usefulness of sorting and diagramming data for systematic data organisation to aid theoretical development (Bryant and Charmaz, 2007). In accordance with this suggestion the researcher adapted a model to guide analysis using Fernandez’s (2004) high level research model, illustrated as Figure 6 below. The model and structure of analysis is discussed thereafter.
Figure 6: PhD Design – Model of Analysis
(Adapted from Expanded Research Model, Fernandez, 2004)

Clinical Experience → Developing the idea → Initial Literature Review → Determining the Methodology

S h a p e ideas

Entering the research setting

Substantive Research Area
Analysis of data from 42 participant interviews in 5 cluster groups
198 Open codes/1209 excerpts

198 Open codes/1209 excerpts categorised into 3 theoretical/root codes and 12 selective/parental codes with 183 sub-categories/child codes:

Opportunities for assessment/support
- entry by arrest
- access to mental health services
- complex needs
- engagement in services

Modes of action/practice
- unmet needs & resource deficiencies
- increased demands on community teams

Transitions and transfers of care
- poor transition planning
- importance & influence of networks
- continuity of care
- lack of practical assistance
- lack of crisis support
- returning to the security of the prison

Memos & field notes

Theme and Theoretical Saturation

Review existing Literature

Informs and Refines coding

Theoretical Coding

Health and criminal justice policy should focus on transitions rather than discharges and provide transitional case management at the entry and exit points of the criminal justice system

Substantive Theory
Mental Health Assessment is increasingly undertaken in custody but still fails to deliver care in the community
There are no consistent models of multi-disciplinary practice to organise support to meet the diverse health and social needs of individuals at arrest and remand stages
Poor transition planning results in a lack of continuity of care and increased risks of relapse and recidivism

Informs and relates substantive theory to relevant theories in the literature
Data analysis commenced with transcription and review of the first interview of mental health staff in Cluster 1. Immediate analysis is a distinguishing characteristic of the GT method and guided the direction and content for the next interview (Charmaz, 2006; Glaser & Strauss, 1967). Transcription enables close examination and analysis of the text. Notes were made in the margins for points of interest, areas of clarification and singular or repeated comment, which support coding and future theory development.

Four stages of analysis were undertaken in this research. These were transcription, open coding, selective coding and theoretical coding. The interviews and analyses of the data were conducted by the researcher. Throughout the course of the research, field notes, theoretical memos and reflective memos were maintained to keep track of the ideas emanating from the research.

3.18.(i) CONSTANT COMPARISON

In GTM constant comparison is the process of sequential data collection and analysis also referred to as the iterative cycle of induction and deduction of existing and new findings and further data collection (Strauss and Corbin, 1990; Miles & Huberman, 1994). This cyclic data gathering process combined with analysis is central to CGT. The data spiral continues whilst the researcher constructs meaning, interprets and develops theoretical concepts from the data. Hypotheses are constructed to confirm or reject explanations until the most meaningful and accurate interpretation is found (Charmaz, 2006). This process continues by generating concepts until an overarching theory is constructed that suitably accounts for data similarities and variations.
CGT is open and flexible, with the researcher remaining ‘close’ to the data; codes are simple, precise and include participants’ language, attitudes and values. Data was compared, word by word, line by line, incident by incident, coded and re-coded and reviewed frequently, termed the ‘constant comparison method’. Actions, thoughts, reflections and comments on potential categories or themes were consistently and extensively noted for use in the overall analysis. This was important as subtle nuances, for example, within prisons regimes are relevant to developing knowledge, understanding and the construction of theory. Dedoose software (Version 6.1.18, 2015) supported data management and content analysed using the techniques of CGT, including initial coding, axial coding, theoretical coding and selective coding, which are illustrated in Table 7 below:

Table 7: Four Stage Coding Technique of CGT:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Identifying basic constructs that allow the key points of the data to be gathered</td>
</tr>
<tr>
<td>Concepts</td>
<td>Collection and linking of codes of similar content to facilitate data grouping</td>
</tr>
<tr>
<td>Categories</td>
<td>Broad groups of similar concepts/themes are linked and ordered to generate a theory</td>
</tr>
<tr>
<td>Theory</td>
<td>A collection of categories that explain the subject of the research</td>
</tr>
</tbody>
</table>

3.18.(ii) INITIAL/OPEN CODING:

Initial Coding in CGT applied within this PhD study involved making basic notes, insights and descriptors to each portion of the textual data; line by line; within each of the transcripts, commencing with mental health staff in Cluster 1. This continues through each transcript using the line by line, section by section principle. Due to the volume of data, also spanning five cluster groups, distinctive numbering and colouring for each cluster group was applied.
3.18.(iii) AXIAL CODING:

Axial coding comprises the process of identifying relationships among the initial/open codes. Useful concepts were identified with attributable key phrases highlighted. This process involved linking portions of data to bigger concept/s to group the data, which supported theory construction. Developing concepts, groupings and theories guides the content of future interviews to clarify meaning or filling in gaps in the data. This is common during the axial coding process as interpretations, groupings and concepts are tangible, flexible and subject to change.

3.18.(iv) SELECTIVE CODING:

This stage involved linkage between the concepts and theoretical perspectives which is where social capital and network theory converge. As coding continued, examples were extracted and relationships constructed about how meanings link to a larger, more inclusive concept. Negative case analysis was undertaken to establish cases or data portions that did not conform to the model or majority perspective. The development, refinement and integration of concepts, relationships and explanations continued until a central category and theoretical model was constructed, which is represented in Figure 3. Further interviews were conducted to test the integrity of the model whilst data continued to be analysed. The constant comparison method was employed throughout these preliminary stages of analysis (initial/axial and selective coding) and is described below.
3.18.(v) THEORETICAL CODING:

The final stage of the analysis was theoretical coding. The core category was established and a number of sub-categories were intrinsically related and linked. Connections between categories were constructed and succinctly and plausibly refined by the selective coding process (Charmaz, 2006), staying true to participants’ accounts. Categories were then systematically linked through theoretical codes, which ultimately integrate to construct an “inductively driven theory of social or psychological processes grounded in the material from which it was derived” (Tweed and Charmaz, 2012, pp.132).

3.18.(vi) MEMOS AND FIELD NOTES

In this study field notes were taken throughout data collection to aid understanding and interpretation of primary data (Arthur and Nazroo, 2003). Memos and field notes were regarded as a source of multi-level data within the analysis process. In essence, memos and notes supported the development of understanding as existing data was re-examined alongside new material (Charmaz, 2006; Corbin & Strauss, 2008).

Diligent and prompt memo and note-making are crucial to CGT to assist the maintenance of various insights, interpretations and theoretical concepts to support analysis (Hutchinson, 1986). Notes include reference and reflection on the meaning and where it may lead or influence the theory. Field and observational notes helped to identify, explore gaps and connections between data, to support analysis and report-writing. Examples of memos are presented in Table 8 & 9 below:
Table 8: Analytical Memo:

“Today it was difficult to resist diving in and arranging to see X again! It’s going to be weeks and weeks until the CCTT pick her up and she’ll probably end up drinking and in custody again”.

Generally, I believe that being a practitioner/researcher is a positive combination that enhances research by the potential to understand clinical/research environments through active listening skills, rapport/relationships building and having clinical credibility. However, I had to resist a natural tendency as a humanistic clinician to want to ‘help’ people in addition to conducting the research interview. This situation would not necessarily arise for a non-clinical researcher so who is best to conduct sensitive research with ‘hard-to-reach’ groups? And further is this a distinct training need for clinical researchers, particularly when conducting qualitative research?

Table 9: Personal Note:

“...today has been a good day, up early, very well organised (it helps!) .... and the long journey paid off; a relief I've got some family input…. Interviewed a lovely family member (for over 2 hours!) and got some fabulous information. Just glad I went to the Family and Carers Group” -

but my organisation was not so good (doesn’t help!) as consent forms were for service users and not family members. The dilemma was not to interview or to ask them to sign a consent form for service users with hand written amendments for carers and apologise – I opted for the latter ….but felt annoyed at myself.

3.19. RESEARCHER REFLEXIVITY

A constructivist approach promotes researcher reflexivity, which is the declaration of assumptions and perspectives that may contradict or align former experiences and viewpoints (Mruck & Mey, 2007). The explanation of researcher reflexivity within a study enhances
confidence in the data collection, analysis methods and procedures within a study as Sandelowski & Barroso (2002) explain;

“Reflexivity is a hallmark of excellent qualitative research and it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share”

(Sandelowski and Barroso, 2002, p. 222)

Reflexivity involves critical thinking and introspection of research methods, theoretical understanding and the assumptions held by the researcher and has a powerful role in shaping the data within qualitative studies (Ely et al, 1991, p. 179).

A fundamental technique that aided the development of reflexivity was the maintenance of a research diary throughout the study, which contained five types of memo/field notes; 1) observational, 2) methodological, 3) theoretical 4) analytical and 5) personal notes. Observational notes were generally descriptive about research settings, environmental constraints including time pressures. Methodological memos were around thoughts and actions, for example, during interviews and consideration about the appropriateness of selected methods. Theoretical memos were in relation to impressions about the data and initial coding, interpretation of meanings and construction of theory from the volume of data. Analytical
memos contained contemporaneous recording of potential and recurrent themes and how these might relate to the literature or methods. The fifth element ‘personal notes’ were more private and pertained to inner feelings about the personal journey of undertaking a PhD. This included comments about performance anxieties, particularly in certain areas such as concerns about finishing the thesis within the timescales and personal commentary about family illnesses jeopardising deadlines.

3.20. RESEARCH ETHICS

Ethical approval was granted by Research Ethics Committee in Wales (REC Study Reference Number: 11/WA/0177) on the 14 July 2011 (Appendix 1). NHS Approval was obtained and the University of Manchester endorsed the study. The study was granted portfolio status by the Mental Health Research Network. A substantial amendment was submitted to the Research Ethics Committee in Wales to broaden the sample to include staff members from primary and secondary care community mental health teams, in response to developing themes about access and referral difficulties. Approval was granted in September 2012 (Appendices Section - Appendix 1)

Ethical approval and permissions are imperative to protect the safety and the welfare of participants. The nature of the research may involve the discussion of events, behaviours, feelings or issues that some participants may have found distressing or uncomfortable to recall. However, protocols from a previous study involving discussion of personal and sensitive subjects, was amended for use this study. There was an established history of research in mental health, offending and/or suicide/self-harming behaviours within the University of Manchester, to
guide the facilitation of this study. The researcher has an ethical duty to collect, interpret and report the data in an honest and transparent way, faithfully representing the accounts of participants (Holloway and Biley, 2011). The ethics of a project rests, from beginning to end, with the researcher (Neuman, 2003). It is essential that the researcher provides a comprehensive account of methodological decisions, the process of data analysis and interpretation (Reissman, 2008) to assure of ethical practice. The procedures undertaken to support ethical conduct throughout the study are outlined in the next sub-sections.

3.20(i) CONSENT AND DISCLOSURE OF SENSITIVE INFORMATION:

All participant research requires the researcher as a minimum to explain the study including the topic, types of questions, data storage and presentation of findings prior to obtaining written consent from each participant (Richards & Schwartz, 2002).

Information sheets were produced to describe the study rationale, aims, objectives and procedures. Information sheets were produced for each stakeholder group to cater for variations in knowledge and experience among participants. Separate information sheets (Appendices Section - Appendix 4) were produced for service users in accessible language as many individuals involved in the criminal justice system have below average literacy and numeracy rates, 50% have a reading age and 66% numeracy levels below 11 year old (Clark and Dugdale, 2008). Participants on remand were given at least 24 hours to consider the information prior to providing consent. As stated in earlier sections of recruitment this was not practical for arrestees, as follow up after release from custody was problematic.
Of importance to this study was the artificial nature of the interview, relevant body language, potential motivations and meanings in the participants’ statements (Hutchinson and Wilson, 1992). A range of behaviours may be evident within interviews whereby people may adopt various strategies to present themselves in certain ways as a result of low self-esteem, symptoms of mental illness, institutionalisation, environmental effects (police stations and prisons) and the researcher must be aware of these behaviours within the conduct of the interview and during analysis.

It was important for the researcher to understand the importance of the relationship formed with participants and to recognise the effect on the participant’s account (Rapley, 2001). Participants can be affected by research participation evident in overly assertive or defensive strategies including excessive politeness and approval-seeking (Hutchinson and Wilson, 1992). Other mechanisms are showing anger to convey distress and obedience (Felson, 1984) or ‘self-handicapping’ to avoid taking responsibility by the generation of excuses for poor performance (Aronson et al, 2009, p.174). These are termed ‘social desirability bias’ and represents a body of research (Tedeschi et al, 1984) which is relevant to social research but cannot be comprehensively examined within the scope of this PhD study.

Participants were thanked for consenting to take part in the study and reassured they could choose to decline to answer any questions without explanation (Green & Thorogood, 2004). Participants were also informed that they could ask for the interview to be paused allowing time for re-composure. It was also reinforced that at any time they could terminate the interview,
withdraw their consent and the recording would be destroyed. This demonstrated the researcher was aware that recalling events or situations can evoke upset or distress and that the emotion evoked by reporting events may facilitate withdrawal of consent. Participants were reassured that decisions to take part should not be made on the basis of concern about the care they receive or future job prospects and should not be hindered in describing negative experiences as information would remain anonymous.

3.20(ii) CONFIDENTIALITY AND ANONYMITY

The interviews were recorded using a digital audio-recorder. All identifiable data was removed at the transcription stage, and each transcript was saved using the unique research ID to ensure confidentiality. Any potentially identifiable data was anonymised and not entered onto the research database. This process involved amending details without affecting the integrity of personal accounts (Wengraf, 2001).

3.20(iii) MANAGEMENT OF DATA & STUDY INFORMATION

All data was stored on an encrypted pen drive and a password protected computer secured against unauthorised access, within the Department of Community Based Medicine at the University of Manchester, in accordance with the participating Trust/University policies and procedures.

A study master file was established, containing all relevant documentation such as funding application, ethical approvals, research protocol, study information sheets tailored for all groups
of participants, confidentiality statement/protocol, consent forms for various participants, information on intensive case management as used in other clinical areas, interview schedules and progress reports written for sponsors, host organisations and funders. The researcher maintained a practice research file in electronic and paper format containing minutes of meetings at study sites, field notes, power-point presentations and participants by Research ID number that were screened, enrolled, consented or withdrawn from the study. A diary of research activity noting areas of interest and limitations in the data collection process supported the analysis of data.

3.21. EVALUATING THE METHODOLOGICAL RESEARCH PROCESS

Charmaz (2005) provided evaluative criteria which guided the researcher to reflect on the research methods, process, findings and outcome. The four criteria are detailed below in Figure 7 accompanied by the researcher’s explanation of the application of each criterion within the study.
Figure 7: Evaluative Criteria for CGT Studies (Charmaz, 2005, pp.527)

**Credibility** - familiarity with the research context and setting to accurately and systematically analyse the data and generate a coherent story and overarching theory from the data.

**Originality** - the researcher’s study is an original investigation which could provide highly relevant theoretical insights to challenge and refine current policies and practices for transitional care of arrestees and remand prisoners.

**Resonance** - the researcher is able to draw links, raise pertinent points and provide interpretation of participants’ narratives in a meaningful way for service users, managers and funders alike.

**Usefulness** - the study is useful to understand the barriers and facilitators to developing a structured programme of transitional care for arrestees and remand prisoners and may contribute to improved community reintegration.

Interpretive concepts of ‘credibility,’ ‘transferability’, and ‘dependability’ (Hirschman, 1986) were also applied to demonstrate data and study integrity and trustworthiness. The first criteria ‘credibility’ consisted of developing a logical chain of evidence. This included citations and participant quotes, relating to the relevant sections of the thesis and study reports. Secondly, the practice of forwarding transcriptions and interpretations to participants for confirmation of accuracy and interpretation, termed ‘member checking’. Thirdly, credibility was maintained through the development of study protocol, information sheets and data collection processes.
The second criterion, ‘transferability’ relates to whether a study’s findings are considered transferable to other settings or research methods. CGT studies do not seek to produce results that are portable or generalisable. Secondly, transferability can be viewed as participant generalisability, that is the extent to which findings can be applied to another situation or population (Merriam & Simpson, 1995).

The third criterion, ‘dependability’, relates to determining whether the researcher’s judgements and decisions were dependable and consistent with the available data. In this research study dependability (reliability) was pursued by the maintenance of a study file containing copies of the protocol, interview guides, field notes and other documents relevant to the field, such as operational policies for teams. An audit trail shows how data were collected, categories derived and how various methodological or theoretical decisions were made. In summary, credibility, transferability and dependability were considered throughout the research process to ensure that a high level of rigour was maintained.

3.22. POTENTIAL LIMITATIONS OF PhD STUDY:

The purpose of the PhD study was to explore the experiences of mental health care from the perspectives of stakeholders and not to construct generalisable theory, applicable to all male arrestees and remand prisoners.

The participants in the study were drawn from one large geographical area served by a single mental health trust, police force and prison service (males only). The descriptors of being ‘mentally ill’, an ‘arrestee’ or ‘remand prisoner’ are socially constructed; therefore different geographic, institutional, cultural or gender contexts could generate different observations and
Understandings.

In qualitative research the researcher has significant influence throughout the study including design, interviews, interpretation and theory co-construction. The researcher has endeavoured to be transparent, organised and to adhere to the CGT methodology.

### 3.23. CHAPTER SUMMARY:

This chapter has outlined the theoretical and methodological background to the study. Given the complexity of the research problem, as well as the epistemological stance of the researcher, a qualitative approach was adopted. The CGT methodology to data collection methods and analysis was selected as the intention was to derive rich detail from participants. The data collection process involved selection of the study sites of police stations and a remand prison, sampling participants, conducting semi-structured interviews, memo-writing and transcribing of data. Dedoose software (Dedoose - Version 6.1.18, 2015) supported data management, and content was analysed using the techniques of CGT, including initial coding, axial coding, theoretical coding and selective coding to co-construct the theory grounded within the data. The ethical considerations for conducting qualitative interviews and social network analysis were explained. Finally, the researcher’s position and role in shaping the data was discussed.
Chapter 4

4.1 Introduction

This chapter presents the main findings from the study, gained through the application of CGT methods. Dedoose software (Dedoose - Version 6.1.18, 2015) supported the analysis of transcripts and memos resulting in 198 individual ‘open’ codes and 1209 relevant excerpts, which are shown in Appendix 8.

Familiar patterns between codes and excerpts within and between stakeholder groups were differentiated, compared and combined. This generated five layers of coding with parental codes linked to three root themes, which are illustrated in Table 10 below:
Table 10: Summary of Themes & Codes

<table>
<thead>
<tr>
<th>Root Themes</th>
<th>Parental Themes/Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opportunities for Assessment/Support</td>
<td>Entry by arrest</td>
</tr>
<tr>
<td></td>
<td>Access to mental health services</td>
</tr>
<tr>
<td></td>
<td>Complex needs</td>
</tr>
<tr>
<td></td>
<td>Engagement in services</td>
</tr>
<tr>
<td>2. Modes of Action/Practice</td>
<td>Unmet needs &amp; resource deficiencies</td>
</tr>
<tr>
<td></td>
<td>Increased demand on community teams</td>
</tr>
<tr>
<td>3. Transitions and Transfers of Care</td>
<td>Poor transition planning</td>
</tr>
<tr>
<td></td>
<td>Continuity of Care</td>
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<tr>
<td></td>
<td>Lack of practical assistance</td>
</tr>
<tr>
<td></td>
<td>- Housing</td>
</tr>
<tr>
<td></td>
<td>- Finance and benefits</td>
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<td></td>
<td>- Education and employment</td>
</tr>
<tr>
<td></td>
<td>- Substance misuse</td>
</tr>
<tr>
<td></td>
<td>Lack of crisis support</td>
</tr>
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<td></td>
<td>Returning to the security of the prison</td>
</tr>
<tr>
<td></td>
<td>Importance and Influence of Social Networks (see Chapter 5)</td>
</tr>
<tr>
<td></td>
<td>Stigma and Labelling (see Chapter 5)</td>
</tr>
</tbody>
</table>

The paper entitled ‘Into the Void: Meeting the transitional care needs of arrestees and remand prisoners’, outlines the findings in relation to the over-arching theme of ‘Transitional Care’ and forms part of this chapter. The remaining findings in relation to the two other root themes of ‘Opportunities for Assessment/Support’ and ‘Modes of Action/Practice’ with associated codes and excerpts are discussed in this chapter.
The theoretical framework by Lin (1999; 2001) ‘network theory of social capital’ incorporating three components - ‘inequalities’, ‘capitalisation’ and ‘effects’ informed the grouping of codes, interpretation and implications of results (Lin, 1999, p.35). Lin defined social capital as ‘resources embedded in a social structure that are accessed and/or mobilised in purposive actions’ (Lin, 2001, p.29). Social capital is understood on both individual (micro) and collective (macro) levels (Putnam 1993; 1995). On a collective level social capital is representative of trust, values, bonds and social cohesion produced by and for the community (Coleman 1990, Putnam 1995a, 1995b). Conversely, micro-level social capital denotes the availability of resources to support the individual’s functionality, well-being and objectives (Erickson 1996; Flap 2002; Lin 1999a; 2001), which are the sentiments adopted within this study. I posit that offenders may gain some form of social capital through social contact with others such as family, and friends. However, support becomes more limited where significant substance misuse, relapse or frequent periods of incarceration feature (Travis and Waul, 2004). Resources are embedded in social structures; but access to and use of supports may differ according to individuals’ desires or abilities and the willingness of network members to share resources. Lin’s three characteristics of social capital resonate with the three root themes 1) ‘Transitions and Transfers of Care’, which incorporates ‘Inequalities’, i.e. the inequitable service structures for offenders and the inadequacies of transfer of care arrangements, 2) ‘Opportunities for Assessment/Support’ which influences ‘Capitalisation’. i.e. the availability of support 3) ‘Modes of Action/Practice’ refers to the ‘Effects/Returns’, i.e. purposeful actions or behaviours which provides both positive and negative returns. The central root themes, codes and associated excerpts are presented within this chapter. The findings are interwoven with the relevant
literature to provide an integrated discussion. The salient points are summarised within the conclusion of this chapter.

Attached to these root themes are a range of parental codes/themes: ‘entry by arrest’, ‘mental health assessment’, ‘complex needs’, ‘increased demands on community teams’, ‘engagement in services’, ‘unmet needs & resource deficiencies’ and ‘increased demand on community teams’, with codes are presented below. Another parental theme titled the ‘Importance and Influence of Social Networks’ is discussed in Chapter 5 in relation to the social support available to service users. Themes discussed relate to the findings from semi-structured interviews with forty-two participants, in five cluster groups; service users (arrests/remands), carers/family members, mental health staff (criminal justice and community teams), criminal justice staff (police and prison officers) and mental health commissioners. The recruitment and sampling strategies are contained within Chapter 3 ‘Methods’ and within the paper Into the Void: Exploring the transitional care needs of arrestees and remand prisoners, which as stated above accompanies this chapter. In total 42 interviews were conducted as illustrated in Table 11 below:
Table 11: Participant Identifiers

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Interviews</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster 1:</strong> Mental Health Inreach (MHI)</td>
<td>5</td>
<td>1 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Criminal Justice Liaison (CJL)</td>
<td>6</td>
<td>2 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Primary Care (PCMHT)</td>
<td>2</td>
<td>1 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 female</td>
</tr>
<tr>
<td><strong>Cluster 1:</strong> Mental Health – Secondary Care (CMHT)</td>
<td>3</td>
<td>2 female</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 male</td>
</tr>
<tr>
<td><strong>Cluster 2:</strong> Criminal Justice – Police Officers</td>
<td>5</td>
<td>5 male</td>
</tr>
<tr>
<td><strong>Cluster 2:</strong> Criminal Justice – Prison Officers</td>
<td>5</td>
<td>3 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 female</td>
</tr>
<tr>
<td><strong>Cluster 3:</strong> Service Users - Arrestees</td>
<td>5</td>
<td>3 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 female</td>
</tr>
<tr>
<td><strong>Cluster 3:</strong> Service Users - Remand Prisoners</td>
<td>6</td>
<td>6 male</td>
</tr>
<tr>
<td><strong>Cluster 4:</strong> Family/Carer</td>
<td>3</td>
<td>1 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 female</td>
</tr>
<tr>
<td><strong>Cluster 5:</strong> Mental Health Commissioners</td>
<td>2</td>
<td>1 male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 female</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td></td>
</tr>
</tbody>
</table>

The above table details the numbers of interviews conducted within each of the five cluster groups. Specifics descriptors of gender and employment status are included. This is not to provide an analysis of the differences in responses by gender; but to demonstrate the purposive sampling strategy, facilitated inclusion of a range of participants. The first theme presented concerns service users’ entry to the criminal justice system, by arrest.

**4.2. Entry by arrest**

The entry point to the criminal justice system is through the arrest process, which also provides a gateway to mental health services. Police and prison officer participants were unequivocal in
relation to the increasing numbers of mental health needs among offenders. “We’re seeing more and more mental health cases and it’s increasing every year” (ID: 1015 police).

“The police service is like a social funnel…. Everything comes in and drops down and we are left with it. It’s like a big bowl. Every other service says oh we don’t do that or we can’t take them, he’s not our remit, but we can’t pick and choose, everyone coming here is our catchment” (ID:1017 police).

Fundamental changes in mental health and law enforcement policies over the decades have contributed increased contact with the police by people with mental health problems (Lurigio & Harris, 2007). The most recent policies to impact on mental health and criminal justice agencies include the ‘Mandate from Government to NHS England’ (DH, 2013), ‘No Health, Without Mental Health’ (2011) and ‘Closing the Gap’ (2014), which emphasise the need to attain ‘parity of esteem’, between physical and mental health services. In addition, the Mental Health Crisis Care Concordat endorses the agreement between health, criminal justice and social care agencies for provision of urgent and emergency community-based mental health care, available 24 hours a day, 7 days a week (DH, 2014). Despite, the expressed commitment there has been no additional funding to extend mental health crisis services other than to expand CJL services. CJL has been available to police custody suites for over decade, but national provision has been patchy and poorly coordinated (Bradley, 2009). In 2014, Norman Lamb, Care Minister announced an additional 25 million to provide liaison and diversion services to police and courts across the country stating;
“Too often people with mental health illnesses who come into contact with the criminal justice system are only diagnosed when they reach prison. We want to help them get the right support and treatment as early as possible. Diverting the individual away from offending and helping to reduce the risk of more victims suffering due to further offences benefits everyone”.

The increased resource allocation intends that everyone in police custody or in court settings has their mental health, learning disability and associated needs assessed and are referred on to appropriate care and treatment. Police participants noted improvements since the expansion of criminal justice liaison teams “it’s much better now we have mental health in custody 7 days a week, before it was a nightmare… now it’s just a nightmare when they’re not here” (ID 1016 police).

Assessment of health and social needs within police custody provides an early opportunity to engage people in appropriate support services before escalation of revolving door crises and crime (Bradley, 2009; Commander et al, 1997). Criminal justice liaison (CJL) screen, assess and signpost individuals to appropriate health and social services. The system is largely reliant on police officers who are “extensively trained but have limited mental health knowledge” (ID: 1017 police) making a referral. Arrestees may present with mental health problems of a severe and obvious nature, which police identify as a ‘cause for concern’. Individuals may already be known to services, and the role of CJL is to support re-engagement with mental health services. However, many arrestees may present with less marked illness, but have significant vulnerabilities linked to a range of health and social needs that require support.
“I reckon 40% of the people we see here haven’t had any contact with mental health services before. 60% have, but it’s not always been positive” (ID: 1013 CJL).

Current CJL practice is to cross reference the custody log against the mental health database to identify individuals who may not have disclosed or exhibited behaviour that would trigger mental health assessment. However, the service is not available on a twenty-four hour basis; consequently, people with mental health related needs may still be missed in police custody. Furthermore, changes to familial and social structures have contributed to reduced availability and access to social support, which results in contact with emergency services, such as A&E and the police (Canadian Mental Health Association, 2005).

4.3. Access to Mental Health Services

Following assessment by CJL, local arrangements dictate referral to the ‘Single Point of Access’ (SPoA), for primary or secondary mental health services. However, mixed views about the effectiveness of the system were expressed by participants.

“Single point of access…pah! More like round the houses” (ID: 1030 Arrestee)

“I’m still not clear about how you are supposed to get in… there’s no clear pathways it’s more like spaghetti junction” (ID: 1041 Carer)

CJL reported challenges in relation to acceptance by the SPoA and two staff expressed a view that the unofficial practice was to delay or decline referrals in an effort to manage escalating demands on the team. “Barriers are put up to protect the team and not to support the individual
and that’s a problem we come across all the time. We are almost fighting a battle to get someone into services” (ID: 1020 CJL). With poor coping strategies, limited social support service users and carers can be forced to adopt demanding, hostile or extreme behaviours in order to elicit a response (Maiese, 2003; Van Ommeren et al, 2005).

CJL highlighted duplicated processes whereby the community teams repeat the mental health assessments conducted by CJL in custody. The practice of duplicating assessments pertains to assessment for suitability for community interventions and inpatient treatment and the repetitive nature of the process was reported as frustrating for service users, carers and staff. The National Collaborating Centre for Mental Health (NCCfMH), (2012) produced guidance to improve the care experiences of service users in adult mental health services. The qualitative evidence suggested that “a long and drawn out assessment process, delays in receiving a diagnosis, and being given multiple diagnoses could lead to a poor experience of assessment (NCCfMH, 2012, p.63)”. The key problems included lack of involvement of service users, limited therapeutic relationships, inconsistent diagnoses and a lack of information about care planning (NCCfMH, 2012).

“I’m so sick of going over the same things..... over and over again...getting asked the same questions and nothing getting sorted...it’s like going out with nowhere to go...pointless (ID: 1039 arrestee)

“They do another assessment even though we’ve done it, which sometimes feel like a smack in the face because we’ve seen them, highlighted an issue but they still want to send someone out to double check, they kind of disregard what we’ve said… It’s like our assessment’s invalid and
it’s a bit insulting at times” (ID: 1002 CJL participant). “Repeating assessments is a waste of time and resource; they could be doing something else with someone instead of re-doing what we’ve done. We all use CPA so the assessment is the same anyway” (ID: 1013 CJL).

Carers described being excluded, despite trying to offer information to the assessment process. “We felt shut out, it was horrible it’s like we’re not important. We were completely disregarded yet know him best” (ID: 1040 Carer).

Another carer described feeling “out of the loop”, until concerns were escalated by serious offending. “We were never asked, we tried to speak to professionals but they didn’t want to know. Nobody wanted any information from us until X was admitted. We knew something serious was going to happen because he was in such a mess……” (ID: 1041 Carer). The lack of involvement described by carers is consistent with the literature indicating the focus on service users alone and neglect carers roles and needs (Hervey & Ramsay 2004). The limited information provided to carers has been highlighted (Fruin, 1998) as due to professionals’ perceptions of the need to maintain confidentiality (Rethink, 2003) and the lack of permission from service users (Pinfold & Duggan, 2010). The role of carers was elevated within the National Service Framework for Mental Health (DH, 1999) and guidance issued to improve communication (RCP, 2004). However, carers continue to feel excluded from assessment and care planning processes (Ridley et al, 2010).

After referral, the next process within Single Point of Access (SPoA) arrangements is an ‘opt in’ letter, with a tear off slip for service users to return confirming a wish to receive the service.
“Having to opt in is a barrier cos they’re motivated when they’re here but as soon as they go through that door other things take over’ (ID: 1022 MHI). The process of opting in, which is a partial booking procedure, has been shown to have limited success (Kreyenbuhl et al, 2009; Reda & Makhoul, 2001)). O’Brien et al (2008) reported that young, low social-functioning males are more likely to disengage with potentially serious consequences (Kreyenbuhl et al, 2009), which is recognised within Lin’s theory (1999; 2001). The development of therapeutic relationships, patient-centred care and shared decision-making have been shown to positively impact on attendance for appointments (Adams & Drake, 2006; Deegan et al, 2008; Mistler & Drake, 2008; Stewart et al, 2000), which are not supported within a simple ‘opting in’ procedure. Relationships and feeling empowered facilitates a sense of being able to access support which will bring about positive effects/results to individuals lives (Hawe & Shiell, 2000).

The next stage of the access process is to wait for a vacancy. However, primary care teams have a waiting list of “about 30 weeks unless expedited due to clinical issues” (ID: 1031 community mental health team), resulting in “people coming back into custody that are still on the waiting list” (ID: 1019 CJL). Difficulties in rearranging appointments were highlighted by service users; one service user reported.

“I have seen someone here [police custody] before and been referred to community mental health but I couldn’t go. I phoned to change the date, cos it’s difficult getting out of work in the
middle of the day and they said they’d send another appointment but never have” (ID: 1035 arrestee).

Caseload management procedures in community teams include discharge from services following three failed appointments without any follow up to check on the welfare of the service user. Disengaging during active mental health treatment is common (Marshall et al, 1998), particularly among dual diagnosis populations (Klinkenberg & Calsyn, 1996) and can have serious implications for social adjustment, community reintegration and recovery from mental illness (Kreyenbuhl et al, 2009) and as Lin posits limited social capital (Lin, 1999). Engagement strategies should be put in place that target high-risk groups and high-risk periods to optimise service involvement (Doyle et al, 2014).

“I was discharged before I’d got any help cos they said I didn’t turn up for appointments I’d rearranged one or two but it’s your word against theirs and it doesn’t count for zip” (ID: 1026: Remand prisoner).

“I think one of most concerning issues for me is that people are discharged from the CCTT [community team] for three failed appointments and it might be they have become unwell or got into difficulty” (ID: 1013 CJL).

4.4 Complex needs

Increasingly complex health and social needs of people, at all stages within the criminal justice system were highlighted by participant groups. “most of them have deep rooted complex
problems and we have to determine the areas where we can actually help....to the exclusion of others” (ID: 1031 community mental health team). “we get referrals all the time for people with very complex needs, like drug and alcohol issues, PD [personality disorders] and learning disabilities. There’s no straightforward schizophrenia any more” (ID: 1004 MHI).

The service users described a range of difficult and upsetting life experiences, which as Lin states limited abilities to positive generate social capital through family and community resources (Lin 1999, 2001). There is a body of literature about relationships between abuse, neglect, poverty in childhood and subsequent aggression, criminality and post-traumatic disorder (PTSD), (Hussey et al, 2006; Widom & Maxfield, 2001; Smith et al, 2005; Skowyra & Cocozza, 2006). Furthermore, a suggestion of an underlying mental health component, alongside the PTSD often with substance misuse associated with violent offending which is unrecognised and untreated (Gray et al, 2003).

“I was sexually and physically abused in care....I was only 11 years old. I’ve always wanted to get off my head to deal with it, it’s the voices and the flashbacks out there that make me wanna cut [self-harm]” (ID: 1024 remand prisoner)

“I’ve lived on the streets since I was 13 years old” (ID: 1027 remand prisoner)

“My life has been hard, too hard” (ID: 1035 arrestee)

“I thought there were people coming to kill me...I was trying to survive, I kicked off and I didn’t stop until they tasered me and then it took 7 of them to restrain me and get me into hand and leg cuffs” (ID: 1025 remand prisoner)
“I get stressed. I am angry, very angry - cos of the way my life has worked out (ID: 1034 arrestee).  

Health and criminal justice participants linked the disruptive and distressing past histories with limited coping skills “Most have poor coping skills and use substances to blot stuff out, which leads to more problems and they end up in trouble with the police” (ID:1037 commissioner). “a lot [service users] are frightened, this comes across as they’re angry and they need someone to show they want to help” (ID: 1003 CJL participant). Two service users described having techniques for dealing with stress such as fishing and walking “the thing that helps me is walking, it stops the pressure building, but I can’t do that in custody” (ID: 1036 arrestee). Understanding how people cope with pressures could usefully be part of the assessment process and care planning process. Service users stated a wish to change “I want to feel better and change my life, but I need help to do that” (ID: 1035 arrestee). “I need to change .... I know that, but I’ve got nothing and no-one and I can’t do it on my own” (ID: 1027 remand prisoner), highlighting the sense of isolation and inability to access any form of practical or emotional support (Lin, 1999; 2001; Travis & Waul, 2004).  

“We try hard to help, but it’s not enough. Some of them do OK here then go out to chaos and families and friends where offending is more or less the norm” (ID: 1021 MHI). The presence of repeat offending was reported within families and throughout generations. Three prison officers described working with offenders, siblings and previously their parents. Mental health staff concurred “they re-enact the experiences of their parents with drug use, poor education, poor housing and most of them go on to be in and out of relationships... some of them are
“rootless” (ID:1023 CJL). “Family day is a window into the future prison population as sad as it sounds” (ID: 1014 prison officer). There is evidence about offender concentrations in certain families, inter-generationally and in particular communities (Farrington et al, 2001; Lin 1999; 2000). This includes exposure to multiple risk factors such as poverty, deprivation, antisocial males, negative parenting styles featuring poor attachment, violence or rejection, lack of supervision, limited boundaries and disrupted family lives (Brezina, 1998; Farrington et al, 2001; Fergusson et al, 2004). However, families are important, for the provision of support to individuals in coping with life events, avoiding re-offending and engaging with professionals (Barnardo’s, 2015; Lin 1999; 2000; Travis & Waul, 2004).

4.5 Increased demands on community teams

Community staff disclosed work related pressures due to case-load numbers, service re- structuring and recording systems. “haven’t got the time to work with offenders, they take more time that we’ve got” (ID: 1033 community mental health team).

“It’s so stressful, we’ve got high case-loads full of demanding and challenging clients and most of them aren’t compliant and need lots of input ….we can’t provide. You dread going on holiday because you don’t know what you’re coming back to” (ID: 1034 community mental health team).

“it’s increasingly difficult to help people....we’ve had to cut back on what we do face to face to document what we do...how mad is that” (ID: 1033 community mental health team). “I came into nursing to help people. I didn’t expect to spend most of my time on a computer… that’s an
administrator’s job”, (ID: 1032 community mental health team). Reductions in clinical time for direct interventions with individuals have been recognised by NHS England (DH, 2014). However, the impetus was on improving the situation for inpatients. The accompanying ‘Compassion in Practice Implementation Plans’ (2015) guidance document attempted to expand the sentiments of direct care to other settings, such as learning disabilities and community mental health; but application within offender health pathways are negated.

As a consequence, one of the developments among mental health practitioners to cope with the clinical demands such as crises and relapse is to request support from the police in the form of welfare checks; “I know mental health is busy and they have a lot of cases but it’s a recurring theme they ring up saying they haven’t been able to make contact with John Doe and can we go round and see if he’s ok…. it’s the 4.45pm brigade as we call them” (ID: 1018 police participant). The police reported that each week between 15 to 35 such requests are received across the county resulting in officers being deployed, without access to mental health information and taken away from other investigations for many hours. “I get the distinct impression that services are under pressure so they pass it to us… they pass the baton and run….we’re left not knowing what to do” (ID:1017 police participant). “You can’t do nothing…you have to do something. We can’t wait to see what evolves, we have to respond immediately” (ID: 1018 police participant).

4.6 Engagement in services

Police identified remand to custody as the most efficient way of ensuring service users with complex needs gained access to mental health services “if they get bail, you know they won’t
get support, they have a better chance of getting the help they need if they are remanded” (ID: 1018 police participant). However, the lack of early intervention, particularly with less serious offending was highlighted “the shoplifter may not get help because in the grand scheme of things we’re not bothered about shoplifting it’s not serious enough......things get left until they escalate to more serious offending or mental illness” (ID:1017 police participant). Bradley (2009) stressed the importance of early intervention and diversion services for offenders with mental health problems to avoid unnecessary imprisonment.

Mental health and prison staff regarded prison based mental health services as a positive addition to the care, rehabilitation and support of offenders “people have left here in far better shape than when they came in (ID:1021 MHI), as there were access a range of health and social support (Lin, 1999; 2000). “they get a good service in here and they like it...we have to prepare them for getting less when they go out cos their expectations are too high” (ID:1012 MHI). “when people get released what the community team offer is probably adequate, but they think they should get more like they got in prison, but it’s not possible (ID: 1010 MHI).

Consequently, despite engagement in custodial based services many disengage from services after release (Lennox et al, 2012) “we concentrate on assessment and signposting people to services, but are never sure what happens after that” (ID: 1003 CJL).

“Mental health services in police and prison is a positive thing as most won’t engage in the community. A lot are discharged before they have really attended (ID: 1042 commissioner).
4.7 Unmet needs/resource deficiencies/work pressures

Mental health staff and service users reported particular difficulties in accessing services for people with dual diagnoses; including substance misuse, personality disorder and learning disabilities. Mental health staff working in all sectors highlighted increased pressures since the reduction in availability of inpatient beds. “Since the beds have gone it’s got much worse, it’s been a big impact and this will only get worse. It’s not what I went into the job for to assess someone and have no choice but to see them arrested for their own safety....yeh we should have alternatives, but we need the option of a bed sometimes” (ID: 1033 mental health community team).

The closure of Day Services was considered by all stakeholders to have impacted on service users’ quality of life and available support in the community. “I think there’s been a problem since they shut all the day centres, it was somewhere they could get out the house and go to, where people were there for them to talk to, have a cup of tea and basically break up the day for them” (ID: 1038 police). “I think we could do worse than have mental health nurses in Weatherspoon’s, it’s where everyone is now days since day centres closed” (ID: 1013 CJL).

Service users highlighted organisational and environmental factors in connection with custody. “I felt low being in custody, I hate being in a cell, it’s too quiet and bare. There’s no privacy and I’m being watched by camera, I keep looking up, wondering who’s watching me” (ID: 1030 arrestee). “I am just sitting in this cell staring at the walls waiting for what seems like eternity. There’s no information and nobody seems able to push things along” (ID: 1036 – arrestee). “Being on remand has been hard, having dates cancelled no wonder I was paranoid about stuff
going on in here and the police and all that” (ID: 1026 – remand prisoner). One commissioner interpreted participants concerns informing “crisis provision is currently being evaluation with the contracts for prisons and police custody up for review next year” (ID: 1042).

Police and community mental health staff reported high levels of stress. The police highlighted increased mental health demands and mental health staff the need for more offender related interventions, which support people in the community (Lin 1999; 2000). In addition to client related pressures health and criminal justice staff posited the increasing business related approaches and expectations as a source of stress (Robinson et al, 1997; Walsh et al, 2006). Over half of staff interviewed reported insufficient senior manager support, which contributed to work related pressures and low morale “senior managers don’t appreciate what we’ve got to do and make no effort to. Their pressures are pushed down on us with no concern about the impact” (ID: 1034). Community mental health, police and prison staff described changes in job role, terms and conditions and organisational restructures as both ‘concerning and damaging’. Whilst stress may be a necessary part of everyday life, excessive levels can lead to tiredness, impaired judgement, poor decision making and increased exposure to physical and mental health problems (Gray, 1999). Work related pressures can lead to psychological distress, longer term mental ill-health, sickness, low staff morale and increased staff turnover, particularly during significant organisational and environmental changes, which have taken place throughout the public sector including police, prisons and health services. Therefore, it is critical that health and criminal justice services develop more integrated working practices, facilitating greater staff support and improved client case management.
Despite numerous comments about the physical and psychological effects of both police custody and prisons, service users acknowledged the improved access to health services with which they felt more comfortable and less stigmatised. Radical improvements to the range and quality of health care have been accomplished, which remand prisons appreciated with three reporting that they had intentionally re-offended to regain access to prison health services. In addition to feeling safe, supported and in familiar environments the quality of the interaction and relationships were acknowledged by service users. The improvements to the services delivered, amidst declining funding has resulted in staff ‘being expected to do more within existing resources’, adding to work related pressures. Staff groups conveyed their desires to ‘make a difference’, to ‘assist’ and ‘improve outcomes’ for people, evident in expressions about the lack of feedback about how individuals settle into the community on release from custody. “we get to know if they re-offend and come back” (ID: 1014). Mental health staff described a division between workforce and managers in terms of priorities “all we need to do is make sure recording is up to date, nobody is bothered about the quality of the human interaction”.

4.8 Summary and Conclusion

The findings and associated literature presented within this chapter highlight the challenges in relation to access and engagement for service users with complex needs in community mental health services, which elevates risk of relapse and re-offending. Offenders may access mental health treatment in the prison, make positive changes, which are then lost when they are released, due insufficient transitional support programmes (Bradley, 2009; Lennox, 2012). The lack of practical assistance to resolve basic needs, for example accommodation, finance and employment in the community was highlighted (Bradley, 2009; Nacro, 2007; Rethink, 2009).
The provision of time-limited intensive support has the potential to engage offenders in meaningful services that improve mental health well-being. However, such services are non-existent for offenders in the community, particularly at the entry points to the criminal justice system. The consequences of which are the development of repeated cycles of criminal justice involvement, largely because of the failure to recognise the links between instability, reduced support and offending behaviour (Draine et al, 2002; Lurigio & Swartz, 2000; Petrila et al, 2003).

Recognising and responding to the health and social needs of offenders, as early as possible on the offender pathway, is at the centre of the government’s Health and Criminal Justice Programme. The involvement of service users, carers and independent sector organisations are emphasised, including expanding social support available in the community. The construction of support networks, as part of assessment and care planning processes, does not feature within the clinical practice of the host Trust. Therefore, there is no impetus for staff to identify important family links to develop the support networks of service users. Consequently, many service users are very isolated at the point of transition from services, which forms the discussion within Paper 4: Tying up Loose Ends: expanding the social networks of offenders released from short term custody and Chapter 5. The next section is Paper 3: Into the Void: exploring the transitional care needs of arrestees and remand prisoners.
Paper 3
Pearsall A, Edge D, Doyle M, & Shaw J (2016), Into the Void: exploring the transitional care needs of arrestees and remand prisoners

In Draft

This paper is in draft form and therefore not yet finalised. The references are located within the main reference section of this thesis.
Into the Void: Exploring the transitional care needs of arrestees and remand prisoners

[Alison Pearsall\textsuperscript{ab}, Dr Dawn Edge\textsuperscript{a}, Dr Mike Doyle\textsuperscript{ac} and Professor Jenny Shaw\textsuperscript{ab}]

\textsuperscript{a}The University of Manchester
Manchester Academic Health Science Centre
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Email: alison.pearsall@postgrad.manchester.ac.uk

\textsuperscript{b}Lancashire Care NHS Foundation Trust

\textsuperscript{c}Manchester Mental Health and Social Care Trust

Corresponding author:
Alison Pearsall
Offender Health Research Network
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Tel: +44 0161 275 0723

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ABSTRACT

Background

Individuals involved in the criminal justice system have a higher prevalence of mental illness than the general population. Their presentations are often complex, with a high incidence of co-morbidity affecting engagement with mental health treatment and support services in the community. Many have repeat contact with health and criminal justice services. Entry into and release from the police station, prison or a forensic institution are recognised as specific vulnerable points in offender care pathways. Mental illness missed at the entry points can remain undetected resulting in individuals transiting into the community with inadequate health and social support.

Materials and Methods

Police, prison officers, mental health staff, service users, carers and commissioners were interviewed in a study of mental health care available at the transition points to the criminal justice system. Forty-two interviews with five stakeholder groups were conducted in total and analysed using Grounded Theory Methods. Trustworthiness of the study was supported considering credibility, transferability, dependability and confirmability. The study took place between April 2011 and March 2014.

Findings:

Important challenges were identified including poor preparation for service transitions and missed opportunities to engage individuals in community mental health care. Converging perspectives of service user needs and the types of practical support required were found within and across professional groups. Various resource deficiencies and challenges were reported.
Conclusions:

Transitions within and between services are particularly problematic for people with mental health problems involved with the criminal justice system. The focus of discharge planning is often completion of a specific item of care rather than linkage to a continuing care pathway. Emphasis on discharge arrangements, rather than transitional care planning may actually contribute to poor continuity of care. Practice and policy changes are required to move away from discharge planning to a focus on ensuring safe and effective transitions and transfers of care.

Research highlights

- Transitions within and between services are particular points of vulnerability for offenders
- High levels of need accompany higher rates of service disengagement
- Offenders are unprepared for service transitions
- Practice and policy needs to ensure safe and effective transitions and transfers of care

Keywords

‘Offender’; ‘Mental Health’; ‘Criminal Justice System’; ‘Community’; ‘Transition’; ‘Complex Needs’

INTRODUCTION

This paper explores the multi-disciplinary, service user and family perspectives of needs and care provision concerning individuals with mental health problems at the transitional points of the criminal justice system. In 2014, 1.1 million people were arrested and 100,000 remanded into custody increasing the total prison population to 84,372 (Prison Reform Trust, 2015). High
rates of mental health problems are found in offenders in comparison to the general population (Birmingham et al, 1996; Butler & Allnutt 2003; Bradley, 2009; Fazel & Danesh 2002; Singleton et al, 1998). Higher prevalence and increased incidences of co-morbidity exist among remand prisoners (Birmingham, 1996; Brooke et al, 1996; Singleton, 1998). Poor treatment during imprisonment and limited access to support services post-release contribute to high re-offending rates among offenders with mental illness (Prison Reform Trust, 2013; Sneed et al, 2006).

**COMPLEX HEALTH AND SOCIAL NEEDS**

Offenders have complex health and social needs often stemming from difficult, challenging and traumatic experiences in childhood, including high incidences of being in care and truanting from school (Social Exclusion Unit, 2002). Consequently, many have limited reading, writing and numeracy skills (McMahon et al, 2004). These underlying health and social issues are often exacerbated by limited identification of needs and poor access to the full range of health and social care services in the local community, including substance misuse services (Day & Howells, 2006; Smith & Trimboli, 2010). Compared to physical disabilities, people with mental illness experience greater levels of discrimination, have less access to community services and experience poorer quality of life (Brodwin et al, 2002; Henry and Lucca, 2004; Hong, 2002).

**THE TRANSITION POINTS**

Bradley (2009) highlighted the importance of accurate identification of mental disorders in offenders at the transition points within the criminal justice system. Early detection provides the greatest therapeutic opportunity, particularly for individuals experiencing co-morbid conditions.
such as concurrent substance misuse. Appropriate screening, assessment and treatment can reduce the cycle of repetitive entry, detention, release and readmission into the criminal justice system of people with mental health problems (Ogloff et al, 2007). Such screening can take place within police custody, court and remand prison settings before sentencing decisions are made. However, studies have reported mental illness missed in police custody can remain undetected throughout sentence and following release into the community (Bradley, 2009; McGilloway & Donnelly, 2004, Shaw et al, 1999).

Offenders face multiple and diverse challenges when returning to the community, from short-term custody, including finding stable accommodation and employment (Baldry et al, 2006; Travis et al, 2001). Offenders with mental health problems have substantial health and social needs that can remain unmet following release into the community (Kariminia et al, 2007). Many have limited functional social support networks (Baillargeon et al, 2010) coupled with poor coping strategies (Prison Reform Trust, 2013), which adversely affects initial community resettlement. Consequently, the rates of relapse and recidivism are higher among offenders with mental health problems than those without (Cloyes et al, 2010; Day & Howells 2008; Smith & Trimboli, 2010). Individuals with mental illness are increasingly recognised as ‘revolving door’ offenders (Baillargeon et al, 2009; Howerton et al, 2009; Padfield & Maruna, 2006); “trapped in a cycle of petty crime, incarceration, release, homelessness and re-imprisonment” (Thompson, 2008, p. 103).

Recognising and responding to the needs of offenders as early as possible is at the centre of the government’s Health and Criminal Justice Programme but is reliant on effective communication
between the NHS Commissioning Board, Clinical Commissioning Groups (CCGs) and Health and Well-being Boards. However, there has been limited agreement as to the best approach to support offenders’ transitions to the community (Hartwell, 2010). Hartwell (2010) highlighted the gap in understanding the experiences of offenders during transition to the community and purported “qualitative research and description that documents the local barriers and resources influencing community reintegration is needed to inform post-release planning and transition services for ex-inmates with psychiatric disabilities” (p. 280). Interventions to meet the diverse and complex needs of individuals including housing, benefits or employment, mental health, substance misuse and social support, which are provided for by different public and independent sector providers that are often inexperienced in joint and cross-agency working (Mears et al, 2012). This paper explores multi-disciplinary staff, service user and family perspectives to construct a grounded theory of transitional care to meet the mental health needs of offenders at the transition points of the criminal justice system.

**METHODS**

This study aims to describe stakeholders’ experiences, understanding and interpretations of the characteristics of mental health care and to construct a substantive theory about the usefulness of transitional case management, applied at the entry and transitional points of arrest, remand and release from short term custody. Individual interviews were conducted with stakeholders within police custody and remand prison settings during 2012 and 2013 in the North West of England. Research Ethics Committee, NHS and NOMS approvals and permissions were gained at the outset of the study.
Participants comprise of five cluster groups:

1. Mental health staff (criminal justice and community teams)

2. Criminal justice staff (police and prison officers)

3. Service users (arrests/remands)

4. Carers/family members

5. Mental health commissioners

Participants were recruited using a purposive approach, specifically ensuring a wide range of views for example different ages, work experiences, length of time on remand, variance in offences and knowledge of custodial care (Bryman & Bell, 2007). Participants received a written information sheet, designed specifically for each cluster group involved in the study and informed consent was obtained prior to interviews taking place.

INCLUSION CRITERIA

The following were eligible for inclusion:

a) Staff working routinely with adult offenders with mental health problems.

b) Family members/Carers providing care and support for individuals with mental health problems with experience of the criminal justice system.

c) Male and female arrestees and remand prisoners with mental illness aged between 18 and 65 years, whose mental health state was considered stable and had capacity to consent (judged by qualified mental health practitioners).
d) Remand prisoners were limited to males due to the host prison within the locality serving male prisoners only.

**EXCLUSION CRITERIA**

- Individuals lacking capacity to consent determined by mental health practitioners;
- Individuals deemed to be too violent or a risk to the researcher, judged by mental health practitioners;
- Immigration detainees;
- Language issues – for example those who do not speak English as a first language were excluded for practical reasons.

**The sample**

42 interviews were conducted in total and are illustrated in Table 12 below:
Table 12: Interview Participant Descriptors:

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Participants</th>
<th>Descriptors 1</th>
<th>Descriptors 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service User - Arrestee</td>
<td>5</td>
<td>1 employed, 4 unemployed</td>
<td>3 male, 2 female</td>
</tr>
<tr>
<td>Service User - Remand</td>
<td>6</td>
<td>1 prior employment, 5 unemployed</td>
<td>6 male</td>
</tr>
<tr>
<td>Family/Carer</td>
<td>3</td>
<td>1 employed, 1 retired, 1 full-time carer</td>
<td>1 male, 2 female</td>
</tr>
<tr>
<td>Mental Health – Criminal Justice</td>
<td>6</td>
<td>5 nurses, 1 social worker</td>
<td>4 female, 2 male</td>
</tr>
<tr>
<td>Mental Health – Prison In-reach</td>
<td>5</td>
<td>3 nurses, 1 social worker, 1 occupational therapist</td>
<td>4 female, 1 male</td>
</tr>
<tr>
<td>Mental Health – Primary Care</td>
<td>2</td>
<td>2 nurses with a range of therapy qualifications</td>
<td>1 male, 1 female</td>
</tr>
<tr>
<td>Mental Health – Secondary Care</td>
<td>3</td>
<td>3 nurses</td>
<td>2 female, 1 male</td>
</tr>
<tr>
<td>Criminal Justice – Police Officers</td>
<td>5</td>
<td>Custody, first response and offender management</td>
<td>5 male</td>
</tr>
<tr>
<td>Criminal Justice – Prison Officers</td>
<td>5</td>
<td>Safer custody, induction, visits and resettlement</td>
<td>3 male, 2 female</td>
</tr>
<tr>
<td>Mental Health Commissioners</td>
<td>2</td>
<td>CCG and Specialist services</td>
<td>1 male, 1 female</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURE**

Semi-structured interviews were held in police stations, prison healthcare departments and community clinics to optimise engagement and simplify travel arrangements for participants. Interviews were conducted in private interview rooms to maintain confidentiality. Interviews were of varied duration of between 37 minutes and 2 hours and 23 minutes. The shortest was a remand prisoner and the longest the mother of a prisoner. Field notes were taken referencing context, settings and items of interest to enhance understanding of for example detention and working environments and how these may have impacted on participants. Interviews were
recorded and transcribed. Transcripts were verified by participants, where practical, to enhance trustworthiness of the data. Transcripts and field notes were analysed systematically through iterative and repeat reading to gain richer understanding of individual viewpoints, relationships and links within and across participant groups.

**DATA ANALYSIS**

Data analysis was undertaken to explore the within and between perspectives among participant groups. In this instance, the Constructive Grounded Theory (CGT) method was utilised, primarily because of suitability to exploratory research and the principle of embedding the narratives of participants in reporting the findings. The difference between the CGT and more traditional social sciences research approaches are evident in the analytical procedures. The CGT method includes distinct stages of analysis including ‘open coding’, ‘selective coding’ and ‘theoretical coding’, before ‘saturation’ and ‘sorting’.

The CGT method employed in this study directed the sequential data collection and analysis also referred to as the iterative cycle of induction and deduction of existing and new findings and further data collection (Strauss & Corbin, 1990; Miles & Huberman, 1994). Categorising and summarisation of the data was undertaken, by the construction of codes, labels and descriptors. Transcripts and memos were analysed using Dedoose software (Dedoose -Version 6.1.18, 2015), generating 198 individual ‘open’ codes, supported by 1209 relevant excerpts. Familiar patterns between codes and excerpts within and between stakeholder groups were differentiated, compared and combined. Discussions about the data, including recurrent, indiscriminate and isolated codes and categories were discussed with peers, participants and
supervisors to confirm relevance, dependability and credibility in the data. The data spiral facilitated the construction meaning, interpretation and theoretical conceptualisation from the data. Hypotheses were constructed to confirm or reject explanations until the most meaningful and accurate interpretation was found (Charmaz, 2006). This process continued by generating concepts until an overarching theory was constructed that suitably accounts for data similarities and variations.

**FINDINGS**

The analysis produced five layers of coding with twelve parental codes, and three root codes of ‘Mental Health Assessment’, ‘Modes of Action/Practice’ and ‘Transitions and Transfer of Care’.

This paper presents the salient themes from the data relating to concerns about one of the main themes ‘Transitions and Transfers of Care’, which comprises of five main sub-themes - *poor transition planning*, *continuity of care*, *lack of practical assistance*, *lack of crisis support* and *returning to the security of prison*.

The over-arching constructed grounded theory is for health policy to refocus on transitional care planning, as opposed to discharge arrangements as most people do not completely exit services. Most people remain in receipt of some form of care or support and thus transfer to another part of the service. Of concern is *discharge* eliminates responsibility and confuses accountability for ensuring effective transitions to another pathway or care provider. During transitions individuals are at greater risk of medical error, adverse events including duplicated, omitted or incomplete care provision, much of which is preventable by effective transition planning to maintain continuity of care (Honsleman, 2008; Kripalani, 2007).
CONTINUITY OF CARE

The importance of continuity of care is widely recognised, however, participants’ experiences in this study were of fragmented care “There’s no continuity of care, it’s the opposite, it’s hemmed tightly around each part of the service... There’s no concept of onward, backward or sideways movement. We all work in silos” (CJL participant - ID:1013). Mental Health Inreach (MHI) practitioners reported similar disrupted care arrangements “referrals are made but often by the time they leave there’s nothing tangible in place to make sure they’re supported when they go out” (MHI - ID:1012). Service users reported limited access to information and poor communication with agencies after release. “There’s nobody about for you when you go out. It all stops. There’s no communication you don’t know anything” (Arrestee - ID:1030). Service users are known to disengage without effective care programmes in place, prior to release as one arrestee pointed out “I don’t ask for help until I’m off it and then it’s pretty obvious and the help isn’t wanted by that time” (Arrestee - ID:1039). The community mental health team provides a distinct high-intensity support function, prioritising people discharged from hospital. Released arrestees and remand prisoners are not currently eligible for this pathway. “Oh, it’s definitely not seamless, it’s disjointed, fragmented and sometimes in complete disarray” (community mental health - ID:1033). “They all talk about seamless care but I am yet to see any evidence of it, there’s a lack of what I would call proper release planning” (Carer - ID:1040).

TRANSITION PLANNING

Offenders are known to have multiple health and social needs, which can heighten vulnerability, particularly at points of transition such as release from short-term custody. Many face significant stress on release in relation to accessing benefits, housing and health and social care services,
evident in thirty-one excerpts from participant transcripts, which are now discussed.

**Housing**

The primary concern for service users was about finding suitable accommodation, particularly for those currently on remand. Five of the six participants on remand described housing problems prior to incarceration, which remained unresolved during their imprisonment. A range of accommodation options were disclosed including temporary residence with friends or associates and going to the council to present as homeless. The emphasis was on the temporary nature of placements with three referring to their ongoing accommodation as changeable or ‘sofa-surfing’ which is repeatedly moving from place to place. One prisoner was hopeful about reuniting with his parents on release, although there were no firm plans in place. Three arrestees also commented on the instability of their current accommodation, one was anticipating eviction, a further had house-share arrangements coming to an end and another had become homeless due to the nature of the arrest. Of significance was the stress that having no stable address evoked.

“When I left here [custody] I saw a housing worker who put me on the list and then got me a few nights at a B&B but after that I was homeless” (Remand - ID:1025). Similarly, the police reiterate “I’d say that housing is probably the number one priority for us, if we are working with someone who doesn’t have anywhere to live then that is a big red flag and we’d want to try to sort that asap as they are at high risk of offending (Police - ID:1017).
Each week there are a number of prisoners released without accommodation plans being in place. “There’s between 20 and 50% of prisoners released every week with nowhere to go and that can’t be right” (prison officer - ID:1014). “Accommodation is a bit ‘hit and miss’, particularly for remand it’s really difficult to get them somewhere especially if they’ve no family who can assist with bonds, furniture, finance and stuff” (prison officer - ID:1008)

**Finance and Benefits**

On release from prison, prisoners are issued with a discharge grant to support their initial release. Discharge grants are currently in the region of £47.00; however, remand prisoners are not entitled to such provision. Given that many are not convicted on release and have experienced similar disruption and turmoil as a result on incarceration, this was perceived as unfair.

“I’m going out of here with nothing, the prison aren’t giving me anything, no release grant or anything and it’ll be weeks before my money comes through” (benefits). Without family or friends to turn to for financial support service users felt there was no other alternative but to return to crime merely to survive. “I’ve got no choice, as soon as I get out of here I’ll be bang at it again [offending] to get money” (Remand - ID:1029). The police officers interviewed also highlighted links between lack of money and likelihood of re-offending “without money our guys are going to offend” (Police - ID:1016).

“The lads have said it takes a long time to sort benefits….in that time they’re expected to pay for accommodation….they can’t and get kicked out, have nowhere else to go, but mental health services don’t seem to see it as a priority …..what they do is send them to benefits agencies
Criminal Justice Liaison participants highlighted the significant and increasing debts among arrestees “these pay day loans are absolutely horrendous, there’s people getting themselves into so much debt……one lady was being charged 4000% and had no way of paying it” (CJL - ID: 1019). Comparable views were expressed by police officers “they have got all these short-term, high interest loans so when they get their money they have to repay or just blow it and then they’ve nothing left for the rest of the week or fortnight so this is a big problem and leads to them coming into contact with us” (police - ID:1015).

“If we really want to stop these lads re-offending we need to make sure when they leave here they have somewhere to live, have money and something worthwhile to do and the other thing is someone to contact when they need help” (prison officer - ID:1008).

**Education & Employment**

The limited availability of appropriate education, training and employment opportunities for offenders with mental health problems was expressed. “Education is a massive issue, they’re not properly educated and have no chance of getting jobs, they are robbing, extracting money, nicking peoples’ cash card and before you know it they have a raft of offences and nobody is going to trust them with a job” (prison officer - ID:1004).

Employment after release, was the second major concern for remand prisoners and recognised as a contributory factor for re-offending. Obtaining employment is important for offenders to
successfully reintegrate into the community and to maintain independent living. Two arrestees highlighted the implications of psychiatric medications prohibiting working in specific occupations or roles, which ultimately restricted already limited opportunities. Two of the remand prisoners identified the limited employment opportunities for offenders, particularly with disclosure of mental health problems. “I mean who wants to give an ex-con a job, as soon as you say you’ve been in prison or you’ve got mental health, you ain’t getting the job” (Remand - ID:1028). “I’m sick of going to the job centre, and getting told this and that, it stresses me out I’d rather be back in jail” (Remand - ID:1026).

Employment was also regarded as important for self-esteem and self-respect “I have worked before and I didn’t enjoy the job, but I was happy on pay day. It felt good to have earned it instead of nicking or selling gear” (Arrestee - 1035). One remand prisoner was in paid employment before incarceration although felt it unlikely that they would return to previous employment.

One of the remand prisoners felt that completion of training would optimise his chances of gaining employment and consequently described having renewed hope. “I’ve got my CSCS card so I can get a job on any building site” (Remand - ID:1025). Another was confident about getting a job, “I always get work, if you want a job, there’s work out there. My problem isn’t getting a job, it’s keeping it.... Sooner or later I start drinking, taking drugs and it all gets fucked up” (Remand - ID:1027).
Substance Misuse

The implications of increased substance misuse were highlighted in sixty-two excerpts from participants’ transcripts with every service user disclosing some form of substance misuse including cocaine, amphetamines, cannabis and alcohol in excessive or dependent proportions. Substances misuse is a significant concern among offender populations and is associated with instability and mental health relapse. Mental health staff concurred noting the prevalence of substances and relevance to mental illness and offending. The two carer participants spoke of the effects of alcohol and other substances on familial relationships and of feeling intimidated on more than one occasion due to the service user’s intoxicated behaviour. “When X is drinking and using drugs he changes instantly, he’s nasty, demanding this, that and the other. He frightens me cos you never know what he’s going to do, he shouts, bang doors, throw things and a few times he’s pushed me....but when he’s sober you couldn’t meet a nicer person” (Carer - ID1041).

Prison officers and police participants highlighted alcohol, in particular, with increased levels of aggression “alcohol seems be getting worse, it used to be heroin, but by far and away the worst is alcohol, heroin users don’t fight, cannabis users don’t fight but alcohol is a recipe for disaster there’s more violence and it’s so unpredictable…..happens with people who on paper you wouldn’t think would be violent but when drunk are a different story” (police - ID:1038). “They can be arrested for a minor breach of the peace, but kick off on the way to the station end up with other charges....assaulting a police officer and go straight back to jail” (police - ID:1018).
RETURNING TO THE SECURITY OF PRISON

Three of the six remand prisoners interviewed disclosed re-offending purposefully to return to prison. Prison was not perceived as a deterrent; moreover, it provided familiarity, belonging, safety from the stresses of the outside world and more recently the best place to access health care.

“I was only out for a couple of days, I couldn’t cope, I had nowhere to live, no money so I got myself arrested and got back in. I’m comfortable, got a bed, food, a job and a good pad mate. I’m better off in here” (remand - ID:1026). This rationale was reiterated by prison officers, one reporting “there’s lads that have gone out of here at 8.45am and we’ve said they’ll be back and sure enough they are by the end of the day, the same day, they’ve not lasted 24 hours” (prison officer - ID:1005). In addition to returning to prison to escape the stresses of community living, three remand prisoners stated that a major motivating factor for their return to prison was to access health services. The Department of Health strategy of improving health services within the prison walls may have future implications for re-offending rates, given that offenders’ expectations of access to equivalent healthcare services are raised in custody which are then not delivered in the community. “I got on well with X [mental health inreach - staff name withheld] she was sound, she’d come down to the wing every week but when I got out the staff in the community team didn’t want to know me, let alone help me” (remand - ID:1025). This issue was summarised by a mental health inreach participant “the lads in here have got access to far better services than in the community, they see the same consultant psychiatrist monthly, have a named care co-ordinator and can see a crisis member of staff within four hours if that’s what was needed. Out there they probably wouldn’t get a consultant, they’d have lots of different
Mental health staff and not be referred to crisis support” (MHI - ID:1006).

**Mental health Crisis Support**

Nine of the service users interviewed reported gaining support at times of stress or upset when in custody (police and prison). They found the assessment process cathartic in that they could talk about things that were bothering them or ‘let off steam’ about not getting the support they needed in the community (Arrestee - ID:1036).

Difficulties in accessing mental health crisis support in the community were reported by service users which resonated across participant groups. “I have phoned the crisis team once or twice but they didn’t really do anything because they said they didn’t know anything about me” (Arrestee - ID:1039). “I was given numbers to phone and they said they wouldn’t come out and told me to get a drink and go to bed. Nobody came out or rang me back, they weren’t interested” (Remand - ID:1028). Many offenders exhaust all avenues of informal support and turn to illicit substances to deal with overwhelming emotional and practical pressures which inevitably leads to further criminal justice involvement. The stark differences in crisis support inside and outside of the prison walls was a source of confusion and frustration for service users, family and criminal justice staff. “How come the community crisis services can’t see offenders at least the same day that they request support” (prison officer - ID:1014). One arrestee disclosed having wanted services to help him to fill the void left by the death of his mother and of feeling rejected when the response he wanted was not forthcoming.
“The crisis team should be renamed because they don’t do anything if you are having a crisis they can’t even talk to you on the phone, they make arrangements don’t stick to them and let you down” (Arrestee - ID:1030). Police staff rationalised their negative experiences “the Crisis Teams are invariably understaffed, overworked or refuse to come out and it’s getting worse by the minute. We end up stuck with someone who shouldn’t be with us” (police - ID:1017). However, another officer reflected “I think they probably do get support in a crisis because things would be 10 times worse and it’s bad enough as it is. There must be a lot of people who we never hear about we just hear about the ones who slip through the cracks for whatever reason” (police - ID:1018). Participants that had recently used mental health services within police custody and the prison reported improvements; however, this added to the disappointment in services received in the community. Clearly, health services had to improve within the prisons; however, greater integration of pathways rather than individual service based care should be put in place.

DISCUSSION

The findings of this study highlight a number of key issues for individuals leaving short-term custodial environments, such as poor continuity of care, despite widespread recognition of its importance (Crawford et al, 2004; Dorwat et al, 1994; Durcan & Knowles, 2006; Lennox et al, 2012). Continuity of care for people has been highlighted by a range of inquiries and post-incident reviews (Manthorpe & Martineau, 2014) and is associated with elevated risks of relapse, suicide and violence (Appleby et al, 2006; Biswanger et al, 2007; DH, 2009; Doyle et al, 2012; Goldacre, 1993). For more than 40 years, continuity of care has been regarded as crucial to the care of people with severe and persistent mental illness; yet remains within service
objectives and commissioning standards. Continuity of care is the essential characteristic of high quality care and the concept is particularly important in regard to vulnerable groups, such as offenders as they often lack the knowledge and resources to compensate for less than optimal care.

Transitional care is more important for mental health services than other specialities as treatment outcomes are more difficult to predict. However, the lack of organised transitional care is stark given that over 1.836 million people were in contact with NHS mental health services, including 21.034 million outpatient and community contacts, during 2014/15 (NHS Confederation, 15/1/2016). Offenders with mental health problems have substantial health and social needs, including the need for practical assistance with matters such as housing, employment, finance, substance misuse and mental health treatment as highlighted by participants; and similarly identified by the Prison Reform Trust (2012).

Prison based mental health care was founded on the ‘principle of equivalence’ to access services of the same standard to those available to the general population (Brooker et al, 2008, p.3). The improvements in health care within in custodial settings have been a welcome strategy; however, this has been poorly implemented. The Department of Health, via local Primary Care Trusts (now Community Care Groups), took over commissioning responsibility for prison health care in 2006, which provided an opportunity to address the health inequalities and social care deficits among offender populations. However, the focus has been on the identification of mental illness and the provision of treatment within prison settings and not on the establishment of integrated care pathways, providing continuous treatment in the community. The report
entitled ‘Too Little Too Late’ concerning the unmet mental health needs in prison highlighted the importance of transition planning in advance of release from prison, particularly for people with mental illness (Prison Reform Trust, 2009). Despite, these recommendations effective care planning is limited for those transiting at the arrest and remand stages of the criminal justice system.

The emphasis on ‘discharge’ in health policy and practice may negatively impact on clinical outcomes, with (13%) of mental health service users re-admitted within 90 days of discharge (Commission for Health Improvement, 2003). However, this may not be as a result of poor inpatient care, but more likely, inadequate transitional care planning. There has been a reduction in acute mental health inpatient provision; however, there has also been a substantial reduction in funding for intensive and crisis support teams (Healthwatch England, 2015). The lack of appropriate transition planning in the criminal justice system for people with mental health problems is evident, resulting in some offenders being in a worse predicament than when they first entered custody. Many individuals have multiple and complex support needs that are largely unmet, due to the lack of suitable community mental health provision, resulting in use of emergency services and repeated periods of relapse and incarceration (Revolving Doors, 2013).

A significant finding in this study is that without such support being available after release, particularly in crises situations, there is a risk that offenders may choose to return to prison to access good quality health care. Of further concern is the lack of preparedness for release, particularly in relation to securing appropriate housing, employment, finance and social support, which can have immediate and long-term health implications (Wilkinson & Marmot, 2003).
Many engage in treatments, such as medication or counselling, but the benefits are lost when interventions are discontinued on release from custody. The need for practical assistance with matters such as housing, employment, finance, substance misuse and mental health treatment were highlighted by participants; similarly identified by the Prison Reform Trust (2012).

There have been attempts to provide continuity of care for people with significant mental health needs in the community, through the introduction of mental health case management modalities. Intensive case management (ICM) was available in the UK for several decades as a service modality to co-ordinate and integrate health and social care resources (Marshall, 1996; Onyett, 1992; Thornicroft, 1991; 1995; Ziguras, 2002). Benefits were reported in relation to improved service engagement and reduced rates of relapse and re-hospitalisation (Marshall & Lockwood, 1998). ICM was considered relevant for individuals with serious mental illness, requiring high levels of support that were at risk of service disengagement (Burns et al, 2001; Kantor, 1989; Mueser et al, 1998; Rosen et al, 2007).

There have been parallel developments within the criminal justice system for offenders leaving custody, particularly in the United States, termed Re-entry Programmes. There has been extensive recognition of substance misuse needs (Friedmann, 2009; Knight et al, 1999), employment advice (Turner and Petersilia, 1996) and housing support (Lowencamp & Latessa 2004). Similar programmes have been initiated in the UK, called ‘Through the Gate’. However, there has been an absence of programmes to support offenders with complex mental health needs, combining substance misuse and a range of social issues (Theurer and Lovell, 2008).
Consequently, offenders with mental health problems are caught ‘in the void’, when they are released from custody, as there are no effective transitional programmes in place to meet the complex health and social needs, in either health or criminal justice agencies. Therefore, there is a need to shift the focus from ‘discharge’ to ‘transitional care planning’. Critical Time Intervention (CTI) is a variant of Assertive Community Treatment emphasising time-limited, intensive case management at critical points, such as release from prison or hospital. The emphasis is on supporting the transition into the community, with a time-limited intensive programme of support that aims to establish effective links in the community (Susser et al, 1997). CTI promotes continuity of care during transitions, by effectively linking service users to community services (Draine & Herman, 2007). CTI has generated positive results when applied to mentally ill prisoners due to be released, improving engagement and continuity of care. CTI is specifically designed to provide transitional support at critical service points, rather than a permanent support system. Moreover, the intensity of support reduces incrementally, reducing longer-term service costs. (Jones et al, 2003).

CONCLUSION

Transitional care programmes can facilitate service users’ movement within and between services, maximising continuity of care and limiting adverse events, often associated with transfer and discharge (Appleby et al, 2006, Dorwat et al, 1994; Rose et al, 2007). There is a recognition by the World Health Organisation (WHO), (2013) of the specific vulnerabilities of people with mental illness and for the need to focus on transition and community reintegration. Transitional care is apposite for ensuring consistent care co-ordination for individuals with complex health and social needs and is a pre-requisite for the development of effective
integrated care pathways. The high prevalence of dual diagnoses including drugs and alcohol reported in this study is noteworthy. The lack of inclusive and flexible approaches to the management of crises among potentially high-risk individuals is also a cause for concern.

The improved health provision within prisons represents a pragmatic life choice for service users to engage more swiftly and comfortably in various high quality health provisions. This may represent a future factor in re-offending rates among this disadvantaged population, generating significant costs to the NHS. Therefore, health and policy directives should consider refocusing on ‘transitions and transfers’, rather than facilitating discharge arrangements. Specific transitional support programmes such as CTI may support offenders’ complex health, social and rehabilitative needs in the community. The recent expansion of criminal justice mental health services provides renewed opportunities for service providers. There has never been a better time to refocus on the entry points of the criminal justice system and to develop appropriate transitional services that are offender-focused rather than offence-focussed.

This paper is in draft form and therefore not yet finalised. The references are located within the main reference section of this thesis.
Chapter 5

5.1 Introduction

This chapter follows the findings presented in Chapter 4, gained through the CGT analysis, using Dedoose software (Dedoose -Version 6.1.18, 2015), which generated five layers of coding with child and parental codes, linked to three root codes of ‘Opportunities for Assessment/Support’, ‘Modes of Action/Practice’ and ‘Transitions and Transfer of Care’. Chapter 4 presented the over-arching theory for health policy and practice to shift away from a focus on ‘discharge’ to a concentration on ‘care transitions’, to improve ‘continuity of care’. Findings suggest the focus on discharge results in the ‘itemisation of treatment episodes’, leading to incomplete or fragmented care, which impacts on service user outcomes. Furthermore, service responsibilities are for ‘context-specific provision’ rather than pathways of care.

As previously stated in Chapters 3 and 4 the theoretical framework of Lin (1999; 2001), ‘network theory of social capital’, informed the grouping of codes, interpretation and implications of results (Lin, 1999, p.35). In this chapter, offenders’ experiences of membership of social networks are discussed, incorporating the data surrounding the two parental themes of ‘Importance and Influence of Social Networks’ and ‘Stigma and Labelling’, using Lin’s Network Theory of Social Capital (1999; 2001), which is outlined below. Participant data highlights the influence and importance of familial relationships and supportive social networks. The lack of practical and legislative support for families maintaining contact during imprisonment and how this affects network structure and functionality are identified. The final parental theme of ‘labelling and stigma’ which occurs both within and external to an individual’s social network,
and the associated impact on transitions is described. This chapter is accompanied by the paper entitled, ‘Tying up Loose Ends: expanding the social networks of offenders released from short-term custody’, which highlights the fragmented and impoverished social networks of service users. Sociograms for the sample (n=11), individual ID codes and corresponding pseudonyms are located in the Appendices Section (Appendix 9).

This chapter supports the data presented in the above paper, applying Lin’s theory of social network capital, in relation to offenders with mental health problems, existing within familial networks. Lin defined social capital as “investment in social relations by individuals through which they gain access to embedded resources, to enhance expected returns of instrumental or expressive actions” (Lin, 1999, p. 39). An individual’s ability to access and mobilise social capital can lead to greater power, influence, wealth and social inclusion (Lin 2001). There are various definitions and descriptions of social capital (Bourdieu, 1986; Burt, 1992; Coleman, 1990; Erickson, 1995, Lin, 1999); however, the main division in the literature concerns social capital accruals being on ‘individual’ (Lin, 1991; Coleman, 1990) or ‘societal’ (Putnam, 1993) levels. Lin (2001) posits that individuals can benefit from transactions in social relations within four mechanisms of social capital, which may improve mental health, well-being and reduce offending behaviour.

Firstly, individuals can benefit from network membership, through access to information, expertise or guidance from network members perceived to be prominent, knowledgeable or helpful. An example, is a trusted network member (mother) raising health concerns that may prompt an individual to modify behaviour or seek professional support, and improve mental
health and well-being (Zambon et al, 2010). However, this is reliant on the choice of and trust in
the network member, as to whether advice is acted upon. Offenders may receive pro-social or
anti-social guidance, due to selection of a particular member. For example, how to avoid high-
risk people or situations or conversely how to avoid detection and offend more successfully.

The second aspect is the power, influence and dominance of network members that impact on
individuals’ vulnerabilities to health or offending related risks (Song, 2007). Within this are the
material resources possessed by individuals within the network that could perhaps support
another member during ‘hard times’, such as unemployment or illness. This may afford
opportunities to optimise alternative or improved prospects, such as a new job or home (Lin
2001). However, at certain times, offenders may occupy less favourable positions within
networks, due to for example, upsetting or offending against a prominent network member; thus
limiting access to such resources/opportunities. The third element is the social credentials
possessed by members of the network. Social credentials can improve trust between members,
thus facilitating improved mental health services and non-offending lifestyles. The final aspect
is that members’ resources can reinforce individuals’ self-identity and social status within
groups or network settings (Song 2007), which may promote mental health and well-being.
Conversely, an individual’s status as an offender can be reinforced.

The study of social networks is relevant to offenders with mental health problems as symptoms,
behaviours and offences may result in the fracturing of relationships with key family, friends
and sometimes geographical areas, which limits the availability of resources and supports. In
order to develop an understanding of the availability and functionality of offenders’
relationships, it is necessary to gain information about their historical experience of social networks, including during formative years, adolescence through to adulthood, through to the present journey within the criminal justice system.

5.2 Individuals’ early experiences of social networks

Individuals’ first experiences of social networks are through family, school and work, which provide learning environments for valuable life skills. However, many offenders originate from socially excluded, disadvantaged backgrounds, where unemployment, poverty, substance misuse and offending are present (SEU, 2002). This can result in poor relational ties, limited availability of resources and therefore hinder the mobilisation of social capital. Prominent or influential family/network members can influence the functionality of the network and within it the relationships between members. These factors may limit individuals early experiences of access to positive, pro-social and functional social relations that impact on sense of self, position within their network and wider society.

Living in socially disadvantaged households and communities may generate a lack of rules, boundaries and social controls, which in turn may support the development of anti-social and criminal behaviours (Sampson & Laub, 1990). The participants within this study described living in families and communities where poverty, social deprivation and family breakdown were evident. This is depicted in the following excerpts from participants’ transcripts; “most of the offenders I have worked with have had difficult upbringings and live in households where offending is largely the norm, which makes it harder for them to make sustained changes” (ID: 1042 commissioner). Similarly, Mental Health Inreach (MHI), ‘we have our regulars, X comes
in every few months ‘cos he just can’t function out there....sad, but he looks so much better after a few weeks, with sleep, a bit of food, coming off the drugs...then he’s back to being himself (ID:1012). One of the prison officers expanded this point, “these lads have been coming in here for years....we know them so well and their dads before them” (ID:1006 prison officer). The parental influence within familial networks can be substantial, particularly in relation to setting the norms and values, which frame the functionality of the network (Lin, 1999). Offenders are two and a half times more likely to have a family member with a criminal history (SEU, 2002).

Dysfunctional networks may provide limited resources, which restrict opportunities for the development of social capital and can also be harmful to individual network members. Stone (2001) suggests that quality and quantity aspects of relationships are visible within the activities or behaviours of individuals (structural social capital) and can be discovered by ascertaining how people think, feel and ultimately trust others (cognitive social capital), (Bain & Hicks 1998). Structural and cognitive social capital incorporates the ties that link individuals such as religion, hobbies, socio-economic groups, drug cultures and living circumstances (bonding social capital).

Two participants described childhood relationships and home environments. Paul (ID:1024) described exposure to criminality “I had no dad...he were in and out of jail and when he wasn’t banged up, he was p****d up”. Dad’s behaviour was tolerated and accepted, for a range of reasons, such as the exertion of power, dominance and influence within the familial network (Song, 2007). Paul detailed the volatility and violence, perpetrated by his father and the effect it had on his development. Paul’s poor relationships with his father and his mother’s failure to
protect, resulted in him spending much of his adolescence in care, where he reports being abused. Removal from the family home generated unexpected changes to the structure of Paul’s network, disrupting already compromised relational ties and potentially resulting in him feeling rejected from the network, thus limiting his cognitive social capital. This is in addition to the physical, psychological and emotional damage associated with the abuse.

Paul described being consumed with anger and seeking comfort through drugs and alcohol. He had limited contact with his mother and sisters, due to substance misuse. “They didn’t want much to do with me.. I can’t blame them... I wouldn’t want much to me with me either”. Paul said in the last couple of years his relationships with his mother and one of his sisters “has got better bit by bit, represented by positive relation (green) on his sociogram. However, Paul’s relationship with another sister was ‘off and on’. Paul (ID:1024) sociogram is presented below:
Paul’s sociogram comprises of five concentric circles for everyday and six segments representing crisis support. Functionality of relationships are shown by green (positive), red (negative) and black (neutral).
Paul’s network is sparse, with few alters and limited functional relational ties. He cited his mother as the most close to him for both every day and crisis situations, although he said “don’t see her or me sisters much”. Paul said he had spent a number of years homeless, living on the streets, in close proximity to four ‘friends’ identified as ‘rough sleepers’ in his network. The four were placed as ‘important’ for both every day and crisis situations; however, Paul acknowledged limited trust “we help each other out and that…but when you’ve got problems with drink and drugs you’ll s**t on your best mate to sort yourself out”.

Individuals with mental health problems have smaller networks; typically comprising of ten to fifteen people (Meeks & Murrel, 1994; Perese et al, 2005; Walsh, 1994) and as few as five or less in people with more significant mental illness (MacDonald et al, 2000), which impacts on health and well-being (Goldberg et al, 2003; Tempier et al, 1998). Consistent with the literature high rates of social network attrition were evident within Paul’s sociogram (Hawkins & Abrams, 2007). The consequence is reduced capacity to mobilise social capital. Of note, Paul’s network could shrink further due to his reported, strained relationship with his mother and tenuous associations with peers, who share a transient lifestyle.

5.3 The Composition and Functionality of Social Networks

The composition and functionality of an individual’s social networks is linked to increased health and well-being (Brugha et al, 2005, Webber et al, 2011). Positive family ties that maintain secure and consistent attachments provide a protective factor in relation to offending behaviour (Liebrich, 1993; Petersilla, 2003; Visher & Travis, 2003). Pro-social family ties function as facilitators for change and have been associated with reduced offending (Cobbina et al, 2012).
“Family clearly remains most people’s first source of support when things go wrong” (Park & Roberts, 2002, p. 203). However, many offenders are unable to access regular or reliable support, due to changes in family structures, relationships and functionality (Putnam, 1993). Weeks proposed these non-traditional structures as ‘families of choice’ rather than ‘families of fate’ (Weeks et al, 2001, p.9). Research reveals the complex, disjointed and dysfunctional family relationships found in individuals with long-term criminal justice involvement (Wright & Khan, 2010). This is evident in Peter’s (ID:1039) sociogram, where three ex-partners and associated children are reported. Peter highlighted negative relationships with two ex-partners, but a functional tie with the third. Peter’s sociogram comprises of complex and emotionally challenging relationships involving ex-partners, siblings and his parents. He felt his poor relationships with “ex’s has affected my relationship with my mam...and my dad as well”. “My mam puts her first over me.... a lot”.

**Peter’s (ID:1039) Sociogram**

Peter’s sociogram, has five concentric circles and six segments, representing every day and crisis support. Functionality of relationships are represented by green (positive), red (negative) and black (neutral). Peter’s Sociogram is displayed below:
Paul and Peter’s sociograms differ in composition, size and functionality. Paul’s network is much smaller, but generally contains infrequent, positive and “easy” interactions. The description of ‘ease’ of interaction may be indicative of limited trust and reciprocity within his
peer associations. Another participant David (ID:1027) (Sociogram located in Appendix 10) spoke positively about his social network “my mum, dad and my daughter and my little sisters are everything to me....I’m very protective of my little sisters, especially ‘J’, I go...where you going, what that’s you’re wearing, who’s he........if anyone ever touched them or disrespected them I’d do ‘em. In the present study, David and Peter (ID:1027, ID:1039) highlighted the need to rebuild relationships within the family. Similarly, James (ID:1028), (Sociogram located in Appendix 10) hoped to repair strained relationships with his sister and mother, but his sister ‘wanted nothing to do with him’. All service participants conveyed value in relationships with family. Philip (ID:1029), (Sociogram located in Appendix 10) was very isolated with only 2 positive alters in the community. He was largely dependent on his mother, who ‘was always there for him’ and visited regularly.

Imprisonment leads to changing structure and functionality within family networks. Different roles and responsibilities are assumed by family members, which can be stressful and disrupting for the cohesion within the network, including for children. Prisoners’ children are at greater risk of developing mental health problems and three times more likely to engage in anti-social or offending behaviour (Ministry of Justice and Department for Children, Schools and Families 2007 Review). The maintenance of contact with family is important for offenders and families alike (Healy, 2010; Richard et al, 2009: McNeill & Weaver, 2010; Visher et al, 2004). Irrespective of the strength and functionality of ties, not having contact with family, has been shown to increase re-offending rates by 39% (MoJ, 2009). Visiting procedures within prisons fail to contribute to maintaining family networks with cumbersome security procedures, confusing rules limiting closeness and poor facilities for children. Families often have to use
expensive public transport may be incompatible with visiting times. Families may face increasing financial pressures, in relation to decreasing family income and additional family expenditure, associated with phone call, visits and financial support to the prisoner. Prison can exacerbate existing socio-economic disadvantage within families, which impacts on relationships within networks (Houchin, 2005), exacerbating risks of family breakdown (SEU, 2002).

The strain on families can be significant and legislation such as the Carers Act does not include them as a potentially vulnerable group. The ‘burden of caring’ is beyond the scope of this thesis. However, the lack of support to maintain relationships is relevant. “We see the strain on families [Family Day - longer visiting session for families, held monthly] but they hold it in and don’t pass it on .....he [prisoner] might not know all the issues that are going on (ID:1014). The need to improve support for families was proposed by a prisoner officer “It would be good to sit in visits, go round every table if they need any help....but we just don’t have the resources (ID: 1014). “what makes it worse is the way you’re treated....not by prison staff, by friends, neighbours and people you don’t even know” (ID:1040).

5.4 Stigma and Labelling

In this study, mental health staff explained perspectives on barriers to recovery and re-settlement associated with the stigma of criminality. Families also voiced concern about the labels of mental illness that are often laden with value-based judgements such as ‘untreatable’ or ‘unmanageable’ and ‘dangerous’ in relation to offenders. James (ID:1028) stated ‘I’d rather be bad, than mad’, referring to the more damaging effects of mental illness labelling. “it’s either
seen as a sign of weakness or a way of getting time out’ (ID:1039).

Prison officers were unaware of stigma for offenders, as the working practice was to ‘treat everyone the same’ (ID:1004). This practice may be considered beneficial in that values are not imposed; however, may hinder offender’s ability to convey distress and for individual characteristics of ill-related behaviour to be identified. CJS highlighted the difficulties in applying person-centred techniques as these are ‘ripe for exploitation’, (ID:1008) leading to more difficult management situations. The importance of person-centred therapeutic relationships for mental health staff was reiterated by mental health staff and is cited in offender rehabilitation literature (Marshall et al., 1999; Marshall et al., 2003; Ward and Maruna, 2007; Andrews, 2001).

Despite recognition of familial influence in providing motivations to change and supporting resettlement (McMurran & Ward, 2004), families are excluded from release or transitional planning. Prisons have a responsibility ‘to provide programs and supervision that will enable the offender to safely reintegrate into the community’ (Motiuk et al, 2005,pp.14). However, resettlement support programmes have generally been restricted to sentenced prisoners; despite those on remand experiencing similar reintegration challenges (Motiuk et al, 2004)

5.5 Reconnecting Network Ties

Release from prison has been described as a “health depleting experience” (Burgess-Allen et al. 2006, p.300), involving both the offender and the family. Many return to communities poor housing, low employment and poverty (Jacobi, 2005, Williams, 2007), which immediately can
strain relationships and friendships (Prison Reform Trust 2009). Furthermore, some are homeless, estranged from families and former friendships and are essentially ‘rootless drifting around between family and friends to get help they want” (ID:1001). Similarly, a carer commented “if he didn’t have me and his sisters he’d probably not be here’ (ID: 1040 Carer), “every time he comes out we have to put him up, sort out accommodation and pay for it ... Of course” (ID: 1040 Carer). “I would assume that the ones with family contact manage better but it depends on the family”, (ID:1034)

All participants disclosed that drug use and offending had impacted on their relationships. Peter long history of dependent polydrug use impacted on familial relationships, which now contained pro-social friendships. Service users described basic plans for the future, which included having a house, job and relationship. “I can earn buckets of money through crime....but it all goes on gear” (ID:1025). Other interview data highlighted the importance of children, two of the remand group were involved story reading for their children. and similarly, “I only want somewhere to live.. Like a nice house, a job that gives me pay every week so I don’t keep coming in here and a nice girlfriend...not much to ask eh?!” (ID:1035). It was clear that arrest and prison experience provided the opportunity to reflect on their relationships with family members in a way “that’s not possible when you off your head on gear” (ID:1039).

5.6 Conclusion

Social network capital theory (Lin, 1999) purports that individuals can benefit from embedded resources available within networks. Benefits include access to information, power and influence, social credentials and self-identity (Lin, 1999). Social factors such as increased rates
of cohabitation, divorce and diverse employment increase social and geographical movement which may contribute to changes in networks (Pahl & Spencer, 2004). The availability of resources within networks can facilitate or hinder opportunities for social capital. Networks differ in composition and functionality and are subject to dynamic, temporary or long-term change, as a result of traumatic life events such as imprisonment. The function of a network can be understood through the resources individuals can access, the quality of relationships and the degree of similarity between ego and alters (Valente, 2010). This means that people form relationships with others that share similar characteristics such as beliefs, values, lifestyle and social circumstances, termed ‘homophily’ (McPherson et al, 2013). This is relevant to offenders in relation to early anti-social behaviour and groupings within areas of deprivation and custodial environments. Homophily restricts individuals’ social worlds, by limiting objectivity of information and diversity of interactions, thus impacting on self-identity. However, homophily may promote bonding social capital, which explains how offenders often function better within prison.

Membership of a social group or network enhances inclusion, thus reducing or eliminating social exclusion and enhancing recovery. Mentally ill offenders experience increased social isolation as they become more immersed in the criminal justice system. Belonging to families, social groups and networks can be both beneficial or harmful and is influential to re-offending (Ministry of Justice, 2013). Impaired social functioning due to mental health problems (Gotlib & Lee 1989), social rejection (Perry, 2012) discrimination (Thornicroft, 2006), and stigma (Link et al. 1989) reduce network size due the impact of social isolation on health and well-being.
Social capital is underpinned by quality social relations, which are essential to community living. The process of rebuilding ties with family and friends, alongside pro-social relationships are important in relation to re-offending (McNeil & Weaver, 2010). The stigmatising effects of mental illness, criminality and imprisonment inhibit engagement in community-based support, resulting in increased isolation and risk of re-offending. The development of networks of support at transitional points, within routine mental health practice would increase continuity of care for his socially excluded population. This chapter has sought to advance understanding about the composition and functionality of individuals’ networks and how long-term criminal justice involvement may deplete already impoverished networks. This has implications for future health and social policy in relation to the provision of support for offenders and their families.
Paper 4
Pearsall A, Doyle M, Edge D, & Shaw J (2016), Tying up loose ends: expanding the social networks of offenders released from short term custody

In Draft

This paper is in draft form and therefore not yet finalised. The references are located within the main reference section of this thesis.
Tying up loose ends – expanding the social networks of offenders released from short term custody

[Alison Pearsall\textsuperscript{ab}, Dr Mike Doyle\textsuperscript{ac}, Dr Dawn Edge\textsuperscript{a} and Professor Jenny Shaw\textsuperscript{ab}]

\textsuperscript{a}The University of Manchester
Manchester Academic Health Science Centre
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Email: alison.pearsall@postgrad.manchester.ac.uk

\textsuperscript{b}Lancashire Care NHS Foundation Trust

\textsuperscript{c} South West Yorkshire Partnership NHS Foundation Trust

Corresponding author:

Alison Pearsall
Offender Health Research Network
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL
Tel: +44 0161 275 0723

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ABSTRACT

Background

Individuals with complex mental health problems involved in the criminal justice system have sparse and dysfunctional social networks, limiting opportunities for support in re-entering the community. Prolonged criminal justice contact restricts access to informal support systems embedded within networks. Consequently, service users become isolated and devoid of contact with significant people who may often have been the ‘first port of call’ for information and the ‘last hope’ if all other forms of support fail.

Materials and Methods

Service users were interviewed about the size, content and functionality of social support networks in advance of release from short term custody. Eleven egocentric network diagrams were constructed in total. Service users provided supplementary data in interview about their views on the benefits and limitations of their social networks in relation to both everyday and crisis support, reflecting on how their networks may have changed.

Findings:

Offenders with mental health problems have limited and dysfunctional social networks, which diminish with repetitive contact with the criminal justice system. Familial relationships are replaced by transient, often untrustworthy and situational associations that provide limited protection, nurturing and support. Mental health professionals have an important role in identifying and ameliorating poor network composition and functionality, through appropriate bridging interventions such as transitional case management.
Conclusions:

Social networks represent the totality of support available to individuals in everyday and crisis situations. Social network assessment should be routinely included within mental health practice to ensure appropriate tailoring of intervention ensuring the balance between support and interference is achieved. Interventions that provide effective bridging to familial and community resources such as transitional case management may facilitate improved engagement in services.

Research highlights

• High levels of health and social need accompany poor access and service disengagement

• The social networks of mental health service users within the criminal justice system are small

• Service users become more isolated with ongoing criminal justice involvement

• Assessment of social networks is important for service transitions

Keywords

‘Social Networks’; ‘Mental Health’; ‘Criminal Justice System’; ‘Community’; ‘Transition’; ‘Complex Needs’

INTRODUCTION

This paper explores the personal social networks of offenders with mental health problems prior to release from short term custody (police stations and remand prisons), which are recognised as vulnerable points in offender care pathways (Birmingham et al, 1997; Bradley, 2009, Shaw et al,
The importance of social networks for people with mental health problems is recognised within current mental health policy (Perry & Pescosolido, 2015). Social networks are described as the collection of interactions, communications and relationships that align people together (McPherson et al, 2013). Social network approaches facilitate exploration of the composition of individuals’ relationships and connections and have been applied extensively to understand how individuals access social support and social capital (Albert et al, 1998, Coleman, 1990; Lin 1999; 2001).

Social networks include structural and transactional components. The structural component refers to the network size, composition, relationships, frequency and intensity of contact between individuals (O’Reilly, 1988; Shye et al, 1995). The transactional component of social networks signifies the value and distribution of social support and other resources among network members (Thoits, 1995).

Membership of networks provides opportunities to access and utilise a range of resources practical, emotional and social support, which provides social capital. There are various definitions of social capital (Bourdieu, 1986; Burt, 2001, 2005; Coleman, 1990; Putnam, 1993; Lin, 1999; 2001; Wellman, 2001). This paper utilised the theoretical framework of social capital network theory described by Lin (1999; 2001); defined as the “investment in social relations by individuals through which they gain access to embedded resources to enhance expected returns of instrumental or expressive actions” (Lin, 1999, p. 39). Lin posits social capital as available through networks, by which individuals access and utilise resources. Networks both support the use of new and existing resources, which is relevant to offenders with mental health problems.
Other scholars have described the composition and functionality of social networks and their facilitation of social capital. Lochner describes social capital as comprising social networks, and more specifically the quantity of relationships, characterised by the reciprocity of ties (quality of relationships), (Lochner et al. 1999). Stone (2001) suggests that the quality and quantity of relationships should be viewed by examining individuals’ activities or behaviours (structural social capital) and separately analysing how people think, feel and ultimately trust others (cognitive social capital), (Bain & Hicks 1998). For offenders, the impact of adverse childhood experiences, mental illness and criminal justice involvement can result in the person struggling to form and sustain trusting relationship with others (Community Development Foundation, 2014). Structural and cognitive social capital incorporates the ties that link individuals, such as religion, hobbies, socio-economic groups, drug cultures and living circumstances; offenders may have common bonds around culture or sub-cultures (bonding social capital).

Other descriptors of social capital are ‘bridging social capital’, which relates to individuals or groups developing relationships based on shared beliefs or views, for example, religious groups. Social capital can also be facilitated by shared experiences within formal institutions such as prisons, community centres or government agencies, termed ‘linking social capital’ (Szreter and Woolcock, 2004). These characteristics of relationships - ‘bonding, bridging and linking’ explain the location, context and type of connection.

Belonging to families, social groups and networks is associated with increased health and well-being. Membership enhances inclusion, thus reducing or eliminating social exclusion and enhancing recovery. Gaining acceptance to groups can be more difficult for people with mental
health problems due to specific entry criteria, norms and rules. These barriers can be amplified for offenders due to a variety of reasons, including social skills, finance, supervision conditions, confidence and self-esteem.

Offenders with mental health problems face greater challenges in maintaining functional and non-fragmented relationships due to symptoms, offences or associated behaviours, thus affecting the availability of resources and supports. Social isolation is common with increased contact with the criminal justice system and is associated with rates of re-offending (Ministry of Justice, 2013). This paper reports on the perspective of arrestees and remand prisoners of the availability, functionality and accessibility of social support networks in advance of release from short term custody, (police station and remand prison). The findings are presented, illustrated with a case example, to highlight a social network approach to assess the benefits and limitations of service users’ social networks and how these can be suitably restructured to support transitions from custody.

METHODS

This study aims to explore service users perspectives of their social support networks, in advance of release from short-term custody. Service users were interviewed about the size, composition and functionality of social support networks, in relation to both everyday and crisis support, reflecting on how their networks may have changed as a result of life events and greater exposure to the criminal justice system.
Eleven service users made up the sample, which formed part of a larger study, exploring the transitional health and social support needs of offenders, from the perspectives of both recipients and providers of care. Basic demographic data was collected at the beginning of the interview. Individual interviews were conducted within police custody and remand prison settings, during 2012 and 2013, in the North West of England. Research Ethics Committee, NHS and NOMS approvals and permissions were gained at the outset of the study.

RECRUITMENT

Participants were recruited, using a purposive approach, ensuring a wide range of views, for example, different ages, length of time on remand/in police custody and variance in offending behaviour (Bryman & Bell, 2007). Participants received a written information sheet, designed specifically for the study and informed consent was obtained prior to interviews taking place.

The sample comprised of eleven participants (see Table 13 below);

Arrestees: 5 (3 males, 2 females)
Remand Prisoners: 6 (6 males)

Table 13: below details the basic demographics of the sample as an introduction to the participants. These are discussed further in the results section of this paper. In Table 13 participants are represented by a pseudonym.
Table 13: Service User Participant Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Research ID</th>
<th>Age</th>
<th>Arrest</th>
<th>Remand</th>
<th>Diagnoses</th>
<th>SubMisuse *</th>
<th>Precons</th>
<th>Housing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul</td>
<td>ID:1024</td>
<td>48</td>
<td>Remand</td>
<td></td>
<td>Schizo-affective PD</td>
<td>Polydrug</td>
<td>164</td>
<td>NFA</td>
</tr>
<tr>
<td>Mark</td>
<td>ID:1025</td>
<td>38</td>
<td>Remand</td>
<td></td>
<td>Schizophrenia PD</td>
<td>Polydrug</td>
<td>98</td>
<td>Temporary</td>
</tr>
<tr>
<td>Philip</td>
<td>ID:1029</td>
<td>28</td>
<td>Remand</td>
<td></td>
<td>Schizophrenia</td>
<td>Polydrug</td>
<td>20</td>
<td>NFA</td>
</tr>
<tr>
<td>David</td>
<td>ID:1027</td>
<td>32</td>
<td>Remand</td>
<td></td>
<td>Schizo-affective PD</td>
<td>Cocaine Alcohol</td>
<td>73</td>
<td>Temporary</td>
</tr>
<tr>
<td>Frank</td>
<td>ID:1026</td>
<td>26</td>
<td>Remand</td>
<td></td>
<td>Schizophrenia</td>
<td>Polydrug</td>
<td>43</td>
<td>Living with family</td>
</tr>
<tr>
<td>James</td>
<td>ID:1028</td>
<td>30</td>
<td>Remand</td>
<td></td>
<td>Schizophrenia</td>
<td>Polydrug</td>
<td>57</td>
<td>NFA</td>
</tr>
<tr>
<td>Stephen</td>
<td>ID:1023</td>
<td>29</td>
<td>Arrest</td>
<td></td>
<td>Bi-polar</td>
<td>Polydrug</td>
<td>12</td>
<td>Temporary</td>
</tr>
<tr>
<td>Jill</td>
<td>ID:1030</td>
<td>27</td>
<td>Arrest</td>
<td></td>
<td>Depression</td>
<td>Polydrug</td>
<td>7</td>
<td>Private Rent</td>
</tr>
<tr>
<td>Sue</td>
<td>ID:1036</td>
<td>43</td>
<td>Arrest</td>
<td></td>
<td>Depression Anxiety</td>
<td>Alcohol</td>
<td>1</td>
<td>Living with parent</td>
</tr>
<tr>
<td>John</td>
<td>ID:1035</td>
<td>20</td>
<td>Arrest</td>
<td></td>
<td>Anxiety PTSD</td>
<td>Polydrug</td>
<td>3</td>
<td>Temporary</td>
</tr>
<tr>
<td>Peter</td>
<td>ID:1039</td>
<td>39</td>
<td>Arrest</td>
<td></td>
<td>Depression PD</td>
<td>None</td>
<td>17</td>
<td>Private Rent</td>
</tr>
</tbody>
</table>

* polydrug use - denotes use of three or more substances
INCLUSION CRITERIA

The following were eligible for inclusion:

a) Male and female arrestees with mental illness aged between 18 and 65 years, whose mental health state was considered stable and had capacity to consent (judged by qualified mental health practitioners).

b) Remand prisoners were limited to males due to the host prison within the locality serving male prisoners only.

EXCLUSION CRITERIA

a) Individuals lacking capacity to consent determined by mental health practitioners;

b) Individuals deemed to be too violent or a risk to the researcher, judged by mental health practitioners;

c) Immigration detainees;

d) Language issues – for example those who do not speak English as a first language were excluded for practical reasons.

DATA COLLECTION

Egocentric network maps, termed sociograms, were constructed using the ‘name generator technique’ (Marin, 2006). Egocentric refers to networks being generated with the individual termed ‘ego’ being at the centre. Other people identified as part of the network, by the service user, were referred to as ‘alters’. Alters were people, with whom the service user had a
connection or relationship. Alters were included using an adaptation of Antonucci’s hierarchical mapping technique of concentric circles (Antonucci, 1986), which included five support layers to distinguish ‘closeness’ to the ego. The adaptation provided additional flexibility for participants in determining closeness of alters. Expansion of the support layers has similarly been applied in other egocentric network studies (Boase et al, 2006; Wellman et al, 2001). The concentric circle technique was developed in 1979, by Antonucci and colleagues to support the first national study of the social networks of older adults in America (Antonucci & Akiyama, 1987) and has been widely applied within social networks studies.

**PROCEDURE**

Antonucci’s technique was applied by creating concentric circles on large, A3 sized paper, with the central circle labelled as ‘you’. The respondents were asked to identify people for the immediate inner circles as people who are ‘most important’ or ‘very important’ that life would be hard to contemplate without those individuals (such as spouse, close family and friends, with ties that were noted to be long term). The middle circle was about people who were ‘important’ but not as close as those in the inner circle (family, friends and peers, which were described as changeable over time). Finally, the outer circles was for people who were ‘less important’ or ‘not important’ at all, but were considered to have a place within the network (such as distant family, professionals and neighbours described as role dependant and short term), (Antonucci, 1986). Participants were asked to write the first initials of the person the relationships (for example M- sister, P- brother, K- partner) on post it note to allow movement of the connection during discussion. Participants were asked to place the name on the diagram as to the current position of ‘importance’ in relation to ‘closeness’ on an everyday basis.
Participants were asked five questions in relation to their visualised network:

Who is in your network?
What is your relationship with the person named?
Who is important to you, and why?
Who would you contact in a crisis?
Has your network changed, and why?

Participants were asked to describe the differences in relationship between people placed in the inner, middle and outer circles to understand the importance and value attributed to these relationships. Characteristics including numbers of alters, relationships between ego and alters (for example; parent, partners, relative, friend), gender, age, frequency of contact and geographical distance between ego and alters were obtained. Descriptors about how often people were in contact, accessed support and potential changes as a result of mental illness, offending and imprisonment were incorporated within the sociograms. Finally, participants were asked to position the name (post it note) on one of the five segments (using the five descriptors of importance above). This provided an opportunity to identify ‘who’ within the network participants could access at challenging or distressing times.

**Data Analysis**

Eleven sociograms were constructed with service, during interviews for a larger study, which were transferred into the software VennMaker (Kronenwett & Adolphs - Version 15) to support analysis. Data from the larger Constructive Grounded Theory (CGT) was analysed using
Dedoose software (Dedoose - Version 6.1.18, 2015) and provided supplementary data to aid understanding of social networks.

PARTICIPANT DEMOGRAPHICS

The study comprised of 11 participants; 5 arrestees (2 female) and 6 remand prisoners (all male). During data collection participant were allocated a research ID code to ensure confidentiality; however, this was replaced with a pseudonym. Below is a description of the basic demographics of participants.

Age

The age range for arrestees was between 20 and 43 years (n=5) and for remand prisoners 26 and 48 years (n=6). The mean age was 31.6 years for arrestees and 33.6 years for remand prisoners. All arrestees were self-defined as white British, and two of the sample were female. One of the remand prisoners (David) was of North African/British parentage and self-defined as Black British.

Mental health

Arrestees tended to experience less severe mental illness, with diagnoses of anxiety, depression, post traumatic stress disorder (PTSD) and one (Peter) having a former diagnosis of personality disorder (PD). Remand prisoners were primarily diagnosed with more serious mental health conditions, including schizo-affective, bi-polar and schizophrenia. Half of the remand sample were also diagnosed with PD, although the type was not specified, nor had a formal assessment using a specialist diagnostic assessment been undertaken. Participants regarded the PD diagnosis
as a label, rather than a way of understanding their personal difficulties. “It’s a way of them [services] saying they don’t have to treat us’ (Paul, remand).

**Substance Misuse**

The use of substances was prevalent within the group (n=11). Arrestees reported using cocaine, cannabis and alcohol, but denied daily or dependent drug use, with Sue using alcohol only. Sue also described non-dependent alcohol use, however, she disclosed heavy binge drinking. Peter (arrestee) was the only member of the sample that was abstinent from both drugs and alcohol. He had a long history of excessive and dependent usage, primarily crack cocaine, heroin and cannabis. Peter said he had achieved abstinence while incarcerated, whereby life-limiting health problems were also identified.

The remand group described high levels of polydrug use (three of more substances), including crack cocaine, heroin, amphetamine, cannabis and cocaine. One participant, David was a dependent cocaine and alcohol user, although he had used heroin on a ‘few occasions’ many years ago.

**Previous convictions, charges or reason for arrest**

All of the sample (n=11) had previous convictions. There was a marked difference in the rates, type and severity of previous offences between arrestees and remand prisoners. The total number of offences for the arrestees was 40 and for the remand group 455. The mean number of convictions for the arrestees (n=5) was 8 and for the remand group (n=6) was 75.8. The calculation of the median mitigates the impact that outliers may have on calculation of an
average score for both groups. This was more of a feature within the remand group. The median for arrestees was 7 and 65 for the remand group. There were further differences between the two groups in relation to the type and severity of convictions. For arrestees, offences including public order, theft and dishonesty, possession of Class B drugs and common assault (Section 39, Criminal Justice Act, 1988). Antecedents were more serious in the remand group and included multiple thefts, burglaries, possession of Class A with intent to supply and assault occasioning actual bodily harm (Section 47, Offences Against the Person Act, 1861) and unlawful wounding/grievous bodily harm (Section 20, Offences Against the Person Act, 1861). The difference in nature and severity was evident in arrest and charges, with a remand prisoner charged with attempted murder.

Housing

Housing concerns were common. Two of the arrestees Jill and Peter reported having their own tenancies. Peter lived alone and Jill with her three young children. Only one of the remand group, Frank had a release address and three others were of no fixed abode.

The basic demographic data, although not statistically analysed demonstrated the high levels of co-occurring substance misuse and significant mental health problems, particularly among the remand group. Also, evident is the social needs, for example, in relation to housing, with only one of the remand group having a stable address for release. Arrestees report high levels of stress about the current situation. Similarly, remand prisoners reported anxiety, despair and frustration about the prospect of ‘no change for the better’. The next section outlines the various network structures and functions, illustrated primarily by a case example John (arrestee).
CASE EXAMPLE

John was a 20-year old man with a history of four arrests and three subsequent convictions. On all four occasions John was arrested by police in an ‘intoxicated state, threatening suicide and causing a disturbance in a public place’. John disclosed his mother’s suicide 12-months earlier. He found her in a state of coma, from which she never recovered, dying days later. On this occasion John was arrested at 2am in a distressed state threatening to jump from a high-rise building, endangering his own and others safety.

John lived with his friend in a rented flat, but had received notice on the tenancy. John’s father sold the house after his mother’s death and used the proceeds to fund his relocation abroad, maintaining limited telephone communication with his sons. John described a non-reciprocal relationship with his father. John had a geographically distant, non-reciprocal relationship with his older brother. John grandmother was his closest alter, although she had a life-limiting illness and he ‘couldn’t burden her with problems. John’s way of coping was to use substances including alcohol, cannabis and cocaine, which invariably compounded his situation. John reported dissatisfaction with his social network, including a lack of support from his brother and a general absence of helpful people in his life. John’s social network is displayed below:
John’s sociogram has five concentric circles representing everyday support and six segments depicting crisis provision. Functionality of relationships is represented by green (positive), red (negative) and black (neutral).
John placed his grandmother as centrally close, but less important in relation to crisis situations due to her ill health. His brother was most important for crisis support although he disclosed a reluctance to contact him with stresses or concerns. John placed his dad as important for everyday and crisis situations ‘cos he’s my dad and that’s what dads should be’. He represented the negativity of the relationship with a red relational line. Two friends were placed as important for both everyday and crisis situations “they were there for me when mum died”. When intoxicated John reported becoming solemn and angry and would “take this out on friends”. He worried about the long-term implications of his behaviour on friendships. His current flatmate, once his best friend, was placed ‘close’ but on the outside for crisis support. This was due to his friend moving away and John feeling alone. John’s network is sparse with limited familial support, particularly in a crisis. John would benefit from support to extend the quantity and quality of ties within his network

**RESULTS**

Table 14 summarises the sociogram data of relational activities occurring within each participant’s (ego) network. The number of positive, negative and neutral reciprocal relations for each participant is displayed. The right-hand column represents the number of reciprocal relations for the participant (ego) with other members (alters) within his/her network.
Table 14: Relational activities within Sociograms
Number and type of network ties between ego and alters

<table>
<thead>
<tr>
<th>EGO Name</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral</th>
<th>Reciprocal Ties for EGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>16</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Peter</td>
<td>61</td>
<td>9</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Stephen</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Paul</td>
<td>15</td>
<td>2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Philip</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mark</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>David</td>
<td>47</td>
<td>2</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>James</td>
<td>24</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Jill</td>
<td>37</td>
<td>8</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Frank</td>
<td>16</td>
<td>8</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Sue</td>
<td>24</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

The data in Table 14 represents participants’ perspectives of the ties between ego + alters and alters + alters. John’s sociogram visually represents the components of network structures in terms of size, density, reciprocity and the strength of ties, which is discussed below.

**Network Size and Density**

John’s network incorporated 7 alters, his grandmother, brother, father and 4 friends, one of whom was his current flat mate. The limited size networks was also relevant to two of the remand participants, Mark reported positive and highly functional network members (mum, brother and two friends). Philip’s network had five members, including two staff based in the prison (mental health and drug team), which are short-term, context-specific relationships. Peter’s network contained interconnected alters, 9 of the 12 were regularly in contact, thus providing greater variety and stability of support.
Network Reciprocity

David, Peter and James reported the highest levels of reciprocity between ego and within alters and Stephen the lowest, with the most reciprocal relationship being between his sister and ex-girlfriend. John’s network contained an absence of reciprocal relationships.

Strength of Network Ties

John’s network was characterised by weak or absent ties. This was also evident in Frank’s network, 2 brothers and 2 friends were drug using and criminal acquaintances. Both brothers have served prison sentences, which had damaged relationships as ‘we all blamed one another’. One brother was abstinent, and although not the closest of ties was an important source of encouragement to change. This may have occurred within John’s external network, resulting in him not feeling able to include extended family members in his network diagram.

Commonalities among the group (n=11) was the absence of fathers in the network, only Peter and Sue (arrestees) reported positive relationships. Conversely, relationships with mothers were of significance in most of the sample. James and David reported strained relationships with their mothers, exacerbated by offending and long-term drug use. Contacting mothers for advice and comfort was consistent among participants and a noteworthy absence for John. Siblings were described as important even when noted as being negative.

Over half of the sample had children, Jill, a single mother of three wanted to ‘make sure my kids have a better life’. Similarly, James, Paul, David and Stephen placed the children in primary positions, as they reinforced the need to ‘keep going in bad times’. All participants reported changes over time in networks, all remand group experienced significant depletion in the quality
and quantity of relationships, with the exception of David. Sue’s network had diminished following conviction, the end of an intimate relationship and return to former home location.

Discussion

Network size refers to the total number of alters present in an egocentric network (Haines et al, 2008). All the networks described by participants were impoverished, indicating the potential limitations in the availability of everyday and crisis support. John network size diminished following the family breakdown and his ability to cope with the traumatic death of his mother. John was diagnosed with Post Traumatic Stress Disorder (PTSD), which may have contributed to his impoverished network. Adverse childhood experiences, severe trauma and stressful life events increase the likelihood of PTSD (Brewin et al, 2000; Ozer et al, 2003). The largest risk factor for onset of PTSD was found to be limited social support (Brewin et al, 2000).

This findings of this study correspond with the literature, indicating people with mental health problems; including psychotic and neurotic conditions, have smaller networks; typically comprising of 10-15 people (Cutler et al, 1987; Halpin, 1995; Goldberg et al, 2003; Hardiman & Segal, 2003; Maguire, 1983; Meeks & Murrel, 1994; Perese et al, 2005; Walsh, 1994). This is compared to an average of 150 functional relationships per individual, within the general population (Dunbar, 1993). The largest networks were Peter, David, James and Jill, which correlates to a greater number of positive ego to alter relations. This highlights that network size may provide greater opportunities for reciprocal tie development between network members.
Evidence suggests that people with significant mental health problems can have networks of five members or less (MacDonald et al., 2000), which impact on health and well-being (Goldberg et al., 2003; Tempier et al., 1998). This was particularly evident in Philip and Mark’s networks, which corresponded to the relatively few positive relations present. Stephen network was slightly larger, however, he had few positive connections and higher negative relations. This was due to relationship breakdown as a result of long-term substance misuse and associated offending.

Network density is the proportion of possible ties between the alters within an individuals network that actually exist (Granovetter, 1976; Ueno 2005). People with mental health problems tend to have more dense networks of primarily family members (Halpern, 1995; Perese et al., 2005; Walsh, 1994). The more interconnectedness between alters, the denser the network (Simmons, 1994), which can host resources for intensive or low-level support. Low levels of interconnectedness were found among participants. However, John’s network had limited interconnectedness with no availability of familial intensive or practical support. John’s network may have had greater connectivity before shrinkage.

Reciprocity refers to cooperative relationships within networks, where actors provide mutual exchanges of support, assistance or items (Jun & Sethi, 2008). Family members increase likelihood of reciprocal patterns of support, due to established norms of sharing of resources (Wellman & Wortley 1989). The presence of strong familial relationships was found to be more significant than friendships within networks (Fiori et al., 2006). Reciprocity adds strengths to networks, as actors form more meaningful relationships through the process of helping one
another (Ellison, 1983; Wasserman & Faust 1994; 1999). However, reciprocity was limited within John’s network and felt isolated and abandoned, ‘there’s nobody there for me and I’m not sorted enough to support anyone else....most of the time I’m trapped in my own head’. He described a strong connection to his grandmother and brother and under different circumstances these could have been influential in John’s life (Berkman & Breslow, 1983; Umberson et al, 2010).

Research has demonstrated that males were less likely to establish mutually supportive connections and tended to utilise more independent, and reckless coping strategies (Frydenberg & Lewis 1993; Haines et al, 2008; Umberson et al, 2010). Without reciprocity networks become sparse, fragmented and have reduced functionality, which was evident in most of the networks.

The strength of interpersonal ties within networks refers to the combination of the amount of time, emotional exchange and mutual support (Granovetter, 1976). Relational ties within families may also be have a negative influence on health and well-being including increased substance misuse (Fowler & Christakis 2008; Umberson et al, 2010; Walen & Lachman 2000). Park and Roberts stressed the importance of family members in networks stating ‘family clearly remains most people’s first source of support when things go wrong’ (Park & Roberts, 2002, p. 203). Relational ties within networks provide cohesion and purpose to some or all network members (depending on the size of the network), which in turn may enhance emotional stability (Antonovsky, 1987).

John is a typical example of many young male offenders in arrest and remand situations. Even at aged 20 years his network has diminished and this shrinkage is relevant to his health and well-
being. Without a network approach the limitations in the quantity and quality of network ties and network functionality would not be recognised. The next section considers the relevance of incorporating a network-based approach routinely within mental health practice and particularly at times of additional vulnerability such as transitions within or between services. Network interventions applied within an early intervention context may be able to both preserve and enhance relationships.

RELEVANCE OF SOCIAL NETWORK ANALYSIS TO MENTAL HEALTH PRACTICE

Social networks are visual representations of existing relationships, illustrating the types and availability of support to the individual (Malone, 1998). Relationships can be uniquely individual and the strength and depth of relationships may vary over time or in response to life changing situations, such as loss of life or liberty. This was significant for arrestees and remand prisoners where involvement in the criminal justice system can be critical, life changing events, affecting individuals and networks. Repeat offending and long-term incarceration impacts on social networks (Mandracchia & Morgan, 2010) in the same way as mental illness, resulting in fewer positive, supportive and reciprocal relationships within networks (Walsh, 1994). Of concern is that networks may continue to diminish, resulting in transient, untrustworthy relationships ‘associates’. This was evident in Paul’s network, where friends had vanished, replaced by context-specific associates ‘they’re not mates I just use gear, rob drink and doss on the streets....I wouldn’t trust one of them’. People with mental illness face additional stigma and disadvantage by involvement in the criminal justice system. However, health and criminal justice professionals may not routinely consider the relevance of diminishing social networks on health, well-being and re-offending during assessment.
Mental health interventions could incorporate strategies to resolve individuals’ network difficulties, including improving interactions, social ties and reciprocal relationships. Intervention should support the expansion of networks where the focus is on improving the quality of social relationships rather than the number of ties. The construction of social networks would provide service users with the opportunity to have a central role in understanding the significance of ties in their networks (Phillipson et al, 2001).

**INCORPORATING NETWORK INTERVENTIONS**

Previous research has indicated that case management programmes can improve the quality and quantity of the social networks of people with mental health problems (Koch et al, 2012). Programmes need to support people to develop new social contacts, as these yield embedded resources which may be invaluable to those with limited social networks (Ozbay et al, 2007). Critical Time Intervention (CTI) is a form of case management providing time-limited support during transition from hospital or prison. CTI promotes continuity of care during transitions, by effectively linking service users to community services (Draine & Herman, 2007). However, whilst the intervention emphasises the establishment of community links the programme does not specifically include social network assessment or interventions. The inclusion of social network analysis would identify the structure, composition, strength and functionality of ties in networks, which would highlight where transitional interventions need to be targeted. Sociograms are a visual representation of the totality of support available, which is meaningful to service users and provide an effective way of engaging a client group with low levels of educational attainment.
Limitations

The limitations in this study were data collected in interview, therefore social desirability bias may have been a factor in reporting, particularly in relation to sensitive or criminal related behaviours. Information on network alters was collected by self-report by the ego and provides a unique perspective, but may be under or over represented.

CONCLUSION

Networks are not simply sources of support for offenders with mental health problems but integral to an individuals’ identity; and access to a wide range of support, central to the recovery/rehabilitative process. The size, composition, how members are connected and communicate with each other impacts on the way individuals think, feel and behave (Bain & Hicks 1998; Lin 1999; 2001; Stone, 2001). Social network analysis applied in clinical settings has the potential to enhance understanding about service users’ relationships, connections, social ties, activities and places of importance in their local community. The purpose of this study was to explore the relevance of these connections on support for transitions from custodial settings. The study both mapped and documented individual perspectives on what was important to support transition to the community.

This paper is in draft form and therefore not yet finalised. The references are located within the main reference section of this thesis
Chapter 6
CONCLUSION OF THESIS

“You cannot shake hands with a clenched fist”
Golda Meir

6.1 Introduction

This thesis is an exploration of the perspectives of recipients and providers of health and criminal justice services about the support needs of arrestees and remand prisoners leaving short-term custody. This final chapter provides a summary of the research study undertaken, reiterating the grounded theory about the importance of shifting the focus on ‘discharge’ to a concentration on transitional care for people with mental health problems in the criminal justice system. This chapter aims to firstly situate the research in the context of key literature and contemporary health policy and practice. Secondly, it aims to demonstrate the significance of the research findings to the research objectives. The contribution of the research to the existing field of transitional care for offenders with mental health problems is also considered. Finally, the research process is evaluated and recommendations for further research are proffered.

This research is a Constructive Grounded Theory (CGT) study, where the methods outlined by Charmaz (2005) were applied. The theoretical framework by Lin (1999; 2001) ‘network theory of social capital’ provided the theoretical framework for the study. Lin defined social capital as ‘resources embedded in a social structure that are accessed and/or mobilised in purposive actions’ (Lin, 2001, p.29), with three central characteristics - ‘inequalities’, ‘capitalisation’ and ‘effects’. Social capital denotes the availability of resources to support individuals’ functionality,
well-being and objectives (Erickson 1996; Flap 2002; Lin 1999a; 2001). Offenders may gain some form of social capital through social contact with others such as family, friends and professionals supporting mental health and well-being (Pinto, 2006). Lin’s theory informed the data collection, coding and interpretation of findings. Lin’s three characteristics of social capital resonated with the three root themes 1) ‘Transitions and Transfers of Care’, which incorporates ‘Inequalities’, i.e. the inequitable service structures for offenders and the inadequacies of transition arrangements, 2) ‘Opportunities for Assessment/Support’, which influences ‘Capitalisation’. i.e. the availability of support 3) ‘Modes of Action/Practice’ refers to the ‘Effects/Returns’, i.e. purposeful actions or behaviours, which provides both positive and negative returns, referred to within Chapters 4 & 5, and papers 3 & 4.

6.2 Principal aims and objectives

The principle aims and objectives of the research were to explore the transitional support needs, from service user, carer and staff perspectives.

Forty-two semi-structured interviews were conducted, with five participant groups; service users (arrestees/remand prisoners), family/carers, mental health staff (criminal justice liaison and mental health in-reach, community mental health teams), criminal justice staff (police/prison officers) and mental health commissioners.

Participants provided unique perspectives about the health and social support, available at the transitional points of leaving short-term custody. This was supported by the construction of 11 sociograms for service users, in both arrest (n=5) and remand (n=6) situations, to highlight the availability and functionality of support networks.
The principal research question addressed was:

“What are stakeholders’ experiences and views of current mental health care provision for arrestees and remand prisoners and could continuity of care at these transition points be enhanced through transitional case management?”

The objectives were to explore participant’s experiences in relation to improving continuity of care at transitional points, which are recognised as points of specific vulnerability. The availability and functionality of social support networks were explored in relation to resources available for offenders to support transition to the community. Finally, the components of transitional case management programmes were considered with reference to enhancing continuity of care for offenders with mental health problems leaving short-term custody.

The grounded theory constructed from participants data, informed by contemporary research proposes transitional care should be embedded in all health policy and practice, and effectively replace routine ‘discharge planning’ within mental health services. The current focus on discharge is reductionist and facilitates a focus on itemised, context-specific care, which is largely detrimental to service user outcome as it absolves teams of responsibility for facilitating onward care. This is exemplified in health and criminal justice literature which describes ‘end to end’ models of care (House of Commons, 2011). Most people are not discharged from services and require further support or treatment by another clinical team or in another setting. As highlighted in Paper 1 - Improving the Transitions for Mentally Disordered Offenders Leaving Custodial Environments there is evidence of the implementation of successful transitional care
programmes in other specialities such as pain management (Brook et al, 2011), paediatrics (Orr et al, 1996), cardiac care (Naylor, 2004) and older people’s services (Rich et al, 1995). However, this has been more limited in mental health services and largely absent in offender health services; hence there is limited continuity of care.

6.3 Continuity of Care

Consistent with the literature was the finding about the importance of ‘continuity of care’, as inconsistent care provision can prevent effective treatment (NCCMH, 2011c). Participant comments in this study highlighted discontinuity of care, for example “there’s no continuity of care, it’s the opposite, it’s hemmed tightly around each part of the service... There’s no concept of onward, backward or sideways movement. We all work in silos” (CJL participant - ID:1013). Similarly, a remand prisoner commented on previous experiences of limited support on release stating, “there’s nobody about for you when you go out. It all stops. There’s no communication you don’t know anything” (Remand - ID:1027).

Transfer and discharge have been recognised as vulnerabilities in care pathways that can generate uncertainty, anxiety and inadequate preparation can exacerbate deterioration and relapse (Kripalani, 2007). Similarly, release from custodial settings present significant challenges for offenders with mental health problems (Birmingham et al, 1997; Bradley, 2009, Shaw et al, 2009). Concerns have been raised about the poor continuity of care (NACRO, 2005, Revolving Doors, 2006), for example, 30% of people are released from prison homeless; despite research estimating stable accommodation reduces re-offending by 20% (The Prison Reform Trust, 2013). Of specific concern is that fifty percent of prisoners with mental health problems
also leave prison without stable accommodation. This is relevant to the findings from this study, as only one of the remand prisoners (n=6) had a confirmed release address and all described strained and fractured relationships with family. Therefore, it is arguable that release is a “health depleting experience” (Burgess-Allen et al. 2006, p.300), which can result in relapse, re-offending and potentially elevate the risk of suicide (Appleby et al, 1999; Farhall et al 2003; Pratt et al, 2006 and Binswanger et al, 2007). The complex health and social needs among offender populations have been highlighted (Social Exclusion Unit, 2002; 2004). Many face multiple and diverse challenges when returning to the community, including finding stable accommodation and employment (Baldry et al, 2006; Travis et al, 2001) and accessing appropriate community services (Kariminia et al, 2007; Lennox et al, 2012). Many have limited functional support networks (Baillargeon et al, 2010), coupled with poor coping strategies (Prison Reform Trust, 2013), which adversely affects community resettlement.

6.4 Complex health and social needs

In practice, many people with mental health problems ‘fall through the net’ in the community (Harris, 1999) resulting in limited clinical outcomes at all stages of the CJS. Offenders have complex health and social needs, often stemming from difficult, challenging and traumatic experiences in childhood, including high incidences of local authority care (Social Exclusion Unit, 2002). Consequently, many have limited reading, writing and numeracy skills (McMahon et al, 2004). Difficulties in childhood often continue into adolescence, resulting in further disadvantage in adulthood; including high rates of unemployment, substance misuse, violence, self-harm and risk of death, from all causes (Cox et al, 1995; Farrell et al, 1995; Sattar, 2001; Pratt et al, 2006; NCI, 2006; Draine & Herman, 2007). Despite high levels of need many have
inconsistent patterns of engagement in services, with fewer than 50% of prisoners registered with a GP (Bruton et al, 2006). Consequently, underlying health and social issues prevail, but these may not always be identified within police and prison settings (Birmingham et al, 1998; 2006, Brown et al, 1992; Coid, 1988; 1991; Dell et al, 1993; McKinnon & Grubin, 2010).

The service users in this study described a range of difficult and upsetting life experiences, which as Lin states, limit abilities to positively generate social capital through family and community resources (Lin 1999, 2001). People with mental health problems tend to have smaller social network (Pickens, 1999; Pinto, 2005). Friends and family are replaced either temporarily or permanently by people met through the mental health system that essentially offer short-term relationships (Breier & Strauss, 1984). This situation is even more critical for offenders, where repeat offending and long-term incarceration impact on social networks (Mandracchia & Morgan, 2010). It is of concern that networks continue to diminish, resulting in transient, untrustworthy relationships ‘associates’. This was evident in Paul’s network (ID: 1024), whereby friends had vanished, replaced by context-specific associates. Depleted and unsatisfactory social networks were identified within all service user sociograms, which are presented within Paper 4 and Chapter 5 respectively. There is a body of literature about the links between poverty, abuse and neglect in childhood and subsequent aggression, criminality and post-traumatic disorder (PTSD), (Hussey et al, 2006; Widom & Maxfield, 2001; Smith et al, 2005; Showyra & Cocozza, 2006). This can result in poor relational ties, limited availability of resources, which can hinder the mobilisation of social capital. Living in socially disadvantaged households and communities may generate a lack of rules, boundaries and social controls, which in turn may influence the development of anti-social and criminal behaviours (Sampson & Laub,
Service users reported significant experiences of abuse, poor coping skills and difficult encounters with criminal justice agencies.

“I was sexually and physically abused in care....I was only 11 years old. I’ve always wanted to get off my head to deal with it, it’s the voices and the flashbacks out there that make me wanna cut [self-harm]” (ID: 1024 remand prisoner)

“I’ve lived on the streets since I was 13 years old” (ID: 1027 remand prisoner)

“My life has been hard, too hard” (ID: 1035 arrestee)

“I thought there were people coming to kill me...I was trying to survive, I kicked off and I didn’t stop until they tasered me and then it took 7 of them to restrain me and get me into hand and leg cuffs” (ID: 1025 remand prisoner).

“I get stressed. I am angry, very angry - cos of the way my life has worked out (ID: 1034 arrestee).

Offenders with mental health problems are disadvantaged on multiple levels due to complex health and social needs, the effects of mental illness, co-occurring substance misuse and offending behaviour, both to survive and as a lifestyle choice. The improvements to police and prison-based mental health services may improve detection of mental health needs and facilitate engagement in treatment (Bradley, 2009). Despite increased stability of mental illness within prison settings; if transitions are not managed effectively offenders are likely to flounder, relapse and re-offend, resulting in a return to prison.
6.5 Early Intervention

Offenders with mental health problems may experience mental health relapse, repetitive re-offending and are at risk of becoming ‘revolving door’ offenders (Baillargeon et al, 2009; Howerton et al, 2009; Padfield & Maruna, 2006). Early detection provides the greatest therapeutic opportunity, particularly for individuals experiencing co-morbid conditions, such as concurrent substance misuse (Howerton et al, 2009). Appropriate screening, assessment and treatment can reduce the cycle of repetitive entry, detention, release and readmission into the criminal justice system of people with mental health problems (Ogloff et al, 2007). Without effective interventions mentally ill offenders can be “trapped in a cycle of petty crime, incarceration, release, homelessness and re-imprisonment” (Thompson, 2008, p. 103).

Studies have reported that mental illness missed in police custody can remain undetected throughout sentence and following release into the community (Bradley, 2009; McGilloway & Donnelly, 2004, Shaw et al, 1999). However, there have been substantial developments in mental health care provided to offenders with the recent expansion of criminal justice liaison and mental health in-reach services, which was regarded positively by participant groups in this study, for example, the assessment process was a ‘cathartic’ experience (Arrestee - ID:1036). Despite further investment CJL is not available on a 24 hour, 365 days per year basis; consequently people are still missed at this critical entry point. The young man aged 20 years (Arrestee - ID:1036) is presented as a case study within the Paper 4: Tying up loose ends – expanding the social networks of offenders released from short term custody, to illustrate the potential application of social network methods within routine mental health practice. As a case example he is fairly typical of other young men on the cusp of the CJS, and motivated to engage
in support services. ID:1036, pseudonym John, had a diminishing social support network. He had experienced significant trauma after finding his comatose mother, following overdose. John had been referred to community mental health services, but was reluctant to take time off work to attend for office-based appointments. Whilst his distress and need for support was recognised by CJL, the significant depletion of functional and reciprocal ties was not identified. John would have benefited from the early intervention support, as recommended by Lord Bradley (2009), to reduce the risk of further criminalisation. “Interventions as early as possible in the criminal justice system would provide the best opportunities for improving how people with mental health problems or learning disabilities are managed” (Bradley Report, 2009, p.29). Another recent initiative within the CJS, although beyond the scope of this thesis, has been ‘Street Triage’ (DH, 2013), which involves mental health staff working jointly with police officers in local communities. The concept is to provide ‘on the spot’ mental health assessment for offenders, thus appropriately diverting from the CJS. Early intervention services provides an opportunity to engage individuals in a pro-active manner with health and social services, before the development of refractory symptoms and more serious offending, Despite the establishment of initiatives such as ‘Street Triage’ the problem of offenders accessing generalist community based mental health services still exists. It is likely that mental health staff working in this role will face exactly the same problems as those highlighted by criminal justice liaison and mental health in-reach staff cited in this study. Without effective engagement in community-based services, which deliver appropriate care programmes the phenomenon of ‘revolving door’ clients is likely to continue. As this thesis proposes there is a need for a culture shift through an emphasis on transitional pathways, as opposed to discharge planning to assure seamless entry into community mental health teams.
6.6 Returning to the security of the prison

A significant finding in this study was that without appropriate support being available after release, particularly in crises situations, there is a risk that offenders may choose to return to prison to access good quality health care. Three of the six remand prisoners interviewed disclosed re-offending purposefully to return to prison. Prison was not perceived as a deterrent; moreover, it provided familiarity, belonging, safety from the stresses of the outside world and more recently the ‘best place to access good health care’.

“I was only out for a couple of days, I couldn’t cope, I had nowhere to live, no money so I got myself arrested and got back in. I’m comfortable, got a bed, food, a job and a good pad mate. I’m better off in here” (remand - ID:1026).

The Department of Health strategy of improving prison health services may have future implications for re-offending rates, given that offenders’ expectations of services are raised in custody, which are then not delivered in the community. This was summarised by a mental health in-reach participant “the lads in here have got access to far better services than in the community, they see the same consultant psychiatrist monthly, have a named care co-ordinator and can see a crisis member of staff within four hours if that’s what was needed. Out there they probably wouldn’t get a consultant, they’d have lots of different mental health staff and not be referred to crisis support” (MHI - ID:1006).
6.7 Transitional Care

Prison-based mental health care was founded on the ‘principle of equivalence’ for accessing comparable standards of services as available to the general public (Brooker et al, 2008, p.3). However, in pursuing this objective the result has been the provision of treatment ‘behind the wall’, rather than on the establishment of pathways of care into the community. Furthermore, limiting interventions to ‘behind the wall’ may risk formation of a new mental health institution within an institution, which does not contribute to optimal service user outcomes or public safety. Without effective interventions to support service transitions there is a danger that the prison health strategy could contribute to future re-offending rates. *Paper 2: Slipping through the net: A Critical Review Paper on Intensive Case Management Programmes for Mentally Ill Offenders Released from Prison*, reviews the literature in relation to prevalence, identification and appropriate case management models to support the transitions from custody to community for offenders with mental health problems. Intensive case management (ICM) was established as a service modality to co-ordinate and integrate health and social care resources (Marshall, 1996; Onyett, 1992; Thornicroft, 1991; Ziguras, 2002). Benefits were reported in relation to improved service engagement and reduced rates of relapse and re-hospitalisation (Marshall & Lockwood, 1998). In practice, these interventions have not been considered suitable for offenders. Similar developments in the criminal justice system are ‘Re-entry’ (in the US) and ‘Through the Gate’ (in the UK) programmes, which have revealed benefits, particularly in relation to substance misuse needs (Friedmann, 2009; Knight et al, 1999), employment advice (Turner and Petersilia, 1996) and housing support (Lowencamp & Latessa 2004). However, there has been an absence of programmes to support offenders with complex mental health needs, combining substance misuse and a range of social issues (Theurer and Lovell, 2008).
Consequently, offenders with mental health problems are caught ‘in the void’, when they are released from custody as there are no effective transitional programmes available in either health or criminal justice agencies. This is highlighted in *Paper 3: Into the Void: Exploring the transitional care needs of arrestees and remand prisoners*, which presents the results from participant semi-structured interviews. Therefore, this thesis contributes to a body of literature, highlighting the importance of transitional case management programmes. In addition, this thesis advocates a change in health policy and practice to shift the focus from ‘discharge’ to transitional care planning. Critical Time Intervention (CTI) is a form of time-limited, intensive case management to support transitions, such as release from prison or hospital. CTI promotes continuity of care during transitions, by effectively linking service users to community services (Draine & Herman, 2007). CTI has generated positive results when applied to pre-release mentally ill prisoners, improving engagement and continuity of care. CTI is specifically designed to provide transitional support at critical service points, rather than a permanent support system; therefore, supporting recovery and rehabilitation. Without such services being in place within the host location, the system for obtaining community mental health treatment and support is via the ‘single point of access’, which is the local referral management system.

### 6.8 Hurdles to support

Participants’ accounts highlight the cumbersome referral management and partial booking systems established to manage community mental health referrals, which I have represented by the phrase ‘hurdles to support’. Offenders have to overcome a range of hurdles, which are described under ‘access and engagement’ within Chapter 4, but are worthy of further reiteration, in this final chapter. The ‘single point of entry’, colloquially termed ‘SPA’ (SPoA), requires the
service user to complete and return an ‘opt in slip’ and wait for an appointment. The local policy of 7-day follow up for discharged inpatients is transferable to offenders with mental health problems. One participant stated “barriers are put up to protect the team and not to support the individual and that’s a problem we come across all the time. We are almost fighting a battle to get someone into services” (ID: 1020 CJL). Thereafter, participants described a process of duplicated assessments; highlighted by one arrestee “I’m sick of going over the same things...over and over again...getting asked the same questions and nothing getting sorted...it’s like going out with nowhere to go...pointless (ID: 1039 arrestee). Service users then wait for an appointment “about 30 weeks unless expedited due to clinical issues” (ID: 1031 community mental health), resulting in “people coming back into custody that are still on the waiting list” (ID: 1019 CJL). Even progressing within the referral management system, three failed appointment result in discharge, without any follow-up to check on the welfare of the service user.

Disengaging during active mental health treatment is common (Marshall et al, 1998), and can have serious implications for social adjustment, community reintegration and recovery from mental illness (Kreyenbuhl et al, 2009) and as Lin posits limits social capital (Lin, 1999). Engagement strategies should be put in place that target high-risk groups and high-risk periods, to optimise service involvement (Doyle et al, 2014). The current arrangements of referral to community mental health services are insufficient, as access is significantly restricted. Even when access is granted ongoing engagement is difficult to maintain. Furthermore, the services are significantly different, consequently in-reach staff have to prepare people for the variation “they get a good service in here and they like it...we have to prepare them for getting less when
they go out cos their expectations are too high” (ID:1012 MHI).

In summary, despite meeting the eligibility criteria and withstanding the referral procedures, the services available are wholly inadequate to meet the complex health and social needs of offenders. CTI has demonstrated benefits when applied to mental health and offender populations, transiting from hospital and prison settings. The programme contains all the components of service that service users, carers and staff identified as important such as housing, finance, employment and importantly initiating and maintaining links in the community. Of further significance is benefits associated with CTI were retained long after the intervention was withdrawn, which highlights improved clinical outcomes and potential longer-term cost savings (Jones et al, 2003). This thesis has illuminated the complex health and social needs, various aspects of discontinuity of care and emphasised the need for better transitional services for people leaving short-term custodial environments. Findings suggest the need for exploration of models of care, such as case management to determine which programmes would be most appropriate to meet the needs of this population.

6.9 Evaluating the Research Process

The research subject area was complex and novel, exploring TICM approaches for use with people with mental health problems at the transition points in the CJS. A critical element within this thesis has been to maintain researcher integrity, which I also value as a clinician. It has been my intention throughout this thesis to accurately and respectfully represent participant accounts. The thesis emphasises ‘early intervention’, and highlights the context-specific ‘Behind the Wall’ interventions provided to offenders. Methodological strengths were obtaining the perspectives
of services users and carers. Service users provided poignant accounts about their experiences of mental illness, drug use and involvement in the CJS. Their descriptions demonstrate the benefits of prison-based services, but also highlighted how interventions are effectively terminated when they leave custody, which raises a number of significant issues, including risk to self and public safety. Additionally, there seems to be an ethical issue in introducing individuals to therapies, such as counselling, which are not assured following release. As identified in this study and throughout the literature offenders have multiple health and social needs, likely to require longer-term treatment. This thesis has identified a lack of parity in the services established for offenders transitions as those for patients discharged transitions from hospital. The main output from this thesis is the construction of grounded theory for health policy and associated practice advocating person-centred transitional care for offenders, which may benefit other service users populations.

6.10 Role of the Researcher

In undertaking this study it was important to consider the role of the ‘researcher’ in relation to the ‘researched’ particularly in relation to service users, where an inherent power imbalance exists. This dilemma also pertains to clinical settings and can be minimised by being open, honest, informative and listening actively to individuals’ narratives. The research was an interactive process, in which the participants talked about their lives; primarily about recipient, supporter and provider mental health experiences. In the role of researcher, rather than clinician I was aware of potential bias and of avoiding interrupting, directing or intervening so participations could express their beliefs and opinions freely. Memos and field notes were taken about participants’ eye contact, body language and tone of voice, which aided the analysis.
Critical awareness of the researcher’s role facilitated exploration of views so that they were recorded and analysed as far as possible to truly reflect the participant’s experiences. This also helped to manage the power dynamics of the therapeutic alliance of the professional-patient relationship and the researcher’s presence.

6.11 Limitations of the study

Limitations of the study were data collected using semi-structured interviews within health and CJS settings, by the researcher only (as described in Chapter 3). Although I am a clinician working in the host Trust I do not work in either research setting, but it could be argued that data collection and analysis were unintentionally biased, including for example influencing the data. The issue of reflexivity is outlined in Chapter 3. Having some knowledge of the research subject and field of investigation ‘termed theoretical sensitivity’ facilitated my comfortable interaction with participants and the research environment. I was able to establish rapport quickly, which aided comfortable and open dialogue. This could have been reduced by more meticulous recordings in a daily journal, rather than the practice of recording regularly, but specific events, items of interest, methodological difficulties and inspirations.

The overall study design was ambitious and like many clinical researchers I fell into the trap of ‘wanting to make the study clinically meaningful’ by expanding the data set. This was evidenced by completion of a substantial amendment submission to the Ethics Committee to include data collection of community mental health staff perspectives. However, this was a time-consuming task due to work pressures among the team. The original intention was to conduct small group interviews with staff from primary (PC) and secondary care (SC) services about pathways into
service. However, it proved impractical to assemble staff to undertake the task. Instead a paired interview was undertaken in Primary Care Mental Health Teams and two individual interviews with staff in Secondary Community Mental Health Care Teams. In hindsight, whilst it provided a useful insight, saturation was unlikely. Similarly, with carers, substantial efforts were made to engage with family via Family Days at the prison and via the Carers Group within the host Trust. However, within the time period I was only able to interview three family members. Another staff group with a significant role with offenders with mental health problems is the probation service. It was my intention to include the views of probation officers, but my enquiries and requests for interview were unsuccessful. It should be noted that this was and remains a time of significant organisational change within probation services.

Sociograms were developed with service users to complement the data gathered in interview and could have formed a distinct study. Sociograms were analysed qualitatively, alongside interview data to consider composition, size, density and strength of ties, which provided an insight into the diminishing nature of networks. Also, illuminated in Paper 4 was the potential to embed SNA into TICM programmes to improve mental health practice. The analysis was limited to qualitative, but further statistical analysis would provide more in-depth understanding about the strength of ties between ego + alters and alter + alter, which would have enhanced findings.

6.12 Involvement of Service Users and Carers

A key objective of the methods employed in this thesis was to explore the transitional support needs from a service user, carer and staff perspectives, which is a Department of Health (DH),
priority (DH, 2008). Across the NHS, service users should be involved in research and services should be service user-centred. NHS guidance states that service user involvement should exist at every stage of research (DH, Research Governance Framework for Health and Social Care, 2001). Traditionally, service users have been excluded from service developments and evaluations, particularly offenders with mental health problems. There are examples of research conducted with and by service users (SCfMH, 2001); and for example, Clinks and User Voice, the latter established by ex-offenders in 2009. The organisation provides mentorship, training and research collaborations, between service users and service providers.

I endeavoured to gain service user input at all stages of this study, including planning, the interpretation of findings and presentation of results. I made several attempts to contact Partners of Prisoners Services (POPS) but these were unsuccessful. However, I did make links with a local recovery-based service called ‘Red Rose Recovery’, which comprises of members with mental health and offending histories. The organisation was very supportive and I attended several regional meetings to update on the progression of the study. From this, I co-authored a bid to the National Institute of Health Research, for funding to conduct a feasibility trial of the provision of Critical Time Intervention for court attendees. The submission involved a number of agencies; the University of Manchester, Lancashire Care NHS Foundation Trust, Red Rose Recovery and the Probation Service; however, the bid was unsuccessful.

This study has highlighted that a socially excluded, multiply disadvantaged population can articulate their support needs. Involving service users in future service development and evaluations should be considered by commissioners and service providers.
6.13 Implications for Future Research

This is the first qualitative study exploring transitional case management for arrestees and remand prisoners, transiting from short-term custodial environments. The grounded theory constructed from the analysis of participants data, recommends a change in health policy and practice to focus on transitional care planning, as opposed to discharge. Further research is required to determine which programmes would be most appropriate to meet the needs of this population.

An initial feasibility study could examine transitional case management applied at transitional points at the ‘front end’ of the CJS to determine suitability and feasibility for delivery of interventions for this population.

A finding from this study highlighted by three remand prisoners’ transcripts (n=6) is exercising the ‘choice’ to return to prison, to access what they perceived as superior health services. Longitudinal studies of service users’ views of health care could explore this phenomenon further.

Two female arrestees participated in this study, it was beyond the scope of this thesis to explore the specific issues relating to women, but this is an area requiring further investigation along with other complex service user groups. This should include people from Black and ethnic minorities, young people, the elderly and specific populations such as sex offenders, whose experiences of transitions from custody would be different in relation to cultural groups, social network and community placements.
Sociograms revealed the diminishing and impoverished networks of service users, which could be analysed more fully using a range of social network analysis methods. This could be expanded to include the perspectives of alters to provide a more complete understanding of networks. Further research could also examine the use of social network analysis methods within transitional case management and routine mental health practice. People with mental health problems; including psychotic and neurotic conditions, have smaller networks; typically comprising of 10-15 people (Meeks & Murrel, 1994; Perese et al, 2005; Walsh, 1994). These can be even more limited in people with significant mental health problems and offending histories, which can comprise of five members or less (MacDonald et al, 2000), which impact on health and well-being (Goldberg et al, 2003; Tempier et al, 1998). As this study has suggested within Chapter 5 networks which are sources of support for members can also contain dominant and negative influences. The social networks of people with mental health problems, particularly within offender populations, should be examined and suitable interventions to enhance social functioning and community integration.

6.14 Concluding comments

This thesis aimed to identify service user, carer and staff perspectives surrounding the provision of transitional support for arrestees and remand prisoners. Offenders with mental health problems continue to be in a precarious situation. In the community they face difficulties accessing mental health services, leading to relapse and re-offending. Following entry to the criminal justice system, assessment may lead them to engage in a range of prison-based health services, which on release may be effectively terminated. There is a need for a culture shift with an emphasis on transitional pathways, as opposed to discharge planning, to ensure seamless
entry into community mental health teams. Without appropriate support many individuals with mental health problems will continue to orbit around the system, gravitating to services within prisons, only to be defined as ‘revolving door’ offenders.
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## Appendices

This section contains the appendices associated with the study.

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b) NHS Approval |
| **2:** Research Protocol | a) Research Protocol  
b) Protocol Flow chart |
| **3:** Critical Time Intervention | Information sheet describing the Critical Time Intervention Model |
| **4** | Participant information Sheets for the five participant groups |
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| **7:** Manual Coding | Sample Transcript Excerpts - highlighting the initial read through and manual coding process |
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| **9:** Service User Participant Identifiers | Service user Research ID and Pseudonym applicable to individual sociograms located in Appendix 8. |
| **10:** Social Networks | Participant Sociograms - Vennmaker 11 sociograms were developed with service users (arrestees and remand prisoners) which are presented and labelled by individual Pseudonym (noted in Appendix 7) |
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| **12:** Dissemination of findings | Presentation Abstracts |
Appendix 1: Study Ethics and Approvals

Appendix 1a): Initial Research Ethics Committee approval letter
Appendix 1: Study Ethics and Approvals

b) Letter of NHS Approval from the host Trust

5th October 2011

Prof Jenny Shaw
Assistant Director, Centre for Suicide Prevention
University of Manchester
Centre for Suicide Prevention
University Place, Oxford Road
Manchester, M13 9PL

Dear Prof Shaw,

Re: NHS Trust Permission to Proceed

Project Reference: 73053

Project Title: An investigation of stakeholder views of the feasibility, relevance and benefits of application of an intrusive transitional case management model for arrestees and remand prisoners

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however, you must ensure you have liaised with and obtained the agreement of individual service/ward managers. You must also contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that directly affects the quality of their care, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (Research Governance Framework for Health and Social Care, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your
Appendix 2a): Research Protocol for the Study
The Research Protocol available to all participants was devised at the outset of the study and contains all the details about study including an overview of the background literature, methods, procedures and ethics in relation to the study.

RESEARCH PROTOCOL
(Version 2, March 2011)

Enhancing the transitional care experiences of arrestees and remand prisoner with mental illness through intensive case management

Professor Jenny Shaw, Assistant Director, Centre for Suicide Prevention
Dr. Dawn Edge, Research Fellow
Dr. Mike Doyle, Research Fellow
Ms Alison Pearsall, PhD student

SUMMARY OF THE STUDY
This intended research will explore the transitional care needs of arrestees and remand prisoners leaving short-term custody from the perspectives of five stakeholder groups and consider whether a transitional, intensive case management model could improve their health and social outcomes. The stakeholder groups are 1) service users (arrestees/remand prisoners), 2) family members/carers (as appropriate), 3) mental health staff (mental health in-reach/criminal justice liaison), 4) police and prison officers and 5) mental health commissioners.

There are few studies on the prevalence of mental illness in police arrestees (6) but high levels of mental health problems among prisoners in England and Wales reported in studies (1); (2); (3); (4) Arrestees in police custody are asked a series of health related questions and they are asked whether they want additional help from a doctor or mental health professional (6). Screening in prison is a statutory requirement (7) and is undertaken by a reception screening nurse as a prisoner arrives at the prison. There has been concern about the high levels of undetected mental health problems in prisons and police custody suites (3), (7). The Bradley Report (8) stressed the importance of early detection of mental health problems and the need for swift delivery of holistic care, focusing on mental health, substance misuse, housing and financial support to avoid the cycle of re-offending and continued imprisonment.

Transitional, intensive case management (ICM) would meet all of Lord Bradley’s recommendations. A form of transitional case management called Critical Time Interventions (CTI)(9) has demonstrated some success for people with mental health problems released from prison. This study will consider the relevance and possible benefits of using ICM in working with arrestees and remand prisoners in the hope that they can benefit from the structured,
practical support and remain mentally well, in touch with services and avoid future re-offending (8).

BACKGROUND
Policy drivers backed by considerable investment have generally improved prison healthcare (12), (21) with prisoners’ health needs recognised as a significant area of concern for primary care trusts who commission prison health care (14). This has resulted in an expansion in provision of NHS health care staff within the prison environment (11). However, very little increased funding has been allocated to police stations for medical examiners or criminal justice liaison practitioners who provide mental health assessments on arrestees. The Department of Health is committed to meeting the healthcare needs of offenders (12). However, improving the delivery of health services to this group is complex, requiring an understanding of the intricate interplay between criminal justice, health and social care agencies. The need for effective information sharing and integration between those providing health care to offenders across the whole criminal justice pathway, is recognised and contained within government policy (e.g. DH 2005).

The Review of Criminality Information (15) and The Data Sharing Review (16) stress the importance of effective multiagency working, essential to ensuring effective care pathways and continuity of care for individuals with mental health problems involved in the CJS. At the beginning December 2009 there were 84,541 people in custody in England and Wales (17) compared to over 190,000 offenders being managed in the community by the National Probation Service (18). If offender health is to be effectively addressed the focus needs to shift to improvement in health across the criminal justice pathway rather than just providing healthcare for convicted prisoners (19). Prison healthcare is just one part of an individual’s complex pathway through the criminal justice system (20),(10).

Prisoners’ health needs have been recognised as a significant area of concern for health trusts who now commission prison health care. Recent studies of psychiatric morbidity in sentenced prisoners in England and Wales indicate that serious mental illness is common, co-morbidity prevalent and that many prisoners have complex mental health needs, demonstrating the significant levels of need and potential for chaotic living amongst this client group. They are predominantly amongst the most disadvantaged in our society, in terms of their life and health outcomes.

The prevalence of mental disorder is higher in prisons than in the wider community (3), (26). Whilst there are no robust prevalence studies in other parts of the criminal justice pathway e.g. remand prisoners, it is reasonable to infer that rates will also be elevated. A previous UK study found that 1.3% of defendants appearing in court direct from the community and 6.6% of those who had been held in police custody overnight had severe enduring mental illness (25), (27).

Offenders often access health services in a crisis-driven way, with high use of non-routine services e.g. accident & emergency departments (27), (25). Such contact is uneconomic, provides poorer long term outcomes, limited opportunities for health promotion and for developing community support structures which may reduce recidivism. Diverting the mentally ill from the CJS at the earliest opportunity is a DH priority but no agreements are in place to
improve service delivery and multi-agency communication. The Sainsbury Centre recently produced an integrated model of diversion to improve standards in this area (2009).

Diversion should ensure that people with mental health problems who enter (or are at risk of entering) the criminal justice system are identified and provided with appropriate mental health services, treatment and any other support they need. It also embraces opportunities to prevent entry through identifying and meeting health and social needs earlier, thus avoiding the risk of escalation of destructive and self-destructive behaviours (5),(8),(27). Individuals can be diverted at any stage on their route through the system, but the more swiftly individuals’ access appropriate health and social care the better for prognosis, personal and public safety (11), (14), (26). The Bradley Review (8) into diversion for people with mental health problems and learning disabilities emphasised a need to improve health outcomes for those in contact with the criminal justice service. Bradley’s 82 recommendations were accepted by government and cross-departmental work is underway to develop a coherent developmental work programme.

RATIONALE FOR THE STUDY
Currently, the scope and type of police-based health services vary considerably with no overarching model of best practice for comprehensive service delivery. Often services primarily meet legalistic rather than health related goals, e.g. ensuring fitness for detention. There is no proven best practice model for assessment and treatment of health problems for those in contact with police, court or prison remand services. Police custody has also been recognised as a venue where effective mental health assessments and interventions cannot be assured.

There are many reasons for people being arrested or remanded in prison, including the committal of a serious offence, however, individuals can be remanded for relatively minor offences such as non-payment of fines. Furthermore, arrests and remands can be precipitated by concerning or intimidating behaviour committed in a public place. In such circumstances individuals may be better served by receiving help from mental health services rather than prosecution in court. At the moment, schemes to divert people into healthcare services are of variable quality with little outcome evidence of improving mental health and/or reducing recidivism (23). Services need to be comprehensive, multi-agency, offering a variety of flexible and responsive interventions, which promote sustained engagement with appropriate community based services to meet the health and social needs of such a complex client group.

Unfortunately, many individuals become revolving door patients or prisoners who cause distress and frustration to those who encounter them and generate significant cost concerns to health and criminal justice agencies alike (Revolving Door, 2002). However, improving the delivery of health services to this group is complex, requiring an understanding of the intricate interplay between criminal justice, health and social care agencies. The need for effective information sharing and integration between those providing health care to offenders across the whole criminal justice pathway, is recognised and contained within government policy (e.g. DH 2005).

Poor access and engagement in health care is not due primarily to agencies’ availability but connected to a range of lifestyle and social issues including offending, substance misuse, relationship issues, long term unemployment, low educational attainment and underlying mental illness (3), (13). Personal, social and emotional functioning can affect an individuals’ capacity
to access support until a crisis or critical life event necessitates or leads to contact with professional help. However, critical life events can provide valuable ‘turning points’ for people that can facilitate successful changes (20) and as such provide opportunities to engage with individuals who might not normally contact to request support.

Furthermore, critical life events can increase the risk of suicide and self harming behaviours. Several studies have reported higher levels of suicide among the offending population those serving community sentences (34); those under probationary supervision (38); those released from custody on licence (39); those who have been recently released from prison (37) and, most recently, arrestees involved in police investigations (35; 36). These studies examined suicide mortality rates but, there is no published research examining the social and clinical circumstances of those committing suicide following arrest pending further police investigation and/or awaiting trial, or those found guilty and awaiting sentencing. Linsley, Johnson & Martin (36) assert that further help is needed in this area to enable criminal justice professionals to better identify and manage those ‘at risk’ when they come into contact with them. Pratt et al., (37) identified the need for all criminal justice professionals to share the responsibility for providing both health and support services for offenders identified as ‘at risk’. An ICM approach would enable all agencies to work together within a common, shared framework, to provide health and support services to people within the criminal justice system, but particularly at the arrest and remand stage to avoid prolonged or repetitive offending and imprisonment.

This proposed study will establish the perspectives of stakeholder groups on whether a transitional ICM model would benefit (and in what way) arrestees and remand prisoners. ICM ‘combines brokerage and clinical functions to promote community stabilisation and enhanced quality of life’ (31). This study will expand on a recent study of transitional, intensive case management, namely ‘critical time interventions’ (CTI), (9) applied to pre-release prisoners with serious mental illness, which was developed from an original study on discharged homeless psychiatric patients (15). The former research evaluated the pilot study of providing CTI approaches at two prison sites over a twelve month period during 2007 to 2008. The CTI model provided specialised interventions during the transitional period complementing, not replacing existing community services. The approach was time limited and holistic in three distinct phases; ‘transition to community’, ‘try-out’ and ‘transfer of care’. Initial findings suggested positive outcomes for a pre-release prison population in terms of increasing engagement with mental health services on release.

This study will explore the perspectives and views of individuals detained by the CJS and the various professional groups who provide mental health or criminal justice interventions to this, often complex client group, to establish whether an ICM model like CTI would be useful. The ultimate aim of introducing an ICM model to CJL and MHI teams would be to improve health/social outcomes, reduce social exclusion and criminal recidivism in a cost effective way (23).

**PRINCIPLE AIM OF THE STUDY**

To investigate the views of five stakeholder groups (service users, family, police/prison officers, mental health staff and commissioners) on the feasibility, relevance and benefits of the provision of an intensive, transitional case management (ICM) model for arrestees and remand prisoners
OBJECTIVES:

1. Conduct a literature review on intensive case management models (ICM) to develop further understanding of models and applicability for arrestees and remand prisoners. A ‘levels of evidence’ typology distinguishing domains and standards for ICM will be used to rank the various ICM models (32). The literature review will consolidate the current research around ICM and identify gaps which could be addressed by this (or a future) study’s findings. The review will inform the study and further refine the research questions or methodology. The review will be published in a scientific journal.

2. To examine the utility, relevance and potential benefits of ICM, such as CTI from the five stakeholder perspectives

3. To consider how this type of model would need to be adapted (if necessary) for use by Criminal Justice Liaison/Mental Health Inreach (CJL/MHI) practitioners for arrestees and remand prisoners with mental health problems, in conjunction with service providers and commissioners. Guidance and a training manual will be produced to enable implementation of this approach in identified clinical areas within mental health and criminal justice services.

4. To improve my knowledge and skills in conducting qualitative research and writing for publication to support a future research career

METHOD

A mixed method, qualitative approach (using systematic review of the literature, interviews and focus groups) will be used. This will most effectively understand the experiences of arrestees, remand prisoners and staff before any changes to service provision are considered or implemented.

STAGE 1/ OBJECTIVE 1: – Systematic Review of the literature on intensive case management models, to determine which may be relevant and applicable for arrestees and remand prisoners. A systematic search will include all case management studies and interventions that meet the eligibility criteria. Broad search techniques will be used in an attempt to identify and include studies that have been poorly indexed. The electronic databases PsycINFO, MEDLINE, CINAHL, EMBASE and Sociological Abstracts will be consulted, together with the Cochrane Collaboration registers of randomised controlled trials and the Campbell Collaboration library of systematic reviews (between Jan.1970 - Jan.2010) using combinations of keywords relating to offenders, aftercare, interventions and diversion. There will be no language restriction. References will be hand-searched for other references; including to grey literature over the last 5 years. The authors of published studies will be contacted for additional information as required.

Reports will be excluded if they are superseded by subsequent work and their inclusion would involve duplication of data. A standardised form will be used to extract the data, using ‘levels of evidence’ typology (31, 32), including information on study design, inclusion and exclusion criteria, geographical location, sample size, characteristics of the participants including gender, age, diagnoses, type of aftercare or diversion programme, primary and secondary outcomes and method of attainment of outcomes. Intervention content, development, fidelity and sustainability will be assessed. An assessment of the quality of study findings will be included. Recipients’
perceptions and experiences of interventions contained in the studies will be noted. A narrative summary will be provided explaining in detail the findings from each of the included studies. This will include extensive descriptions of the interventions being evaluated, target populations, outcomes and results. Narrative synthesis will be performed in three steps: firstly, by developing a preliminary synthesis of the findings of included studies; secondly, by exploring relationships in the findings; and thirdly, by assessing the robustness of the synthesis produced. The main findings will be summarised, including the strength of evidence for each outcome. Limitations at the study and outcome level (e.g. risk of bias) and review level (e.g. reporting bias) will be discussed. The literature search will consolidate the current research around ICM and identify gaps which could be addressed by this (or a future) study’s findings. The review will inform the study and further refine the research questions or methodology. The review will be published in a scientific journal.

A structure for searching the literature is illustrated below:

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<thead>
<tr>
<th>Review existing or ongoing reviews (using Database of Abstracts of Reviews of Effects/DARE &amp; Cochrane Database of Systematic Reviews/CDSR)</th>
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<tr>
<td>• Applying predetermined inclusion criteria (IC) generated from research question</td>
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<tr>
<td>• Pilot – apply IC to sample papers</td>
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<tr>
<td>• Comprehensive search of the literature</td>
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<tr>
<td>• Titles &amp; abstracts screened</td>
</tr>
<tr>
<td>• Accepted = obtain full paper, Rejected = why? – reasons recorded i.e. not relevant, or topic relevant, but fails other criteria</td>
</tr>
<tr>
<td>• Data extracted using predetermined format e.g. author, conflict of interests, study type, population/numbers included, aims, hypothesis, interventions, outcome, conclusions, costs etc.</td>
</tr>
<tr>
<td>• Critical appraisal check list - assess quality, strengths &amp; weakness using ‘levels of evidence’ typology (31, 32)</td>
</tr>
<tr>
<td>• Report writing to funders, participating agencies, dissemination of findings (e.g. conferences), publication in scientific and professional journals</td>
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STAGE 2: STUDY INFORMATION PREPARATION & ETHICAL ISSUES:

The research question and methodology will be refined as required on completion of stage 1. At this stage semi-structured interviews and focus groups have been suggested to obtain the distinct perspectives of stakeholders and then group based discussion around possible service guidance and training materials to put ICM into practice within particular mental health and criminal justice services. Service users’ views will be sought on the design and methodology and also a pilot which may lead to further adaptation of the data collection procedures and materials, which will developed in a user friendly format.

Data collection tools will be developed and modified including semi-structured interview schedule and discussion guidance formulated for the focus groups. An information sheet will be prepared detailing the study aims, objectives and rationale to be made available to stakeholder representatives participating in the study. Two separate sheets will be produced because research has identified that many individuals involved in the CJS have below average literacy and numeracy rates, 50% have a reading age and 66% numeracy levels below 11 year old (16).
A further sheet, prepared in advance, will describe in written and diagrammatic format transitional ICM, in order that participants in the study are fully aware of the model. Participant information was prepared for the CTI in prison research which can be adapted for use in this study. Ethics committee, research governance and police/prison service approval will be obtained prior to commencement of stage 3 of the study. An advisory group will also be established comprising of supervisors and stakeholder representatives.

**STAGE 3/OBJECTIVE 2 – INTERVIEWS & FOCUS GROUPS WITH THE STAKEHOLDER GROUPS:**

Two CJL and MHI teams have agreed to participate in the study. These have been selected because of accessibility to the researcher and prior knowledge of ICM through a previous study and preparatory work in developing this project. The interviews will be semi-structured and will ask questions to establish participants’ perspectives on current service provision in police custody and for remand prisoners and whether this care could be enhanced by the provision of an integrated case management model which could positively impact on (i) stability, (ii) community assimilation and (iii) recidivism. Interviews will cover issues such as symptoms of mental illness, identification of problem, offence/offending history and care and supervision received prior to arrest and remand.

The nature of the research may involve the discussion of events, behaviours, feelings or issues that some participants may find distressing or uncomfortable to recall. However, protocols have been designed for previous projects involving discussion or personal and sensitive subjects which will be taken into account and amended for this study. There is an established history of research in mental health, offending and/or suicide/self harming behaviours within the prison system, for example numerous large scale studies by Liebling et al, Brooker et al 2008 and the 1998 Office for National statistics prison psychiatric epidemiology survey. Relevant literature about conducting research into sensitive issues for example Goldberg et al, 1987 noted "there is no evidence that asking about suicide increases the likelihood of an attempt: on the contrary, many patients report relief of feelings of anxiety and guilt after they have had such a discussion".

The Mental health inreach/Criminal justice liaison staff will select a purposive sample of individuals. Semi structured interviews will be conducted with consented representatives of the stakeholder groups, approximately 5 individuals from each group, however, interview numbers will cease when theme saturation has been achieved; service users (10) (5 remand and 5 arrestees), family members (5) (as appropriate), CJL (5) & MHI (5) practitioners, police (5) and prison personnel (5) and commissioners (5). Remand prisoners will be male due to prisons in the locality being for males only, however, arrestees will include both male and female participants. All participants will sign a corresponding consent form. Family members will be recruited by the service user participant agreeing for their family member to be approached to obtain consent. Contact details for family members will be provided by the service user or MHI/CJL staff member with the service user's permission.
FEASIBILITY: There are inherent difficulties in conducting research in the CJS, including (i) the dynamic nature of prison and police stations where potential participants move quickly through the system having consultations with investigating officers, legal representatives or health workers and as such may decline involvement due to feeling overwhelmed by interviews. (ii) the dynamic nature of the individual’s risk of violence, mental state, degree of intoxication and mental capacity to consent to enter the research project. (iii) The limited window of time available to the researcher to engage with arrestees and remand prisoners before their release from custody. Taking these limitations into account the MHI/CJL staff will select a purposive sample of prisoners.

SAMPLING: Purposive sampling will be deployed by the MHI/CJL staff to ensure data can be gathered on the perspectives of specific groups e.g. BME and older participants along with the experiences of white, males who dominate prisoner numbers. Sample sizes are practical and in keeping with former research (31, 32), but may be adjusted in light of emerging themes or gaps in the data. Theoretical sampling will be applied to obtain specific data about individual experiences of stakeholders which will also contribute to the emergent theory. Semi structured interviews will be conducted with consented representatives of the stakeholder groups, approximately 5 individuals from each group, however, interview numbers will cease when theme saturation has been achieved; service users (10) (5 remand and 5 arrested), family members (5) (as appropriate), CJL (5) & MHI (5) practitioners, police personnel (5) and prison officers (5) and commissioners (5). Approximately 40 interviews in total will be conducted with the stakeholder groups.

INCLUSION CRITERIA: Arrestees and remand prisoners who have SMI and are aged between 18 and 65 years, whose mental health state is considered stable enough and have capacity to consent (judged by CJL/MHI practitioners) will be informed by CJL and MHI team practitioners of the study. It will also ensure confidentiality of service users and staff. Staff from the stakeholder groups will be approached, via line the manager to provide informed consent prior to participation in the study.

EXCLUSION CRITERIA: (i) Individuals lacking capacity to consent to participate or the CJL/MHI practitioner informs that the individual does not wish to participate. (ii) The individual is deemed by CJL/MHI practitioners to be too violent or a risk to the researcher. (iii) Immigration detainees. (iii) Language issues – a large number of the individuals involved in the CJS do not speak English proficiently. Those who do not speak English as a first language, but are able to understand sufficiently to provide informed consent and participate in an interview will be included as their perspectives will add to the richness of the study. Language Line provides translation services to HM Prison Service prisoners whose first language is not English. This will be available for the project under the prisons' Service Level Agreement, so that non-English speakers may be included. However, this is more difficult to arrange within police stations as this scarce resource is only utilised for formal interviews following arrest. Therefore, those who have been arrested and do not speak English proficiently and do not have access to a reliable interpreter for research purposes will be excluded for practical reasons.
PROCEDURE
Information sheets and the research protocol will be sent to senior managers who have responsibility for the current services provided by agencies/services by which the five stakeholder perspectives will be examined during the study. The five stakeholder groups are service users (arrestees/remand prisoners), family members, mental health staff (criminal justice liaison/mental health inreach), criminal justice staff (police/prison officers) and commissioners. The information sheet and research protocol will be supported by presentations and discussions about practicalities, implications and potential benefits of conducting the study around this client group and with this type of approach.

The CJL/MHI teams will identify people aged between 18 – 65 years old who have serious mental illness e.g. schizophrenia and request their permission to pass on their name to the researcher. The researcher will discuss the study with individuals, including providing information sheets and ask them if they and/or family members will consider participating in the study. Participants will provide informed consent prior to interviews and focus groups and will be free to withdraw at any point, without prejudice. The individuals will have the opportunity to ask any questions they may have and be given at least a 24-hour time period to look over the study information and decide if they wish to take part. Capacity assessments will be verified by the researcher, based upon guidance set out by the Mental Capacity Act 2005, [MCA 2005]. The threshold for capacity to take part is relatively low, although some individuals by virtue of intoxication, very disturbed behaviour or psychosis may be unable to consent.

Staff representation of the stakeholder groups will be gained by circulating the study information and research protocol, meeting with relevant service managers, explaining the project, providing a presentation, information materials and a copy of the consent form. The relevant manager will then approach staff members to ask if they would volunteer to participate in the project and meet with the researcher. The researcher will then arrange to meet with the staff member to explain the study and obtain formal, written consent for participation.

All participants will be consented for participation in individual interviews and focus group discussions whereby these qualitative parts of the study will be recorded using audio recording equipment. All tapes will be transcribed verbatim and wiped once transcription is complete. Any potentially identifying information will be removed.

STAGE 4/OBJECTIVE 2 & 3: DATA COLLECTION, INTERPRETATION & ANALYSIS
All identifiable data will be removed from the qualitative interviews/focus groups at the transcription stage, and each participant will be assigned a unique research ID and pseudonym to ensure confidentiality. Any required, potentially identifiable data will be anonymised and not entered onto the research database. Confidential data e.g. list of names of participants will be stored and maintained by MHI/CJL within existing healthcare databases e.g. NCRS clinic list.

Data will be analysed using thematic analysis as it includes reading the data critically and identification of theme typologies e.g. behavioural or specific language which will help to capture similar or different views among stakeholders (33). Appropriate software packages e.g. Dedoose will be used to process, understand, theme and present data. Qualitative data will be
transcribed and analysed against the themes and hypothesis generated from the systematic review. Iterative coding will continue until themes are described and saturation achieved. Any gaps in data, will be identified and themes explored further using further interviews or focus groups to clarify emerging confusing themes. Negative and discrepant data will be presented and discussed in relation to the overall findings. Ethical related issues will be recorded and addressed throughout the project.

The researcher will establish and maintain a study master file, containing all relevant documentation such as funding application, REC and NHS approvals, research protocol, study information sheets tailored for all groups of participants, participant proforma, inclusion and exclusion criteria, confidentiality statement/protocol, consent forms appropriate for various participants, information on intensive case management as used in other clinical areas, interview schedules and focus group structures (ensuring these do not contain identifiable participant information) and any progress reports written for sponsors, host organisations or funders. The researcher will also maintain a practice research file in electronic and paper format containing minutes of meetings at study sites, field notes, power-point presentations of the research study suitable for staff and service users, lists of participant groups and unique research IDs and the numbers of individuals (from each stakeholder participant group) who have been screened, enrolled, consented and have withdrawn from the study. A diary of research activity will established, noting any areas of interest and limitations in data collection process or overall methodology, the content of which will be useful to take into account when interpreting and analysing the data. As the study continues any deviations from the original protocol will be identified, renewed ethical approval gained and the reasons for amendments will be recorded. The file will also have a copy of the procedure for adverse or untoward incident reporting and any relevant documentation pertaining to specific reported incidents, which will not contain service user identifiable information.

Regular supervision and project meetings will support and guide the review of findings and further investigation of specific themes, as required to ensure full understanding and an accurate construction of meaning. This will demonstrate the range of perspectives on the utility, relevance and benefits for stakeholders, particularly service users and family members.

**STAGE 5/OBJECTIVE 3 – DISSEMINATION STRATEGY**

The findings will be written up using a range of presentation styles to maximise impact and interest including anecdotes, which will be fully anonymised to protect confidentiality. This will demonstrate the range of views, perspectives, construction of meaning, consideration of areas of agreement/disagreement which all woven together to create a more complete picture about the effectiveness of current approaches used by CJL/MHI teams and whether an intensive case management model applied at the initial point of the criminal justice pathway might be beneficial to stakeholders, particularly service users and family members. The findings will be presented at academic conferences and in peer-reviewed academic and professional journals. The findings will also be presented in an internal report and also made publicly accessible on the Prison Health Research Network website.
The adapted ICM training manual and materials will be produced following stakeholder focus groups, using an action research approach, with an accompanying strategy and guidance to facilitate effective implementation of ICM in mental health and criminal justice services. The aim would be multi-disciplinary training for mental health and criminal justice staff with an agreed protocol for ICM in both agencies. This would fulfil Lord Bradley's review (DoH, 2009) requirements providing holistic, early intervention, which is multi-agency and co-ordinated and aims to reduce escalation of offending and imprisonment.

**Project Time schedule:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year One</td>
<td>Study design, including proposal revisions, obtaining ethics approval &amp; access. Systematic review of the literature on transitional intensive case management models. Publication from the systematic review. Production of information sheets describing ICM and the research study written in simple plain English</td>
</tr>
<tr>
<td>Year Two</td>
<td>Data collection including semi-structured stakeholder interviews &amp; focus groups. Data entry &amp; interpretation</td>
</tr>
<tr>
<td>Year Three</td>
<td>Data &amp; theme analysis &amp; saturation, write up, dissemination and publication of research study and associated guidance and training materials for implementation of ICM for this client group.</td>
</tr>
</tbody>
</table>

**SAFETY OF PARTICIPANTS:**

**Interviewees:**

- Research will be carried out on a one to one basis, with no-one else present to allow participants to be more comfortable and candid
- The interview will not commence until the researcher is satisfied that the participant is relaxed, is aware of the process of the research and has asked any questions they may have. The participant will be reassured that they do not need to answer any questions they do not want to, without providing an explanation and that they can withdraw form the process at any point, without prejudice.
- At the end of the interview the participant will again be given time and opportunity to ask any further questions they want to ask.
- It will be made clear to the participant that the content of the interview will remain confidential, with the exception that the researcher will be obliged to disclose any information that would otherwise pose an immediate danger to the health, safety and well-being of the participant, those around him or the general public.
- If such concerns occur and disclosure is required the researcher will inform the MHI/CJL staff member, healthcare or personal/wing officer to enable appropriate action to be taken.
- The researcher will explain at the beginning and reinforce at the end of the interview specifically what the participant should do in the case of reaching a crisis point. Due to the nature of staffing a large establishment such a prison or police station on a 24 hour
basis the research team do not feel it appropriate to provide the participant with a named staff member to approach at a crisis point. To illustrate, a specifically named member of healthcare staff, chaplaincy or the prisoner's personal officer (all traditionally used as contact points in the management of distress as a named individual may not be on duty or available when asked for, perhaps leaving the prisoner feeling let down and that they don't have any immediate access to help. The research team feel that it is more effective to reiterate to prisoners that any member or prison or police staff can be approached at any time to help them with any level of distress experienced following participation in the research process. The researcher will however talk through with prisoners the most effective ways of getting that help, thereby checking and reinforcing prisoner's adaptive coping skills. If any support systems have already been established internally for example an additional session with MHI or wing officer this will be conveyed to the prisoner by the respective staff member and reinforced by the researcher at the end of the interview.

- Wing and cell staff where the prisoner is housed will have been made familiar with both the researcher, content and feedback process before any fieldwork is undertaken. The on duty senior officer will be informed of the names and cell locations of those prisoners who have taken part in the research to ensure adequate supervision and support can be provided after the interview.
- With reference to participating staff the above interview process will be followed and line managers/clinical supervisors’ will be informed of participating staff members’ names, office locations and date/time of interview to allow for the provision of support should this be required after the interview. It will be explained to staff that their participation, whilst appreciated, is entirely voluntary and they do not have to take part, provide any reasons for declining and no pressure will be put on them to try to change their mind. They will also be informed that if they decide not to take part, or withdraw at any stage, their professional role or prospects within this role will not be affected.

**SAFETY OF RESEARCHER:**
Due to the sensitive nature of the topic, researchers will regular clinical supervision independent of academic supervision. These sessions will provide the researcher with the opportunity to discuss the psychological impact of conducting this type of research and any other issues which arise throughout the research.

To minimise any risk during interviews details of the researcher's itinerary and appointment times - including names, addresses and telephone numbers of people being interviewed will be shared with the research team. Agreed communication ‘check-in’ protocols will be employed between the researcher and the team to maintain contact and to ensure the researcher is safe during interviews. Interviews will be held in safer locations within prisons and police stations i.e. closer to staff occupied areas or covered by cameras and negotiated where risk assessment indicates. Interviews will be carried out adopting best practice principles and in line with relevant policy guidance (i.e. Lancashire Care NHS Foundation Trust Lone Worker policies).
ETHICAL CONSIDERATIONS - DATA SECURITY:

As the study will obtain personal and sensitive information the research team have focussed on ways to maximise the security of the service user information stored and to keep the amount of identifiable information and sensitive data to a minimum. The researcher will receive identifiable information from the MHI/CJL staff of an individual who has agreed to participate in the study. As soon as this information is received it will be encrypted and stored on a separate database to any other research data and on a computer that is only connected to an internal network. All participants will be assigned a research ID and no home addresses will be recorded.

Study data will be stored on password-protected computers in password-protected spreadsheet documents at the University of Manchester. Computerised records will be stored on an internal network at the University of Manchester and not on an external server. This means that they cannot be accessed by people outside of the research team. Only those people registered to do so can access the data and this access is restricted. All computers are password protected.

The researcher will be based at the National Confidential Inquiry at the University of Manchester, and work alongside researchers from the Inquiry, therefore this study will benefit from the data security procedures already in place. The security of personal data is ensured by the Information, Security and Management Policy of the National Confidential Inquiry and the System Level Security Policy for the study. The policies on appropriate security measures for computerised and manual personal data are set out in these policies. Amongst other things this sets out protocols for a) information handling and storage, b) regular data backup to protect against information loss, c) risk review, d) disaster recovery policy and e) restricted access to identifiable data.

POSSIBLE OUTCOMES & IMPACT OF OUTCOMES

The study will help fill the current gaps in health information in this area and build upon current research in mental health, by enhancing the ability of health and criminal justice agencies to work together within a common framework.

The research will allow an examination of the possible service needs of this potentially vulnerable and politically and socially disadvantaged group. Such knowledge could be used to inform key stakeholders, practitioners and policy-makers to assist the development of health promotion and offending prevention initiatives and procedures to better identify and support ‘at risk’ individuals across the CJS.

REFERENCES

8. The Bradley Report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health; 2009 *
22. Aslan M, Smith M (2008), The Thrive Approach to Recovery & Mental Wellness, Crazy Diamond Ltd *
Appendix 2b): Research Protocol Diagram - summarising the methods and procedures described above

RESEARCH PROTOCOL IN FLOWCHART FORMAT
(Version 1, May 2011)

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

1. SUMMARY OF THE STUDY - This study will explore the transitional care needs of arrestees and remand prisoners leaving short-term custody from the perspectives of five stakeholder groups to consider if transitional, intensive case management model (see information sheet defining and describing Critical Time Intervention CTI, a form of Intensive Case Management -ICM) may be beneficial

2. The stakeholder groups are: 1) service users (arrestees/remand prisoners), 2) family members/carers, 3) mental health staff (mental health in-reach/criminal justice liaison), 4) police and prison officers and 5) mental health

3. Why the study? Lord Bradley Report stressed it was important to detect mental health problems early and that a range of support was needed including: mental health care, substance misuse, housing and financial support to avoid the cycle of re-offending and repeated imprisonment.

4. Has it been used before? CTI is a type of ICM which has been used with homeless people in the US and with pre-release prisoners in the UK and has shown promising results so this study will see if CTI could be used with people with mental health problems who have been arrested or remanded

5. This study will consider the relevance and possible benefits of using ICM in working with arrestees and remand prisoners in the hope that they can benefit from the structured, practical support and remain mentally well, in touch with services and avoid future re-offending

6. Firstly completion of a Literature Review of the literature on intensive case management models, (including Critical Time Intervention/CTI), to determine which may be relevant and applicable for arrestees and remand prisoners.

7. The study will be discussed with interested people and those who wish to participate will be given further information and then sign consent forms if they want to take part.

8. Interviews will take place with consented individuals from the stakeholder groups 1) arrestees/remand prisoners, 2) family members, 3) mental health staff, 4) police/prison officers 5) commissioners. Confidentiality will be maintained by the use of a research ID

9. Sociograms of Service User (arrestee and remand prisoners) to facilitate understanding of the composition and functionality of social networks

10. Development of grounded theory to explain transitional care needs of arrestees and remand prisoners leaving short-term custody to inform health policy and practice. The findings will be presented at academic conferences and in peer-reviewed academic and professional journals
Appendix 3: Summary of Critical Time Intervention Model (CTI)

Critical Time Interventions
(a form of Intensive Case Management)

Information Sheet (May 2011)

Model
Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in satisfactory living arrangements with access to needed supports. We believe that focused, time-limited assistance during this critical period can have enduring positive impacts. Although most of our work to date has been with adults with mental illness following institutional discharge, we believe that this approach may also be relevant to other populations at a variety of critical periods.

CTI was originally developed and tested by researchers and clinicians at Columbia University and New York State Psychiatric Institute with significant support from the National Institute of Mental Health and the New York State Office of Mental Health. The model is currently being broadly applied and tested in the US and abroad. The principal goal of CTI is to prevent recurrent homelessness and other adverse outcomes during the period following placement into the community from shelters, hospitals, and other institutions. It does this in two main ways: by strengthening the individual’s long-term ties to services, family, and friends; and by providing emotional and practical support during the critical time of transition. An important aspect of CTI is that post-discharge services are delivered by workers who have established relationships with patients during their institutional stay. Typically these workers are bachelor’s or master’s level individuals operating under the supervision of an experienced clinically trained professional. The CTI workers must be flexible and creative as well as comfortable working primarily in the community. At the same time, they must be committed to following a rather focused model of care. Once the worker has established a relationship with the client and begun to organise his or her support plan, the post-discharge phases of the intervention are delivered as follows: (1) Transition to the community, (2) Try-out, and (3) Transfer of care.

Transition to the community The first phase focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers. Ideally, the CTI worker has already begun to engage the client in a working relationship before he or she moves into housing in the community. This can be accomplished formally or informally,
depending on the institutional setting and the role of the worker within the institutional system, and may consist of multiple meetings or just one or two contacts. This is important because the worker will build on this relationship to effectively support the client following discharge from the institution. During the first few weeks following this move, the CTI worker maintains a high level of contact with the client, both through regular telephone calls and home visits. Interim psychiatric treatment (including providing access to medication as needed) can be arranged by the team until adequate community arrangements are in place. This assures that treatment will not be interrupted during this early critical period of transition. Clients are accompanied to appointments with selected community providers, such as mental health and medical clinics. The CTI worker “introduces” the client to his or her new providers in order to facilitate the development of a durable tie and encourages them to negotiate compromises when problems arise.

The CTI worker also meets with key figures in the client’s residence. These figures are most often the primary caretaker in a family home or staff in a supervised residence, but in some cases may include a single-room occupancy hotel manager or an involved neighbour. The CTI worker offers support to these persons while making it clear that he or she is prepared, when necessary, to mediate a compromise between them and the client. They discuss potential housing crises and try to identify ways to avoid them or possible coping strategies and resources, should a crisis occur. The CTI worker also works with the client and primary caretaker on skills for crisis resolution, such as how to listen to each other, and how to speak to each other without going on the attack. Tensions tend to arise quickly as caretaker or staff and client attempt to adjust to one another. As with the community service providers, a compromise developed during this early phase of adjustment may prevent later loss of housing. This work sometimes takes the form of family psycho-education in which the CTI worker may educate a family member about the client’s mental illness; this frequently contributes to enhanced family support as relatives come to understand that problem behaviours have causes other than “bad behaviour” or substance abuse. However, compromise is not helpful or appropriate in all situations. For instance, when the primary caretaker is a mother with a history of injection drug use who relapses after the client moves back in with her, the best plan of action may be to assist the client in locating alternative accommodations.

During these initial intensive contacts, the worker is also gathering data needed for treatment planning in the transition period. He or she works together with clients and service providers to detail proposed arrangements to ensure medication adherence, money management, or control of substance abuse. These arrangements are then tested in vivo and modified if necessary during the transition period. The CTI worker generally makes detailed arrangements in only the handful of areas that are seen as most critical for the community survival of that individual (i.e., medication adherence); it is important not to be overly ambitious. There is also a strong emphasis on assessing the feasibility of the support systems that are established because they are intended to persist well after the CTI worker has terminated services. During this initial period, the worker must also recognise when clients’
lack of participation in some programs may indicate that the services being offered are incompatible with their needs. For example, a young man with a substance abuse problem explains that he does not regularly attend the treatment group meetings to which he has been referred because the issues discussed by the other, much older, group members do not address his concerns. In this case, rather than attempting to help the client to adjust to the group, the CTI worker may help him identify another group composed of younger people.

**Try-out** The second phase of CTI is devoted to testing and adjusting the systems of support that were developed in the first phase. By now, community providers will have assumed primary responsibility for the provision of support and services, and the CTI worker can focus on assessing the degree to which this support system is functioning as planned. During Phase Two, the worker encourages the client and members of his or her support system to handle problems on their own. The worker meets with the client less frequently, but maintains regular contact in order to observe how the plan is working and be ready to intervene when a crisis arises. In many cases, further modification of the support system is required. Such “system adjustment” may be accomplished via a case conference or less formal meetings between the client and those involved in the support system. The CTI worker acts as a primary resource for all parties and assists them in devising a framework for resolving potential conflicts. For some clients, this period requires a renegotiation of treatment plans and a more active role for the CTI worker in facilitating the implementation of these plans. The in vivo monitoring role assumed by the worker may also be helpful in identifying specific clinical treatment issues (such as medication non-adherence) that may elude even the most caring office-bound clinician.

**Transfer of care** The final phase of CTI focuses on completing the transfer of care to the community resources that will provide long-term support to the client. One of the strengths of the CTI model that differentiates it from the services typically available to clients during transitional periods is that the transfer-of-care process is not abrupt; instead, it takes place over nine months. Throughout the intervention, the CTI worker has gradually reduced his or her role in delivering services to the client in the community. By the time Phase Three begins, the worker has gradually prepared the client and linkages for his or her new role as consultant. The main function in this phase is to ensure that the most significant members of the support system meet together and, along with the client, reach a consensus about the components of the ongoing system of care. Ideally, this occurs at least one month before the end of the nine-month period of the intervention. This gradual process ensures that the termination of CTI is not perceived by the client and the members of his or her support system as a sudden, potentially traumatic, loss.
Appendix 4: Information Sheets
a) Participant information Sheet for Service Users

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

STUDY INFORMATION SHEET FOR SERVICE USER PARTICIPANTS
(Version 3, August 2011)

You are being invited to take part in a research study. Before you decide please read the following information carefully. Part 1 explains the purpose of the study and what will happen to you if you take part. Part 2 gives more detailed information about the how we will do the research. When you’ve read it, please ask any questions you have and we will do our best to provide answers to help you decide if you want to take part or not.

Part 1:
1.1 Purpose of this study?
This study is looking at a form of Intensive Case Management (ICM) called ‘Critical Timed Interventions’, (CTI) and if it could benefit people in the future like you who have been arrested or are on remand. The study will look at your views but will also obtain the views of other people including family members (with permission). We will also speak with mental health staff that work in prisons or police stations and ask police and prison officers for their views on working with people after arrest or remand. The study will be taking place in two police stations and two prisons within the Cumbria and Lancashire area.

1.2 You have been invited to take part because:
You are between 18 and 65 years old, have mental health problems and are currently arrested or remanded. We would like you to tell us about the type of care and support you have received from mental health, police and prison staff and what you found helpful or unhelpful. We hope to be able to improve the support available for people in similar situations to you in the future.

1.3 Do I have to take part?
No, taking part is voluntary and you can change your mind about taking part at anytime. You don’t have to give a reason, just let us or your mental health team know. We will tell you about the study and go through this information sheet with you. We will then ask you to sign a consent form to show that you understand and have agreed to take part.

1.4 What will happen to me if I take part?
You will be asked to take part in an informal interview lasting about 60 minutes. The questions will be about the care and support you got in the past from mental health services and if and how this could be made better for people who may be arrested or remanded in the future. After the interviews you may be asked if you would want to be part of a group meeting to try to develop a training programme for staff. This is also voluntary and you can withdraw at anytime without having to tell us why.

Interviews will be with Alison Pearsall, who is a PhD student based at the Department of Community Based Medicine at the University of Manchester. All of the information collected will be strictly confidential and will be stored securely by Alison Pearsall, under the supervision of Professor Jenny Shaw, the principal investigator.
1.5 What are the possible benefits and disadvantages of taking part?

**Possible benefits are:**
You may have ideas or suggestions about the type of support people with mental health problems need after they have been arrested or remanded. You might also be able to help us develop better services for people in the future by telling us how Intensive Case Management (ICM) needs to be changed to provide the support people want.

**Possible disadvantages:**
Some people may become upset or anxious during the interviews by talking about their symptoms of mental illness or the circumstances of their arrest. You can take as many breaks in the interview as you need.

1.6 What happens when the research study stops?
This study will run for three years in total. At the end of that period we will write to you (or your care co-ordinator/probation officer) to let you know the main findings of the study. We will also give a presentation on the findings of the study within the University of Manchester, Offender Health Research Network and Lancashire Care NHS Trust.

1.7 Will my taking part in the study be kept confidential?
Yes. With your permission, I will record our discussion and then write it up into what is called a transcript. This will allow me to read what you’ve said again to understand it properly. When I create the transcript, I will change the names of yourself and anyone you mention. The original recording and transcript will be kept in a secure place in Manchester University, and later destroyed as set out by the Data Protection Act 1998. Nothing in the written report will identify who you are. If you wish, I will give you a copy of the transcript so that you can be sure that I’ve written it down correctly and that no-one in it can be identified by others.

**Part 2**

2.1 What will happen if I don’t want to carry on with the study?
If you withdraw from the study, the study team will destroy all your study records. If you are have a complaint about the way you have been dealt with you can contact a member of the study team (on 0161 275 0731) who will do their best to answer your questions and help out. You can also see a member of the mental health inreach team to discuss your concerns. If you remain unhappy and wish to complain formally, we will provide information about the University of Manchester and Lancashire Care NHS Foundation Trust Complaints Procedures.

2.4 What will happen to the results of this study?
The results will be written up for publication in a medical journal and the organisations funding this research will receive a report on the findings. Your personal details will not appear on any of these documents and you will not be identified in any way.

2.5 Who has reviewed this study?
This study has been reviewed by the Research Ethics Committee and by the National Institute of Health Research (Department of Health), who are also funding the study.

Thank you for reading this information sheet
Appendix 4: Study Documents
b) Participant information Sheet for Family Members/Carers

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

STUDY INFORMATION SHEET FOR FAMILY MEMBER/CARER PARTICIPANTS
(Version 3, August 2011)

You are being invited to take part in a research study. Before you decide please read the following information carefully. Part 1 explains the purpose of the study and what will happen to you if you take part. Part 2 gives more detailed information about how we will do the research. When you’ve read it, please ask any questions you have and we will do our best to provide answers to help you decide if you want to take part or not.

Part 1:
1.1 What is the purpose of this study?
This study is looking at a form of Intensive Case Management (ICM) called ‘Critical Timed Interventions’, (CTI) and if it could benefit people in the future like you whose family member has been arrested or are on remand. The study will look at your views but will also obtain the views mental health staff that work in prisons or police stations and ask police and prison officers for their views on working with people after arrest or remand. The study will be taking place in two police stations and two prisons within the Cumbria and Lancashire area.

1.2 Why have I been invited to take part?
You have a family member aged between 18 and 65 years old, who has mental health problems and is currently arrested or remanded. We would like you to tell us about the type of care and support your family member has received from mental health services and if and how this could be made better for people who may be arrested or remanded in the future. We hope to be able to improve the support available for people in similar situations to your family in the future.

1.3 Do I have to take part?
No, taking part is voluntary. We will tell you about the study and go through this information sheet with you. We will then ask you to sign a consent form to show that you understand and have agreed to take part. You can change your mind at any time about taking part. It doesn’t matter if it’s before, during or after our discussion, all you have to do is let me know and you don’t have to give a reason.

1.4 What will happen to me if I take part?
You will be asked to take part in an informal interview lasting about 60 minutes. The questions will be about the care and support your family member got in the past from mental health services and if and how this could be made better for people who may be arrested or remanded in the future. After the interviews you may be asked if you would want to be part of a group meeting to try to develop a training programme for staff. This is also voluntary and you can withdraw at anytime without having to tell us why.

Interviews will be undertaken by Alison Pearsall, who is a PhD student based at the Department of Community Based Medicine at the University of Manchester. All of the information collected will be strictly confidential and will be stored securely by Alison Pearsall, under the supervision of Professor Jenny Shaw, the principal investigator.
1.5 What are the possible benefits and disadvantages of taking part?
You may have ideas or suggestions about the type of support people with mental health problems and their families need after they have been arrested or remanded. You might also be able to help us develop better services for people in the future by telling us how Intensive Case Management (ICM) needs to be changed to provide the support people need.

The disadvantages are that some people may become upset or anxious during the interviews when talking about their family member with mental illness or describing the circumstances of their arrest. You can take as many breaks in the interview as you need during the interview.

1.6 What happens when the research study stops?
This study will run for three years in total. At the end of that period we will write to you, if you wish, to let you know the main findings of the study. We will also give a presentation on the findings of the study within the University of Manchester, Offender Health Research Network and Lancashire Care NHS Trust.

1.7 Will my taking part in the study be kept confidential?
Yes. With your permission, I will record our discussion and then write it up into what is called a transcript. This will allow me to read what you’ve said again to understand it properly. When I create the transcript, I will change the names of yourself and anyone you mention. The original recording and transcript will be kept in a secure place in Manchester University. Nothing in the written report will identify who you are. If you wish, I will give you a copy of the transcript so that you can be sure that I’ve written it down correctly and that no-one in it can be identified by others.

Part 2

2.1 What will happen if I don’t want to carry on with the study?
If you withdraw from the study, we will destroy all your study records. If you are have a complaint about the way you have been dealt with you can contact a member of the study team (on 0161 275 0731) who will do their best to answer your questions and help out. You can also see a member of the mental health inreach team to discuss your concerns. If you remain unhappy and wish to complain formally, we will provide information about the University of Manchester and Lancashire Care NHS Foundation Trust Complaints Procedures.

2.2 What will happen to the results of this study?
The results will be written up for publication in a medical journal and the organisations funding this research will receive a report on the findings. Your personal details will not appear on any of these documents and you will not be identified in any way.

2.3 Who has reviewed this study?
This study has been reviewed by the Research Ethics Committee and by the National Institute of Health Research (Department of Health), who are also funding the study.

Thank you for reading this information sheet
Part 1:

1.1 What is the purpose of this study?
This study is looking at whether a form of Intensive Case Management (ICM) namely Critical Timed Interventions (CTI) would be beneficial to service users and professionals working with them after they have been arrested or remanded. See attached CTI Model and Information Sheet for further information on the CTI Model. The study will look at your views as a mental health practitioner but will also obtain the views of other people including service users, family members (as appropriate), police and prison officers and commissioners. It is important to understand if this type of approach would be viewed as useful to all those involved in either receiving, providing or purchasing care at the crucial point of arrest or remand. However, your views are important and ICM could be an approach which CJL/MHI may find beneficial within the service. The study will be taking place in two police stations and two prisons within the Cumbria and Lancashire area.

1.2 Why have I been invited to take part?
You have been asked to take part because you are between eighteen and sixty-five years old, have experience of working with people with mental health problems who have been arrested/remanded. We feel that your knowledge and/or experience of providing care and support mean that you would be able to make an important contribution. Your line manager may have already spoken to you about the study or you may have attended a presentation and we would be grateful if you would consider participating. We anticipate that you will be one of approximately 15 mental health staff who will be invited to take part.

1.3 Do I have to take part?
No, your participation is entirely voluntary. We will describe the study and give you information sheets to read. We will then ask you to sign a consent form to show that you have agreed to take part. You can change your mind at any time about taking part, without giving a reason.

1.4 What will happen to me if I take part?
In this study, we will be conducting ‘individual’ and ‘group’ interviews with a range of people who know about or have an interest in the care and support provided to people following arrest and remand and ask them to describe their experiences. We will also ask them to comment on our suggestions for the content of the proposed intensive case management training package. These discussions will form the basis for developing the intervention further and refining it over the study period.

You will be invited to take part in an individual interview lasting 60-90 minutes and a staff focus group
meeting lasting 90-120 minutes. The focus group meeting will consist of about 10-15 people with knowledge and experience working with people with mental health problems following their arrest/remand to discuss whether ICM would be beneficial. All interviews and focus groups and will be recorded so that comments and suggestions can be analysed in detail. After the interviews you may be sent written information for you to read and comment on including items which may be used to develop into training materials to form a staff ICM training programme.

The interviews will be conducted by Alison Pearsall, who is a PhD student based at the Department of Community Based Medicine at the University of Manchester. All of the information collected will be strictly confidential and will be stored anonymously and securely by Alison Pearsall, under the supervision of Professor Jenny Shaw, the principal investigator.

The service users’ names will not be retained as all participants will be assigned a research ID to identify them for the duration of the study which will assist in protecting confidentiality. Therefore, people can speak more freely without feeling uncomfortable about it affecting their confidentiality.

1.5 What are the possible benefits and disadvantages of taking part?
The benefits of your participation are that your contribution may assist in the development of an adapted ICM approach which may benefit service users and staff alike in the future. As you know many service users leave custody with adverse and unresolved social issues including homelessness and debts. Furthermore many lose touch with mental health and criminal justice agencies on release and therefore have no support to address these problems. This study aims to looks at an ICM approach and whether with some adaption this approach could be beneficial to service users who have been arrested/remanded by maintaining their contact with mental health services and criminal justice agencies. ICM appears to improve ongoing contact because the approach consists of structured, intensive support over a time limited period which addresses practical issues which if unresolved can lead to mental health instability, isolation and reoffending.

The disadvantages are it is possible that some people may become distressed during the interviews or focus group meetings (for example, when talking about their experiences or frustrations working at the boundary of mental health and criminal justice services) but we will try to minimise this as far as possible with pauses and breaks as you feel necessary. Remember also that all the information gathered is entirely confidential and that you are free to withdraw from this study at any point without giving a reason.

1.6 What happens when the research study stops?
This study will run for three years in total. At the end of that period we will write to all participants or their care co-ordinator/probation officer to inform about the main findings of the study. We will also present the findings of the study within the University of Manchester, Offender Health Research Network and Lancashire Care NHS Trust.

1.7 Will my taking part in the study be kept confidential?
Yes. With your permission, I will record our discussion and then write it up into a transcript. The original recording and transcript will be kept in a secure place in Manchester University where only staff involved in the study can access. Nothing in the written report will identify who you are or personal details about you. If you wish, you can have a copy of the transcript so that you can check for accuracy and be reassured that no potentially identifying information has been retained.

Part 2
2.1 What will happen if I don’t want to carry on with the study?
If you withdraw from the study, the study team will destroy all your study records and you will receive no further contact regarding either this study or any follow-up studies.

2.2 What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have any concerns that arise as a result of taking part in this study, you can contact a member of the study team (on 0161 … ….) who will do their best to answer your
questions. Alternatively you may wish to speak to you line manager or my supervisors to discuss your concerns. If you remain unhappy and wish to complain formally, you can do so via the University of Manchester or Lancashire Care NHS Foundation Trust complaints procedures.

2.3 Will my taking part in this study be kept confidential?
Absolutely. The data collected for this study will be looked at only by authorised persons from the Department of Community Based Medicine at Manchester University or by study regulatory authorities. All information that is collected about you during the course of the study will be kept strictly confidential and will be stored and later destroyed in compliance with the Data Protection Act 1998. Your information will not be used or made available for any purpose other than for this research, although the sponsor or R&D (research and development) staff may need to access data for regulatory purposes or for the purposes of audit or screening. To protect your privacy, any information will have your name and contact details removed and an ID assigned so that you cannot be recognised from it. With your permission, this information will be stored at the University of Manchester in locked filing cabinets in a security card protected site. Codes connecting your individual identity to the stored data records will be kept separately. All material will be securely destroyed 10 years after the end of the research study, or on your withdrawal from the study.

2.4 What will happen to the results of this study?
The results will be written up for publication in a medical journal and the organisations funding this research will receive a report on the findings. Your personal details will not appear on any of these documents and you will not be identifiable in any way.

2.5 Who is funding this research?
This research is being funded by the National Institute of Health Research, (NIHR), (on behalf of the UK Department of Health) and forms part of a personal PhD clinical fellowship award. The study investigators and supervisors are not paid for doing this research, other than their normal salary.

2.6 Who has reviewed this study?
This study has been reviewed by the Research Ethics Committee and by the National Institute of Health Research (Department of Health).

Thank you for reading this information sheet
Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

STUDY INFORMATION SHEET FOR POLICE AND PRISON STAFF PARTICIPANTS

(Version 2, May 2011)

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Part 1 explains the purpose of the study and what will happen to you if you take part.

Part 2 gives more detailed information about the conduct of the study. Ask us if there is anything that is not clear or if you would like more information to enable you to decide whether or not you wish to take part.

Part 1:

1.1 What is the purpose of this study?

This study is looking at whether a form of Intensive Case Management (ICM) namely Critical Timed Interventions (CTI) would be beneficial to service users and professionals working with them after they have been arrested or remanded. See attached CTI Model and Information Sheet for further information on the CTI Model. The study will look at your views as a police/prison officer but will also obtain the views of other people including service users (arrestees/remand prisoners), family members (as appropriate, as they are often affected by the wellbeing of service users), mental health inreach and criminal justice liaison staff (as they provide care and support) and commissioners (as they purchase services). It is important to understand if this type of approach would be useful to all those involved in either receiving, providing or purchasing care at the crucial point of arrest or remand. However, your views are important as ICM could be an approach which police and prison officers may also be able understand and contribute to. The study will be taking place in two police stations and one prison within the Cumbria and Lancashire area.

1.2 Why have I been invited to take part?

You have been asked to take part because you are between eighteen and sixty-five years old, have experience of working with people with mental health problems who have been arrested/remanded. We feel that your knowledge and/or experience of providing support, supervision and public safety...
mean that you would be able to make an important contribution. Your line manager may have already spoken to you about the study or you may have attended a presentation and we would be grateful if you would consider participating.

1.3 Do I have to take part?

No, your participation is entirely voluntary. We will describe the study and give you information sheets to read. We will then ask you to sign a consent form to show that you have agreed to take part. You can change your mind at any time about taking part, without giving a reason.

1.4 What will happen to me if I take part?

In this study, we will be conducting ‘individual’ and ‘group’ interviews with a range of people who know about or have an interest in the care, support and supervision provided to people following arrest and remand and asking them to describe their experiences. We will also ask them to comment on our suggestions for the content of the proposed intensive case management training package. These discussions will form the basis for developing the intervention further and refining it over the study period.

You will be invited to take part in an individual interview lasting 60-90 minutes and a staff focus group meeting lasting 90-120 minutes over a 12 month period. The focus group meeting will consist of about 10-15 people with knowledge and experience working with people with mental health problems following their arrest/remand to discuss whether ICM would be beneficial. All interviews and focus groups will be recorded so that comments and suggestions can be analysed in detail. After the interviews and focus group meetings you may be sent written information for you to read and comment for training materials to form a staff training programme for ICM.

The interviews will be conducted by Alison Pearsall, who is a PhD student based at the Department of Community Based Medicine at the University of Manchester. All of the information collected will be strictly confidential and will be stored anonymously and securely by Alison Pearsall, under the supervision of Professor Jenny Shaw, the principal investigator.

The service users’ names will not be retained as along with all other participants will be assigned a research ID to protect confidentiality. Therefore, people can speak more freely without feeling uncomfortable about issues about their confidentiality.

1.5 What are the possible benefits and disadvantages of taking part?

The benefits of your participation are that your contribution may assist in the development of an adapted ICM approach which may benefit service users and staff alike in the future. As you know many service users leave custody with adverse and unresolved social issues including homelessness and debts. Furthermore many lose touch with mental health and criminal justice agencies on release and therefore have no support to address these problems and they often continue to offend and can become ‘revolving door’ prisoners. This study aims looks at an ICM approach and whether with some adaption this approach could be beneficial to service users who have been arrested/remanded by maintaining their contact with mental health services and criminal justice agencies. ICM appears to improve ongoing contact because the approach consists of structured, intensive support over a time limited period which addresses practical issues which if unresolved can lead to mental health instability, isolation and reoffending.

The disadvantages are it is possible that some people may become distressed during the interviews or focus group meetings (for example, when talking about their experiences or frustrations working within the criminal justice system) but we will try to minimise this as far as possible with pauses and breaks as you feel necessary. Remember also that all the information gathered is entirely confidential and that you are free to withdraw from this study at any point without giving a reason.
1.6 What happens when the research study stops?

This study will run for three years in total. At the end of that period we will write to all participants or their care co-ordinator/probation officer to inform about the main findings of the study. We will also present the findings of the study within the University of Manchester, Offender Health Research Network and Lancashire Care NHS Trust.

1.7 Will my taking part in the study be kept confidential?

Yes. With your permission, I will record our discussion and type up the transcript. The original recording and transcript will be kept in a secure place in Manchester University where only staff involved in the study can access. Nothing in the written report will identify who you are or personal details about you. If you wish, you can have a copy of the transcript so that you can check for accuracy and be reassured that no potentially identifying information has been retained.

Part 2

2.1 What will happen if I don’t want to carry on with the study?

If you withdraw from the study, the study team will destroy all your study records and you will receive no further contact regarding either this study or any follow-up studies.

2.2 What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have any concerns that arise as a result of taking part in this study, you can contact a member of the study team (on 0161 … ….) who will do their best to answer your questions. Alternatively you may wish to speak to your line manager or my supervisors to discuss your concerns. If you remain unhappy and wish to complain formally, you can do so via the University of Manchester or Lancashire Care NHS Foundation Trust complaints procedures.

2.3 Will my taking part in this study be kept confidential?

Absolutely. The data collected for this study will be looked at only by authorised persons from the Department of Community Based Medicine at Manchester University or by study regulatory authorities. All information that is collected about you during the course of the study will be kept strictly confidential and will be stored and later destroyed in compliance with the Data Protection Act 1998. Your information will not be used or made available for any purpose other than for this research, although the sponsor or NHS employees may need to access data for regulatory purposes or for the purposes of audit or screening. To protect your privacy, any information will have your name and contact details removed and an ID assigned so that you cannot be recognised from it. With your permission, this information will be stored at the University of Manchester in locked filing cabinets in a security card protected site. Codes connecting your individual identity to the stored data records will be kept separately. All material will be securely destroyed 10 years after the end of the research study, or on your withdrawal from the study.

2.4 What will happen to the results of this study?

The results will be written up for publication in a medical journal and the organisations funding this research will receive a report on the findings. Your personal details will not appear on any of these documents and you will not be identifiable in any way.

2.5 Who is funding this research?
This research is being funded by the National Institute of Health Research, (NIHR), (on behalf of the UK Department of Health) and forms part of a personal PhD clinical fellowship award. The study investigators and supervisors are not paid for doing this research, other than their normal salary.

2.6 Who has reviewed this study?

This study has been reviewed by the Research Ethics Committee and by the National Institute of Health Research (Department of Health).

Thank you for reading this information sheet
Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

STUDY INFORMATION SHEET FOR COMMISSIONER STAFF PARTICIPANTS
(Version 2, May 2011)

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Part 1 explains the purpose of the study and what will happen to you if you take part. Part 2 gives more detailed information about the conduct of the study. Ask us if there is anything that is not clear or if you would like more information to enable you to decide whether or not you wish to take part.

Part 1:
1.1 What is the purpose of this study?
This study is looking at whether a form of Intensive Case Management (ICM) namely Critical Timed Interventions (CTI) would be beneficial to service users and professionals working with them after they have been arrested or remanded. The study will look at your views as a commissioner purchasing mental health services within criminal justice environments but will also obtain the views of other people including service users (arrestees/remand prisoners), family members (as appropriate, as they are often affected by the wellbeing of service users), mental health inreach and criminal justice liaison staff (as they provide care and support) and police and prison officers as they provide support and security. It is important to understand if this type of approach would be viewed as useful to all those involved in either receiving, providing or purchasing care at the crucial point of arrest or remand. However, your views are important as ICM could be an approach which commissioners may regard as an approach MHI/CJL staff could consider utilising.

1.2 Why have I been invited to take part?
The study will be taking place in two police stations and two prisons within the Cumbria and Lancashire area. You have been asked to take part because you are between eighteen and sixty-five years old, have experience of working with people with mental health problems who have been arrested/remanded or purchasing services on their behalf. We feel that your knowledge and/or experiences of purchasing care packages means that you would be able to make an important contribution. Your line manager may have already spoken to you about the study or you may have attended a presentation and we would be grateful if you would consider participating.
1.3 Do I have to take part?
No, your participation is entirely voluntary. We will describe the study and give you information sheets to read. We will then ask you to sign a consent form to show that you have agreed to take part. You can change your mind at any time about taking part, without giving a reason.

1.4 What will happen to me if I take part?
In this study, we will be conducting ‘individual’ and ‘group’ interviews with a range of people who know about or have an interest in the care, support and supervision provided to people following arrest and remand to discuss their experiences. We will also ask them to comment on our suggestions for the content of the proposed intensive case management training package. These discussions will form the basis for developing the intervention further and refining it over the study period.

You will be invited to take part in an individual interview lasting 60-90 minutes and a staff focus group meeting lasting 90-120 minutes. The focus group meeting will consist of about 10-15 people with knowledge and experience working with people with mental health problems following their arrest/remand to discuss whether ICM would be beneficial. All interviews and focus groups will be recorded so that comments and suggestions can be analysed in detail. After the interviews and focus group meetings you may be sent written information for you to read and comment for training materials to form a staff training programme for ICM.

The interviews will be conducted by Alison Pearsall, who is a PhD student based at the Department of Community Based Medicine at the University of Manchester. All of the information collected will be strictly confidential and will be stored anonymously and securely by Alison Pearsall, under the supervision of Professor Jenny Shaw, the principal investigator.

The service users’ names will not be retained as along with all other participants a research ID will be assigned to protect their real names and overall confidentiality for the duration of the study. All data collected either by interview or focus group discussion will be recorded, analysed and reported using the research ID. Therefore, people can speak more freely without feeling uncomfortable about their confidentiality.

1.5 What are the possible benefits and disadvantages of taking part?
The benefits of your participation are that your contribution may assist in the development of an adapted ICM approach which may benefit service users and staff alike in the future. This study aims to look at an ICM approach and whether with some adaption this approach could be beneficial to service users who have been arrested/remanded by maintaining their contact with mental health services and criminal justice agencies. ICM appears to improve ongoing contact because the approach consists of structured, intensive support over a time limited period which addresses practical issues which if unresolved can lead to mental health instability, isolation and reoffending.

The disadvantages are it is possible that some people may become distressed during the interviews or focus group meetings (for example, when talking trying to assemble appropriate care packages or service responses) but we will try to minimise this as far as possible with
pauses and breaks as you feel necessary. Remember also that all the information gathered is entirely confidential and that you are free to withdraw from this study at any point without giving a reason.

1.6 What happens when the research study stops?
This study will run for three years in total. At the end of that period we will write to all participants or their care co-ordinator/probation officer to inform about the main findings of the study. We will also present the findings of the study within the University of Manchester, Offender Health Research Network and Lancashire Care NHS Trust.

1.7 Will my taking part in the study be kept confidential?
Yes. With your permission, I will record our discussion and type up the transcript. The original recording and transcript will be kept in a secure place in Manchester University where only staff involved in the study can access. Nothing in the written report will identify who you are or personal details about you. If you wish, you can have a copy of the transcript so that you can check for accuracy and be reassured that no potentially identifying information has been retained.

Part 2
2.1 What will happen if I don’t want to carry on with the study?
If you withdraw from the study, the study team will destroy all your study records and you will receive no further contact regarding either this study or any follow-up studies.

2.2 What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have any concerns that arise as a result of taking part in this study, you can contact a member of the study team (on 0161 … ….) who will do their best to answer your questions. Alternatively you may wish to speak to your line manager or my supervisors to discuss your concerns. If you remain unhappy and wish to complain formally, you can do so via the University of Manchester or Lancashire Care NHS Foundation Trust complaints procedures, which we will be happy to provide you with.

2.3 Will my taking part in this study be kept confidential?
Yes. The data collected for this study will be looked at only by authorised persons from the Department of Community Based Medicine at Manchester University or by study regulatory authorities. All information that is collected about you during the course of the study will be kept strictly confidential and will be stored and later destroyed in compliance with the Data Protection Act 1998. Your information will not be used or made available for any purpose other than for this research, although the sponsor or R&D (research and development) employees may need to access data for regulatory purposes or for the purposes of audit or screening. To protect your privacy, any information will have your name and contact details removed and an ID assigned so that you cannot be recognised from it. With your permission, this information will be stored at the University of Manchester in locked filing cabinets in a security card protected site. Codes connecting your individual identity to the stored data records will be kept separately.
All material will be securely destroyed 10 years after the end of the research study, or on your withdrawal from the study.

2.4 What will happen to the results of this study?
The results will be written up for publication in a medical journal and the organisations funding this research will receive a report on the findings. Your personal details will not appear on any of these documents and you will not be identifiable in any way.

2.5 Who is funding this research?
This research is being funded by the National Institute of Health Research, (NIHR), (on behalf of the UK Department of Health) and forms part of a personal PhD clinical fellowship award. The study investigators and supervisors are not paid for doing this research, other than their normal salary.

2.6 Who has reviewed this study?
This study has been reviewed by the Research Ethics Committee and by the National Institute of Health Research (Department of Health).

Thank you for reading this information sheet
APPENDIX 5 a)  
ICM Study  
Interview Schedule – Service User Participant  

1) Introduction:  
- Introduce the study, name and where based  
- Discuss the aims/purpose of interview and go through ICM information sheet  
- Discuss what the interview involves and how long will meet for  
- Remind about consent and confidentiality, and times that it may be broken.  
- Reassure the person they can stop for a break or to end the interview at any time  
- Discuss feedback of interview and findings of the study  
- Thank for agreeing/consenting to be part of the study  
- Any questions? 

2) Basic Personal Data:  
- Gender  
- Age  
- Race/ethnic origin  
- Living Group  
- Mental health diagnosis  
- Length of time known to MH Services  
- Medication  
- Substance misuse  
- Current arrest, charge and/or remand
"As you know I am interested in finding out about your experiences of being arrested/remanded, the previous care and support you have received and whether ICM could help you to improve your life in the future in terms of you staying well and avoiding getting into further trouble”. I would like to ask you some questions about this; please take your time and answer as honestly and fully as you can”.

3) **Arrest or Remand Experiences**

- Would you mind telling me about what happened for you to get arrested/remanded?
- How did you feel at the time? What did you think about? Tell me how you managed with these thoughts and feelings?
- What thoughts do you have now? Has this changed (and why)?
- What, if any, positive experiences or thoughts have you had since you were arrested/remanded? Any negative? Examples?
- Can you think of anything that has been helpful since you were arrested/remanded? What effect, if any, did this have on you?
- Can you tell me about anything that has been unhelpful since you were arrested/remanded? What effect, if any, did this have on you?
- Can you tell me any stressors you have experienced and how you coped with these?

4) **Former living and service experiences**

- Who are the most important people to you?
- Who is in your network?
- What is your relationship with the person named?
• Who is important to you, and why?
• Who would you contact in a crisis?
• Has your network changed, and why?
• Can you tell me who is around to support you at critical times?
• What do they do which you find supportive? Or unsupportive?
• What activities do you generally do? What do you think about these?
• Tell me about any contact you have had with mental health services?
• What has been helpful? What has been unhelpful?
• What words would you use to describe your views of mental health care for people who are arrested / remanded?
• Tell me about any contact you have had with criminal justice services e.g. police/ prison officers? What has been helpful? What has been unhelpful?
• What words would you use to sum up your views of police or prison care for with people mental health problems who have been arrested / remanded?

“The last part of the interview looks at if, and how, your future care experiences could be improved by ICM if this were available for you. Please refer to sheet about ICM at any time”. ICM programme is 9 months long, with three distinct phases each of three months duration, ‘transfer to community’, ‘try out in community’ and ‘transfer of care’

5) **ICM in the future:**

The ICM practitioner would refer you to local services (if not already known) and work alongside your care team, would this be helpful to you? And how?

In the first phase the ICM practitioner will develop a care/treatment plan, can you tell me whether focussing on the following would be useful to you, and how?

• Psychiatric treatment – symptom and stress management?
  
  Does this happen now? How would this improve things for you?

• Medication management – education, side effects and self monitoring?
  
  Does this happen now? How would this improve things for you?
• Substance misuse management – harm reduction, motivation to change, triggers for usage and linking with substance misuse services?

Does this happen now? How would this improve things for you?

• Money management - strategy for payment of essential bills e.g. rent, gas etc, checking in receipt entitled benefits, budgeting etc?

Does this happen now? How would this improve things for you?

• Housing crisis management - addressing potential problems, negotiating with housing providers etc?

Does this happen now? How would this improve things for you?

• Family interventions - psycho-education with family on mental illness, symptoms, associated risks, coping with stress and mediation?

Does this happen now? How would this improve things for you?

• Life skills training - occupational and leisure activities and being with others?

Does this happen now? How would this improve things for you?

Are there any other specific issues you would need help or support with in addition to those already mentioned above?

Any other comments you wish to share?

Any questions?

Thank you for taking part.
APPENDIX 5 b)

ICM Study

Interview Schedule – Carer/Family Member Participant

1) Introduction:
   - Introduce the study, name and where based
   - Discuss the aims/purpose of interview and go through ICM information sheet
   - Discuss what the interview involves and how long will meet for
   - Remind about consent and confidentiality, and times that it may be broken.
   - Reassure the person they can stop for a break or to end the interview at any time
   - Discuss feedback of interview and findings of the study
   - Thank for agreeing/consenting to be part of the study
   - Any questions?

2) Basic Data:
   - Gender
   - Age
   - Race/ethnic origin
   - Living Group
   - Relationship to service user
   - Length of time known the service user

"I am interested in finding out about your experiences of what it is like to have a family member arrested or held on remand and if ICM could help to support, them, and you”. I would like to ask you some questions; about your views and experiences, there are no right or wrong answers and please take your time. As I said earlier all the information you give will be
treated as strictly confidential and will not be disclosed to anyone, unless you reveal information which shows someone else could be in danger or at risk of future harm or that an offence has been committed. Please refer to sheet about ICM at any time during the interview and please feel free to pause or stop the interview at any time.

3) **Arrest or Remand Experiences**

- Would you please tell me what has happened when ……. was arrested/ remanded?

- How did you feel at the time? What did you think about? Tell me how you managed these thoughts and feelings?

- Did you have any support for yourself at the time? From whom? Was it helpful? Describe.

- What thoughts do you have now? Has this changed (and why)?

- What, if any, positive experiences or thoughts have you had since …. was arrested/ remanded? Any negative? Examples?

- Have you had any contact with any professional since ..... was arrested/remanded e.g. police etc. Please describe.

- Can you think of anything that has been helpful since ..... was arrested/ remanded? What effect, if any, did this have on ….., and you?

- Can you tell me about anything that has been unhelpful since ……. was arrested/ remanded? What effect, if any, did this have on you?

- Can you tell me any recent issues you have experienced in relation to you family member being in custody and how you coped with these?

- What are your hopes for the future to improve the experiences of carers/family members following your ……. (service user) being arrested/remanded?

4) **Former living and service experiences**

- Who are the most important people to carers/family members following arrest or remand?

- Can you tell me who is generally around to support carers/family members at critical times? What do they provide which is supportive? Or unsupportive?
• What do carers/family members generally do at times of crisis (in relation to the service user)? Do you consider this to be helpful?

• What activities do you generally do? What do you think about these?

• Tell me about any contact you have had with mental health services? What has been helpful? What has been unhelpful?

• What words would you use to describe your views of mental health care for people who are arrested/ remanded?

• Tell me about any contact you have had with police or prison officers? What has been helpful? What has been unhelpful?

• What words would you use to sum up your views of police or prison care for people with mental health problems who have been arrested/ remanded?

“The last part of the interview looks at if, and how, future care experiences could be improved by ICM if this were available. Please refer to sheet about ICM at any time. ICM programme is 9 months long, with three distinct phases each of approximately three months duration, ‘transfer to community’, ‘try out in community’ and ‘transfer of care’ and is designed to complement not replace existing mental health care.

5) ICM in the future:

The ICM practitioner would refer the service user to local mental health services (if not already known) and work alongside the care team? How?

In the first phase the ICM practitioner will develop a care/treatment plan; can you tell me whether focussing on the following would be also be useful for you as a carer/family member, and how?

• Psychiatric treatment – symptom and stress management?
  Does this happen now? How would this impact on you?

• Medication management – education, side effects and self monitoring?
  Does this happen now? How would this impact on you?

• Substance misuse management – harm reduction, motivation to change, triggers for usage and linking with substance misuse services?
  Does this happen now? How would this impact on you?
• Money management - strategy for payment of essential bills e.g. rent, gas etc, checking in receipt entitled benefits, budgeting etc?
  Does this happen now? How would this impact on you?

• Housing crisis management - addressing potential problems, negotiating with housing providers etc?
  Does this happen now? How would this impact on you?

• Family interventions - psycho-education with family on mental illness, symptoms, associated risks, coping with stress and mediation?
  Does this happen now? How would this impact on you?

• Life skills training - occupational and leisure activities and being with others?
  Does this happen now? How would this impact on you?

Any other comments you wish to share?

Any questions?

Thank you for taking part.
1) **Introduction:**

- Introduce the study, name and where based
- Discuss the aims/purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will meet for
- Remind about consent and confidentiality, and times that it may be broken.
- Reassure the person they can stop for a break or to end the interview at any time
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

2) **Basic Personal Data:**

- Gender
- Age
- Race/ethnic origin
- Travel to Work
- Living Group
- Length of time working within Mental Health Services
- Current post and responsibilities
- Length of time working in current post
- Specific training undertaken applicable to current post
Is any specific training required

Specific supervision, frequency and summary of issues raised

"As you know I am interested in finding out about your experiences of working as a mental health practitioner with people with mental health problems who have been arrested/remanded received, current use of the CPA and whether ICM could help you to improve care provision”. I would like to ask you some questions about this; please take your time and answer as honestly and fully as you can”.

3) Arrest or Remand Experiences

- Tell me about working with people who are arrested/remanded?
- On average how long do your initial assessments of individuals take, and what areas do you cover?
- When you began in post were you introduced to any particular models for use in your role?
- Have you since used any specific intervention models in your work with people? If so, what model?
- How do you structure your approach to working clinically with people?
- Would another practitioner work in the same way as you?
- What relevant evidence do you apply to your work?
- How do you know if your interventions are successful, what measures are used?
- Can you tell me about any particular interventions or approaches you have delivered which have been helpful to service users? What effect, if any, did this have on them?
- Can you tell me about any interventions or procedures which you consider are unhelpful to service users following arrest or remand? What effect, if any, did this have on them?
- What thoughts and feelings do service users express to you after their initial arrest/remand?
- What problems/issues do they have which, in your opinion, have contributed to their arrest/remand?
• What, if any, positive experiences or thoughts do people express to you after their arrest/remand? Any negative? Examples?
• Can you tell me any recent issues you have experienced whilst working with service users and how you dealt with these?
• What are your hopes for the future to improve arrest and remand experiences?

4) Former living and service experiences
• Who are the most important people to service users following arrest or remand?
• Can you tell me who is generally around to support service users at critical times? What do they provide which is supportive? Or unsupportive?
• What do service users generally do at times of crisis? Do you consider this to be helpful?
• Do you have routine/frequent/infrequent contact with service users’ family in your role? Would you think this would be useful and how?
• What contact have service users had in general with mental health services prior to arrest and remand? What seems helpful? What seems unhelpful?
• How would you describe mental health care for people who are arrested/remanded? What is helpful? What is unhelpful?
• Sum up your views of prison/police custodial care for people with mental health problems following arrest/remand?

“The last part of the interview looks at if, and how, future care experiences could be improved by ICM if this were available. Please refer to sheet about ICM at any time”. ICM programme is 9 months long, with three distinct phases each of approximately three months duration, ‘transfer to community’, ‘try out in community’ and ‘transfer of care’ and is designed to complement not replace existing mental health care.

5) ICM & CPA:
The ICM practitioner would refer the service user to local mental health services (if not already known) and work alongside the care team? How?

Could you describe the components/tasks of your role as CPA Co-ordinator?
What qualities/skills are required for your role as CPA Co-ordinator?

What do you think the client and other professionals consider your role to be?

What tasks are associated with implementing a care plan?

What are the ‘given’ contents of a care plan for the client group?

What are the current benefits for clients receiving care under CPA/case management?

What are the negatives, if any?

Are you able to access support and services for clients that you deem necessary? What are the barriers, if any?

What are your relationships like with other service providers e.g. criminal justice staff?

What is communication like ‘in’ and ‘between’ services?

Are there any areas where this could be improved?

In the first phase the ICM practitioner will develop a care/treatment plan; can you tell me whether focusing on the following would be useful for the service user, and how?

- Psychiatric treatment – symptom and stress management?
  Does this happen now? How would this impact on care?

- Medication management – education, side effects and self monitoring?
  Does this happen now? How would this impact on care?

- Substance misuse management – harm reduction, motivation to change, triggers for usage and linking with substance misuse services?
  Does this happen now? How would this impact on care?

- Money management - strategy for payment of essential bills e.g. rent, gas etc, checking in receipt entitled benefits, budgeting etc?
  Does this happen now? How would this impact on care?

- Housing crisis management - addressing potential problems, negotiating with housing providers etc?
  Does this happen now? How would this impact on care?
• Family interventions - psycho-education with family on mental illness, symptoms, associated risks, coping with stress and mediation?
  Does this happen now? How would this impact on care?

• Life skills training - occupational and leisure activities and being with others?
  Does this happen now? How would this impact on care?

Are there any other specific issues in addition to those already mentioned above?

Any other comments you wish to share?

Any questions?

Thank you for taking part.
APPENDIX 5 d)

ICM Study

Semi-structured Interview Schedule – Police/Prison Officer Staff Participant

May 2011, Version 2

1) Introduction:

- Introduce the study, name and where based
- Discuss the aims/purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will meet for
- Remind about consent and confidentiality, and times that it may be broken.
- Reassure the person they can stop for a break or to end the interview at any time
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

2) Basic Personal Data:

- Gender
- Age
- Race/ethnic origin
- Living Group
- Length of time working as a police or prison officer
- Current post and responsibilities
- Length of time working in current post
- Specific training undertaken applicable to current post
- Specific supervision, frequency and summary of issues raised
"As you know I am interested in finding out about your experiences of working as a police/prison officer with people with mental health problems who have been arrested/remanded received and whether ICM could help you to improve care provision”. I would like to ask you some questions about this; please take your time and answer as honestly and fully as you can”.

3) **Arrest or Remand Experiences**

- Tell me about how you work with people who have been arrested/remanded?
- What thoughts and feelings do service users express to you after their initial arrest/remand?
- What problems/issues do they have which, in your opinion, have contributed to their arrest/remand?
- What, if any, positive experiences or thoughts do people express to you after their arrest/remand? Any negative? Examples?
- Can you tell me about any particular interventions or approaches you have delivered which have been helpful to service users? What effect, if any, did this have?
- Can you tell me about any interventions or procedures which you consider are unhelpful to service users following arrest or remand? What effect, if any, did this have?
- Can you tell me about any recent issues you have experienced whilst working with arrestees/remand prisoners and how you dealt with these?
- What are your hopes for the future to improve arrest and remand experiences?

4) **Former living and service experiences**

- Who are the most important people to service users following arrest or remand?
- Can you tell me who is generally around to support service users at critical times? What do they provide which is supportive? Or unsupportive?
- What do service users generally do at times of crisis? Do you consider this to be helpful?
- What contact have service users had in general with mental health services prior to arrest and remand? What seems helpful? What seems unhelpful?
- How would you describe mental health care for people who are arrested/remanded? What is helpful? What is unhelpful?
• Sum up your views of prison/police custodial care for people with mental health problems following arrest/remand?

“The last part of the interview looks at if, and how, future care experiences could be improved by ICM if this were available. Please refer to sheet about ICM at any time”. ICM programme is 9 months long, with three distinct phases each of approximately three months duration, ‘transfer to community’, ‘try out in community’ and ‘transfer of care’ and is designed to complement not replace existing mental health care.

5) ICM in the future:

The ICM practitioner would refer the service user to local mental health services (if not already known) and work alongside the mental health care team, would this be helpful to police/prison officers? How?

In the first phase the ICM practitioner will develop a care/treatment plan; can you tell me whether focussing on the following would be useful for the service user, and how?

• Psychiatric treatment – symptom and stress management?
  Does this happen now? How would this impact on care?

• Medication management – education, side effects and self monitoring?
  Does this happen now? How would this impact on care?

• Substance misuse management – harm reduction, motivation to change, triggers for usage and linking with substance misuse services?
  Does this happen now? How would this impact on care?

• Money management - strategy for payment of essential bills e.g. rent, gas etc, checking in receipt entitled benefits, budgeting etc?
  Does this happen now? How would this impact on care?

• Housing crisis management - addressing potential problems, negotiating with housing providers etc?
  Does this happen now? How would this impact on care?

• Family interventions - psycho-education with family on mental illness, symptoms, associated risks, coping with stress and mediation?
  Does this happen now? How would this impact on care?
• Life skills training - occupational and leisure activities and being with others?
  Does this happen now? How would this impact on care?

Are there any other specific issues in addition to those already mentioned above?

Any other comments you wish to share?

Any questions?

Thank you for taking part.
1) **Introduction:**

- Introduce the study, name and where based
- Discuss the aims/purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will meet for
- Remind about consent and confidentiality, and times that it may be broken.
- Reassure the person they can stop for a break or to end the interview at any time
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

2) **Basic Client Data:**

- Gender
- Age
- Race/ethnic origin
- Living Group
- Length of time working within Service Commissioning
- Current post and responsibilities
- Length of time working in current post
- Specific training undertaken applicable to current post
- Specific supervision, frequency and summary of issues raised
"As you know I am interested in finding out about your experiences of commissioning services for people with mental health problems who have been arrested/remanded received and whether ICM could help to improve care provision”. I would like to ask you some questions; please take your time and answer as honestly and fully as you can”.

3) **Arrest or Remand Experiences**

- Tell me about service provision for people who are arrested/remanded?
- What thoughts and feelings have service users expressed to you about their initial arrest/remand? Or have you seen documented?
- What problems/issues do they have which, in your opinion, may have contributed to their arrest/remand?
- What, if any, positive or negative experiences have you had regarding the service provision for people following arrest and remand?
- Can you tell me about any particular interventions or approaches you are aware of which have been helpful to service users? What effect did they have?
- Can you tell me about any interventions or procedures which you consider are unhelpful to service users following arrest or remand?
- Can you tell me any recent issues you are aware of which have arisen for service users that have been arrested or remanded?
- What are your hopes for the future to improve arrest and remand care provision?

4) **Former living and service experiences**

- Who are the most important people to service users following arrest or remand? And what support do they provide?
- Describe your views on the support services available to service users at critical times? What is provided which is supportive? Or unsupportive?
- How would you describe mental health care for people who are arrested / remanded? What is helpful? What is unhelpful?
- Sum up your views of prison/police custodial care for people with mental health problems following arrest/remand?
“The last part of the interview looks at if, and how, future care experiences could be improved by ICM if this were available. Please refer to sheet about ICM at any time”. ICM programme is 9 months long, with three distinct phases each of approximately three months duration, ‘transfer to community’, ‘try out in community’ and ‘transfer of care’ and is designed to complement not replace existing mental health care.

5) ICM in the future:

The ICM practitioner would refer the service user to local mental health services (if not already known) and work alongside the care team? How?

In the first phase the ICM practitioner will develop a care/treatment plan; can you tell me whether focussing on the following would be useful for the service user, and how?

- Psychiatric treatment – symptom and stress management?
  Does this happen now? How would this impact on care?

- Medication management – education, side effects and self monitoring?
  Does this happen now? How would this impact on care?

- Substance misuse management – harm reduction, motivation to change, triggers for usage and linking with substance misuse services?
  Does this happen now? How would this impact on care?

- Money management - strategy for payment of essential bills e.g. rent, gas etc, checking in receipt entitled benefits, budgeting etc?
  Does this happen now? How would this impact on care?

- Housing crisis management - addressing potential problems, negotiating with housing providers etc?
  Does this happen now? How would this impact on care?

- Family interventions - psycho-education with family on mental illness, symptoms, associated risks, coping with stress and mediation?
  Does this happen now? How would this impact on care?

- Life skills training - occupational and leisure activities and being with others?
  Does this happen now? How would this impact on care?
Are there any other specific issues in addition to those already mentioned above?

Any other comments you wish to share?

Any questions?

Thank you for taking part.
Appendix 6: Consent Forms
a) Service Users

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

CONSENT FORM FOR SERVICE USERS
May 2011, Version 2

Name __________________________

Research ID __________________________
(please leave blank)

1) I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions. 

OR

I confirm that I have had the attached information sheet explained to me and have had the opportunity to ask questions.

2) I understand that I can withdraw from the study at any time without having to give any reasons.

3) I hereby give consent to be involved in this research project. I understand that there will be no negative impact if I decide not to participate.

4) I agree to the interview being audio recorded.

5) I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

____________________________          ______________________    _____________
Signature of Participant       Name                              Date

____________________________         ______________________     _____________
Signature of Researcher                   Name                                               Date
Appendix 6: Consent Forms
b) Family Members/Carers

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

CONSENT FORM FOR FAMILY MEMBERS/CARERS
May 2011, Version 2

Name ______________________

Research ID ___________________
(please leave blank)

1) I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions.

OR
I confirm that I have had the attached information sheet explained to me and have had the opportunity to ask questions.

2) I understand that I can withdraw from the study at any time without having to give any reasons.

3) I hereby give consent to be involved in this research project. I understand that there will be negative impact if I decide not to participate.

4) I agree to the interview being audio recorded.

5) I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

____________________________          ______________________    _____________
Signature of Participant                Name                               Date

____________________________         _____________________     _____________
Signature of Researcher               Name                                                Date
Appendix 6: Consent Forms
c) For all Staff (mental health, criminal justice and commissioners)

Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through Transitional Intensive Case Management

CONSENT FORM FOR STAFF
May 2011, Version 2

Name ____________________________

Research ID Number ________________
(please leave blank)

3) I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions.

OR

I confirm that I have had the attached information sheet explained to me and have had the opportunity to ask questions.

4) I understand that I can withdraw from the study at any time without having to give any reasons.

3) I hereby give consent to be involved in this research project. I understand that there will be negative impact if I decide not to participate.

4) I agree to the interview being audio recorded.

5) I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

____________________________          ______________________    _____________
Signature of Participant               Name                              Date

____________________________         ______________________     _____________
Signature of Researcher              Name                                                Date
Appendix 7: Sample transcripts and initial manual coding

### Sample Transcripts

#### ICM Study

**Semi-structured Interview Schedule - Service User Participant**  
**Version 11 May 2011, v1.0**

1) **Introduction:**
- Introduce the study, name and where based
- Discuss the purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will last
- Remind about consent and confidentiality, and times at which they may be broken.
- Reassure the person that they can stop for a break or to end the interview at any time.
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

2) **Basic Personal Data:** (as complemented by gain of consent of CANFAR)
- Gender: Male
- Age: 35
- Marital status: Widowed
- Living alone: Yes, living alone in flat.
- Mental health conditions: Schizophrenia, paranoid delusions, paranoid PD
- Medication: Olanzapine, Clozapine.
- Current problems: Back pain, slipped disc.
- African origin: White Caucasian
- Substance misuse: Yes, alcohol, cannabis, prescription.
- Current arrest and charge: Re-living the incident of assault that the person was convicted of 5 years ago despite encouragement by mental health team to continue, feel he was over-punished and over-tired. Felt that he coped well and doesn’t feel the need to report. Says staff were worried what would I do if I can’t come in my medication, but says he had been ok, he hasn’t shown how well he can do.

**Previous convictions:** Has previous convictions for possession and intent to supply, and assault and violence assault x3.

*As you know I am interested in finding out about your experiences of being arrested/incarcerated, the previous care and support you have received and whether ICM could help you to improve your life in the future in terms of you staying well and living in the community. Here are some questions about this, most of which are not very long and straightforward.*

#### ICM Study

**Interview with Service User R1226**  
**Version 5, 2nd March 2013**

1) **Introduction:**
- Introduce the study, name and where based
- Discuss the purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will last
- Remind about consent and confidentiality, and times at which they may be broken.
- Reassure the person they can stop for a break or to end the interview at any time.
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

3) **Basic Personal Data:** (as complemented by gain of consent of CANFAR)
- Gender: Male
- Age: 25
- Marital status: Living with wife and four children.
- Mental health diagnosis: Schizophrenia, paranoid psychosis
- Medication: Clozapine.
- Substance misuse: Yes, alcohol, cannabis, prescription.
- Current arrest and charge: Re-living the incident of assault that the person was convicted of 5 years ago despite encouragement by mental health team to continue, feel he was over-punished and over-tired. Felt that he coped well and doesn’t feel the need to report. Says staff were worried what would I do if I can’t come in my medication, but says he had been ok, he hasn’t shown how well he can do.

**Previous convictions:** Has previous convictions for theft, robbery, driving, TTOC as a youngster.

*As you know I am interested in finding out about your experiences of being arrested/incarcerated, the previous care and support you have received and whether ICM could help you to improve your life in the future in terms of you staying well and avoiding getting into further trouble.*

I would like to ask you some questions about this, most of which are not very long and straightforward.

#### ICM Study

**Interview with Service User R1226**  
**Version 5, 2nd March 2013**

1) **Introduction:**
- Introduce the study, name and where based
- Discuss the purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will last
- Remind about consent and confidentiality, and times at which they may be broken.
- Reassure the person they can stop for a break or to end the interview at any time.
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

3) **Basic Personal Data:** (as complemented by gain of consent of CANFAR)
- Gender: Male
- Age: 25
- Marital status: Living with wife and four children.
- Mental health diagnosis: Schizophrenia, paranoid psychosis
- Medication: Clozapine.
- Substance misuse: Yes, alcohol, cannabis, prescription.
- Current arrest and charge: Re-living the incident of assault that the person was convicted of 5 years ago despite encouragement by mental health team to continue, feel he was over-punished and over-tired. Felt that he coped well and doesn’t feel the need to report. Says staff were worried what would I do if I can’t come in my medication, but says he had been ok, he hasn’t shown how well he can do.

**Previous convictions:** Has previous convictions for theft, robbery, driving, TTOC as a youngster.

*As you know I am interested in finding out about your experiences of being arrested/incarcerated, the previous care and support you have received and whether ICM could help you to improve your life in the future in terms of you staying well and avoiding getting into further trouble.*

I would like to ask you some questions about this, most of which are not very long and straightforward.

#### ICM Study

**Interview with Service User R1226**  
**Version 5, 2nd March 2013**

1) **Introduction:**
- Introduce the study, name and where based
- Discuss the purpose of interview and go through ICM information sheet
- Discuss what the interview involves and how long will last
- Remind about consent and confidentiality, and times at which they may be broken.
- Reassure the person they can stop for a break or to end the interview at any time.
- Discuss feedback of interview and findings of the study
- Thank for agreeing/consenting to be part of the study
- Any questions?

3) **Basic Personal Data:** (as complemented by gain of consent of CANFAR)
- Gender: Male
- Age: 25
- Marital status: Living with wife and four children.
- Mental health diagnosis: Schizophrenia, paranoid psychosis
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- Substance misuse: Yes, alcohol, cannabis, prescription.
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**Previous convictions:** Has previous convictions for theft, robbery, driving, TTOC as a youngster.

*As you know I am interested in finding out about your experiences of being arrested/incarcerated, the previous care and support you have received and whether ICM could help you to improve your life in the future in terms of you staying well and avoiding getting into further trouble.*

I would like to ask you some questions about this, most of which are not very long and straightforward.
Appendix 8: Interview Data Analysis using Dedoose software

This pictorial representation highlights the range of coding and themes generated after the initial open/axial coding using Dedoose software:
Appendix 9: Research ID and corresponding Pseudonym

Pseudonyms were applicable to Service Users (both arrest and remand) participating in the study. All participants were allocated a Research ID to ensure anonymity. However, to facilitate a more humanistic and personalised description of individual sociograms and personal circumstances service users were also assigned a pseudonym, which are detailed in the box below.

**Research ID & Pseudonym**

<table>
<thead>
<tr>
<th>Research ID</th>
<th>Pseudonym</th>
<th>Arrest/Remand</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID: 1023</td>
<td>Stephen</td>
<td>Arrestee</td>
</tr>
<tr>
<td>ID: 1024</td>
<td>Paul</td>
<td>Remand</td>
</tr>
<tr>
<td>ID: 1025</td>
<td>Mark</td>
<td>Remand</td>
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<tr>
<td>ID: 1026</td>
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<td>John</td>
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<tr>
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<td>Arrestee</td>
</tr>
<tr>
<td>ID: 1039</td>
<td>Peter</td>
<td>Arrestee</td>
</tr>
</tbody>
</table>
Appendix 10: Sociograms of Service User Participants

Sociograms were developed with service user participants (arrestees n=5 and remand prisoners n=6). Each sociogram represents the social support network comprising of relationships with others such as family, friends and professionals. Each network provides the individual’s perspective on the type, strength and functionality of the relationships with others in the network. Each sociogram is made up of five concentric circles representing ‘everyday’ and six segments representing ‘crisis’ support. Functionality of relationships are shown by three coloured lines - green (positive), red (negative) and black (neutral).
Appendix 11: ‘End To End’ Criminal Justice Pathway

This is a diagrammatic representation of the criminal justice pathway from the point of arrest through to prison and release into the community stages. The various components of mental health service provision are highlighted and their relevance at various stages of the criminal justice pathway. The title of the slide is ‘End to End’ which is often described within the criminal justice literature. However, to move away from itemised context-specific discharge and release planning the ‘End’ is crossed out and replaced with transitional case management to signify service users’ ongoing support needs.
Title: Enhancing integrated working and care coordination at the transitional points between custody and community mental health teams

Keywords
transitional care, mental health, custody, process mapping, multi-disciplinary work, England

Introduction: There is a growing need to improve integrated working across agencies at the transitional points of release from short term custody. Despite recent improvements to health care in prisons complex referral systems and barriers impede mental health care following release into the community.

Aims: To investigate the referral processes applicable from custody to community mental health teams

Results: Process mapping is a recognised method to improve care delivery using the experience and expertise of clinical staff and service users. Process maps aim to improve efficiency and effectiveness by identifying good practice, removing barriers, bottle necks and smoothing transitions into and between services. Up to half of all processes involve handovers, transfers and transitions of care where the risk of delay, duplication and error are heightened.

Process maps help to identify complexity in referral and communication processes simultaneously affected by procedures pertaining to the Police and Criminal Evidence Act and mental health requirements. Thus they are diagnostic and can be used as a basis for service improvements eliciting the direct involvement of front line staff from mental health and criminal justice services.

Conclusions:
Movement between services are recognised points of additional vulnerability to relapse, recidivism, poor community assimilation and suicide. Although health provision in prisons has improved there continues to be a lack of seamless care coordination at the gate. New national directives for referral and transitional care are needed to ensure safe and effective transfer from custodial to community based mental health care.
APPENDIX 12 - CONFERENCE ABSTRACTS

International Academy of Law and Mental Health

Académie Internationale de Droit et de Santé Mentale

a/s Chaire de psychiatrie légale et d’ético biomédicale Philippe Pinel
Faculté de médecine Université de Montréal C.P. 6128, Succ. Centre-ville
Montréal, Qc H3C 3J7 tel.: (514) 343-5938 fax.: (514) 343-2452

XXXVth International Congress on Law and Mental Health

City of Prague, 2017

Ville de Prague, 2017

Title: Managing the interface between Mental Health, Social Care and the Criminal Justice System

Keywords: Grounded Theory; Social Networks; Transitions; Case Management

Background: Exploration of participants’ experiences of continuity of care at transitional points in the criminal justice system. The availability and functionality of social support networks were explored in relation to resources available to support transitions.

Method: Forty-two interviews were conducted, with five participant groups; service users, families, mental health and criminal justice staff and commissioners. This was supported by the construction of 11 sociograms for service users, in both arrest (n=5) and remand (n=6) situations. Data was analysed using Constructive Grounded Theory Methods.

Results: The over-arching constructed grounded theory was a need to refocus on transitional care rather than discharge planning to optimise continuous care pathways. Service users’ social networks are diminished lacking essential support at times of transitions. Associated themes included ‘lack of practical assistance’, ‘lack of crisis support’, ‘returning to the security of prison’ and ‘poor transition planning’.

Summary: Entry into and release from the police station or prison are particular vulnerable points in offender care pathways. Transitions are problematic in relation to linking offenders with appropriate community-based services, particularly those with compromised social networks. Transitional case management contains all the components of service identified by participants as important to support transitions from short-term custody to the community.