



VOICES FOR CHANGE

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Report Authors

Fiona McCormack, Research Fellow, Centre for Health and Development
Naomi Ellis, Director, Centre for Health and Development
Lorna Sams, Researcher, Centre for Health and Development
Konstantinos Spyropoulos, Research Associate, Centre for Health and Development
Katie Beeston, Head of Business and Service Development, MPFT
Claudia Jamieson, LENSE Research and Innovation Project Manager, MPFT
Jamie Roberts, Professional Lead for Lived Experience Practice, MPFT
Rachel Penketh, Service Lead for Cheshire Health & Justice, MPFT
Emma Harrison, Senior Lived Experience Worker, MPFT
Dr Adrian Coxell, Consultant Clinical Psychologist, MPFT
Jo Shenton, Team Lead RECONNECT Cheshire, MPFT
Jane Pulfer, Head of Health and Justice Services, MPFT
James Hackett, Senior Information Business Analyst Specialist Services Care Group, MPFT
Fiona Burns, Continuous Improvement Co-production Lead, MPFT
Kate Matthews, Marketing and Communications Assistant, MPFT
June Walsh, Commissioning Lead, NHS England

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Project Leadership and contact details:

Katie Beeston: katie.beeston@mpft.nhs.uk
Jamie Roberts: jamie.roberts@mpft.nhs.uk
Claudia Jamieson: claudia.jamieson@mpft.nhs.uk

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Executive summary

Voices for Change explored how engagement and accessibility can be improved across the Cheshire Health and Justice Services (Liaison & Diversion (L&D) and RECONNECT) delivered by Midlands Partnership University NHS Foundation Trust (MPFT). It explored who is accessing services, barriers to engagement, and opportunities to strengthen pathways for people with health needs in contact with the criminal justice system. Voices for Change supports NHS England's statutory duty on health inequalities and helps MPFT meet its legal responsibilities through evidence-led improvement aligned with Core20PLUS5.

A mixed-methods approach was used, combining analysis of anonymised referral data (L&D n=7,437; RECONNECT n=466), service user surveys and interviews, partner-organisation feedback, and staff workshops. Referral data were examined by protected characteristics to understand patterns of engagement and identify gaps.

Key findings show that once individuals engage with the service, their experience is very positive. People reported feeling listened to, supported, and treated with respect. Staff were praised for their trauma-informed, person-centred approach and for going "above and beyond" to help people access further support, stabilise their circumstances, and make positive changes.

The evaluation also identified some barriers to initial engagement, e.g. consent processes, limited service understanding among partners, and restricted operating hours in custody. Referral data showed high numbers of people declining consent, especially in custody settings, which limits the ability to screen, assess, or offer support. Staff and partners highlighted that clearer communication, simpler language, and improved service promotion could help increase uptake.

Partner organisations valued the service but lacked clarity about what L&D and RECONNECT offer, which affected referral quality and consistency. Staff emphasised the importance of lived experience roles in strengthening trust and engagement.

The project showed the need to keep gathering feedback from service users, staff and partners, improve the quality of referral data, and find safe ways to hear from and research further people who do not consent to support. Making the service easier to understand (e.g., simple leaflets, QR codes, videos) and strengthening partnerships is needed so people fully understand what the services offer. Practical improvements such as building trust, being more visible, and strengthening links with housing were suggested. Longer-term ideas included extending support, increasing lived-experience roles, adding housing navigators, developing service user involvement strategies, and creating a specific approach for under-17s who are less likely to consent.

Overall, the evaluation demonstrates that Health and Justice services deliver meaningful, high-quality support once people are engaged, but improvements are needed to increase awareness, reduce barriers at the point of referral, and ensure equitable access across demographic groups.



Plain language summary

This project wanted to find out about how to make the Health and Justice services better. We wanted to see if there was a way to support more people to use the service. To do this we spoke to those who use the Health and Justice service, as well as service staff and staff from partner organisations. We also looked at information about those referred into Health and Justice services to see if there were any patterns in who was using it based on their age, gender and ethnicity.

We found that service users thought the support was positive and often life changing. They felt listened to and supported by staff. Some felt that past negative experiences with other services might stop some people from wanting to be referred to Health and Justice services. Promoting the service well and linking more with wider organisations were suggested as ways of making the service better. Staff from partner organisations did refer into Health and Justice services but did not always understand what support they offer. Improving their understanding of the services could help them offer it to more people. They also felt that extending the working hours would mean that more people could benefit, especially those in custody.

Staff working for Health and Justice services thought they were able to work well with service users and put their needs first. Building trust and taking time to understand their needs was important. Staff felt that once they are engaged with service users, they are able to give them a lot of support. Encouraging service users to access the service was often difficult and staff came up with some practical ways this could be made better, like using simple language and a video rather than written information. Support workers with lived experience were something both staff and service users saw as important so looking at long term ways of increasing the number of lived experience staff should be prioritised.

1.Introduction



1.1 Background

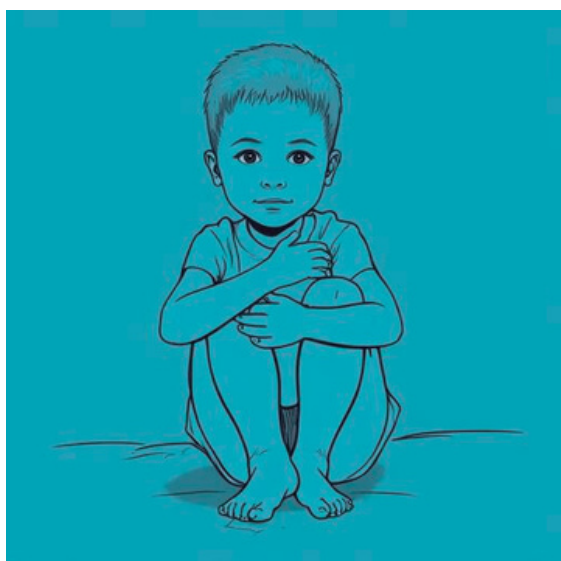
Health inequalities among individuals in contact with the criminal justice system in the UK are pronounced and multifaceted, encompassing social, economic, and health-related determinants. Research indicates that individuals in the criminal justice system often experience significantly poorer health outcomes compared to the general population. This disproportionate burden is exacerbated by social factors such as poverty, which fuels cycles of incarceration and poor health (Fox, 2008).

The unique health challenges facing people who experience incarceration are particularly evident in the prevalence of mental health disorders. Evidence suggests that nearly 90% of people living in prison exhibit symptoms of at least one mental health problem, in contrast to rates in the general population (Hean et al., 2015). Furthermore, individuals with conditions such as attention-deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) are notably over-represented within the criminal justice system.

Studies reveal that people involved in the criminal justice system with ADHD incur substantially higher costs in health and social services, highlighting the substantial economic implications (Young et al., 2018; Young et al., 2011). Similarly, a significant number of individuals with ASD entering the criminal justice system receive inadequate support, largely due to a lack of autism awareness among staff (Burch & Rose, 2020).

The connection between health issues and the criminal justice system is complicated further by insufficient access to healthcare services. When released from prison, individuals face significant barriers to obtaining primary health care, exacerbating existing health inequalities (Carswell et al., 2017). The transition from prison to community life is challenging, as many of those experiencing prison report difficulties in accessing statutory health services, leading to high rates of morbidity and reoffending (Carswell et al., 2017).

Childhood adversity is one of many reasons why people may find it difficult to engage with services intended to support them. Unfortunately, childhood adversity is associated with a wide range of mental and physical health problems (Hughes et al., 2017) and is more common in persons in prison than in persons in the community (Ford et al., 2019). This has important implications for services as there is also evidence that childhood adversity negatively impacts on trust in a wide range of services (including health and social services: Bellis et al., 2024). It is important, then, that services understand that many people with a history of trauma have difficulty coping with their challenges, that these services connect with others non-judgmentally and understand that the persons they serve may have a variety of ways of communicating their distress (Sweeny et al., 2018). In essence, there is a need for services which are Trauma Informed (Substance Abuse and Mental Health Services Administration, 2014) to best support the people that they serve. This project is attempting to increase engagement in people with complex histories often involving a wide range of adversity.



Moreover, the systemic inadequacies in the provision of mental health services for those in contact with the criminal justice system creates a vicious cycle wherein unresolved health issues contribute to continued criminal behaviour. This cycle illustrates the inadequacies of the current service integration between the NHS and the criminal justice system, which remains critical for addressing the complex needs of this population (Lennox et al., 2012). Collaborations aimed at improving interagency communication and care continuity are essential for reducing health disparities among these individuals (Goddard et al., 2019).

The implications of social determinants extend beyond mental health, as the link between substance use disorders and the criminal justice system further complicates health inequalities. A large portion of the criminal justice system population using drugs, particularly those with co-occurring mental health issues, face higher rates of arrest and recidivism post-release (Woodhouse et al., 2016). Addressing substance use within this context requires a comprehensive public health strategy that integrates treatment and rehabilitation approaches tailored to the unique characteristics of this population (Belenko et al., 2013).

Access to healthcare for individuals with protected characteristics in the UK remains a significant concern, with multiple barriers affecting their ability to receive fair and equitable care. Protected characteristics as defined under the Equality Act 2010 include age, disability, gender reassignment, race, religion or belief, sex, and sexual orientation. Each of these factors may uniquely influence the experience of healthcare access and outcomes.

To address these issues holistically, it is essential to implement structural changes within the healthcare system. The Care Quality Commission and other regulatory bodies in the UK are increasingly promoting inclusive practices that uphold the principles of the Equality Act, actively calling for policies that eliminate discrimination and promote health equity (Vipin, 2021). There is an urgent need for interventions that build trust and improve the participation of individuals with protected characteristics in healthcare processes (McFadden et al., 2024).

In summary, health inequalities among those in contact with the criminal justice system in the UK are significant, influenced by a combination of mental health disorders, substance use, and social determinants of health. Systemic changes to improve access to care, enhance interagency collaboration, and implement targeted interventions for mental health and substance use disorders are critical to mitigating these disparities and improving overall health outcomes for this vulnerable population.



1.2 Context

Midlands Partnership University NHS Foundation Trust (MPFT) provide Liaison and Diversion Services (L&D; which includes court, police custody and Outreach) and RECONNECT Services (when people leave prison) within Cheshire, commissioned by NHS England. These services aim to provide a positive experience for service users with an identified health need, which includes mental health and substance use, amongst others. Accessing these services can provide a positive experience and increase the likelihood of future engagement with individuals which can support recovery and reduce reoffending.

Voices for Change is aligned to NHS England's statutory responsibilities relating to health inequalities and subsequently MPFT's role as an NHS Trust provider in contributing to this legal requirement. Voices for Change is enabling MPFT to fulfil their health inequality legal duty and inform an evidence-led improvement approach to healthcare inequalities, in line with Core20PLUS5.

Cheshire has a population of just over 1.1 million people. The county is predominantly White (94.8%), with small Asian (2.3%), Mixed (1.6%) and Black (0.6%) communities (ONS Census, 2021). Although much of Cheshire is relatively affluent, pockets of significant deprivation exist, particularly in parts of Cheshire West and Warrington, where inequalities affect health, income and life opportunities.

Liaison and Diversion service

In Cheshire the L&D service cover three custody suites based in Blacon (West), Middlewich (East) & Runcorn (North), three Magistrates courts (Chester, Warrington and Crewe) and Chester Crown court. The outreach team provide support in the community.

L&D services identify people with mental health needs, learning disabilities, substance misuse issues, or other vulnerabilities when they first encounter the criminal justice system.

The service supports them through the early stages of the process, connects them with appropriate health or social care, and, where suitable, diverts them away from the justice system into more appropriate services. L&D aims to improve health outcomes, reduce re-offending, and spot vulnerabilities early to prevent crises and ensure people receive the right support from the outset.

The L&D pathway includes:

- **Identification** – Police and court staff recognise signs of vulnerability and notify the local L&D team.
- **Screening** – Practitioners carry out brief checks to understand needs, risks and whether further assessment is required.
- **Assessment** – A trauma-informed, detailed evaluation explores the person's vulnerabilities and determines appropriate support or treatment.
- **Referral** – People are connected to relevant health, social care or support services, helped to attend initial appointments, and outcomes are recorded.
- **Outreach** – Multi-disciplinary teams provide holistic support in the community during criminal proceedings, including help with housing, finances and recovery.

RECONNECT service

In Cheshire the RECONNECT service covers three prisons, HMP/YOI Styal which is a female prison and young offender institute, HMP Risley which is a Category C male establishment and HMP/YOI Thorn Cross which is a men's open prison and young offender institute.

RECONNECT is a care-after-custody service that supports people leaving prison or immigration removal centres (IRCs) who have identified health needs.

It works with individuals before release to ensure a smooth transition into community services and to maintain any health gains made in custody.

The service aims to improve wellbeing, reduce health inequalities, and address health-related factors linked to offending. Although not a clinical service, RECONNECT provides liaison, advocacy, signposting and practical support to help people engage with community-based care.

What RECONNECT aim to do:

- Provides release planning and support for up to 12 weeks before release.
- Offers up to 6 months of post-release support, or until health needs are met, with extensions in exceptional cases.
- Assesses referrals and obtains consent before working with an individual.
- Ensures at least two pre-release contacts, delivered face-to-face or via phone/virtual methods.
- Allocates a named worker to support the person before and after release until they are linked into appropriate services; peer support is offered where suitable.
- Coordinates between prisons/IRCs and home-area services when someone is held outside their local area.
- Collaborates with custody-based healthcare teams, including mental health, physical health, substance misuse and support services.
- Provides trauma informed, holistic, person-centred support based on individual needs.
- Supports people on Release on Temporary Licence within 12 weeks of final release where appropriate.

2. Aims and objectives



There is concern that a high proportion of people may not access services for a range of reasons. To begin to address that, the 'Voices for Change' project seeks to review how engagement and accessibility can be improved across the Health and Justice Service. This work aligns with MPFT's service user involvement strategy, that seeks to ensure that people accessing these services 'have a voice' and feed into future changes and improvements.

This project aimed to review how engagement and accessibility can be improved across the Health and Justice Service.

Referrals were examined by protected characteristics, e.g., age, ethnicity, and gender, to provide a better understanding of engagement and any gaps, as well as any differences, across these demographics. This would provide a better understanding of factors that support positive engagement and barriers to engagement. In addition, service users, staff and partner organisations were asked about the impact of the services, any barriers to access and potential improvements.

The project was guided by the following research questions:



- 1. Who is accessing Health and Justice Services (e.g., by age, gender, ethnicity)?**
- 2. What barriers currently exist in relation to accessing Health and Justice Services?**
- 3. What are the facilitators for people accessing Health and Justice Services?**
- 4. How can we increase engagement with our services?**
- 5. How can we improve access to our services across different demographics?**

3. Methods

3.1 Study design

A mixed methods approach was used to address the research questions using non-identifiable quantitative and qualitative data collected by the Voices for Change team.

3.2 Participant recruitment

3.2.1 Referral Data

The Voices for Change team conducted data collection with service users, staff, and staff at partner organisations to capture a variety of perspectives. Anonymised data were shared with researchers at the Centre for Health and Development (CHAD) at the University of Staffordshire, for data analysis. Anonymous routine data from the services database of referrals were also shared for further analysis.



3.2.2 Service users

The opportunity to contribute to this evaluation was offered to all service users engaging with the Health and Justice services within Cheshire for a period of three months.

Attempts were also made to talk to L&D service users who declined to access the L&D service in custody. They had been referred but they declined to access in custody. We wanted to understand what it was that made the person not want to access the service at that point. Unfortunately, timescales around approvals prevented this feedback from being gathered.

Survey

A survey was co-produced with people with lived experience. It included responder demographics and a range of other statements about the service (Appendix 1). People were asked to answer whether they: strongly agreed, agreed, neither agreed nor disagreed, disagreed, strongly disagreed. The survey also asked for '3 things we are doing right', '3 things we could do better' and 'Something you wish we could do'. A further question asked people to select from a range of options (Appendix 2) to indicate 'Improvements or support which would be beneficial'. These options were generated by people with lived experience suggesting they are important to consider further.

During their appointments with NHS practitioners, service users were asked if they wished to complete an anonymous survey to provide service feedback. If the practitioner deemed it unsuitable to request their involvement due to their health needs, they were offered a chance to take part in a subsequent appointment.

Interview

Those completing a survey were also told about the opportunity to give more detailed feedback and were asked if they would consider being contacted to take part in an anonymous interview. If the service user consented, an interview with an NHS practitioner was arranged at a time and location convenient for them, either online, by telephone or face-to-face. Once they had participated in an interview, they were provided with a £20 Love to Shop voucher in compensation for their time.

Practitioners were briefed and supported by the project lead to understand how to engage service users in the project. The practitioners provided the survey to service users at the end of their appointment to be completed.

Practitioners passed on the details of the service users interested in engaging in the semi-structured interviews to the project lead. Service users were then contacted to arrange a time and date for the interview. These interviews were not recorded but notes were taken and written into short anonymous summaries of the interviews.

3.2.3 Partner organisations

The Voices for Change team sent out an anonymous survey (through MS Forms) to team leaders from relevant partner organisations and asked them to share with their staff/practitioners to complete. Partner organisations included: Cheshire Police Force, Geoamey (provides security for courts), and His Majesty's Prison and Probation Service (HMPPS) covering Probation, Court staff (including solicitors, magistrates, ushers, legal advisors etc.), Youth Justice, and Prison Staff. The survey asked participants to respond to questions about their understanding of the service and their referrals into the service (Appendix 3).

3.2.4 Health and Justice service staff

Two workshops were advertised and Health and Justice staff were invited via email by the project lead. The workshops were held during working hours for staff to provide their views on the barriers and facilitators of the Health and Justice services (in terms of their experiences in referring and their reflections on service user experiences). In addition, an anonymous survey was sent out to all teams to provide feedback digitally if they were unable to attend the in-person events. This was supported by team leaders who formed part of the project steering group.

3.2.5 Ethics

The Voices for Change team secured NRC ethics for the evaluation (NRC reference: 1665). Ethical approval was also granted by the University of Staffordshire which covered the receipt and analysis of anonymised data collected by the Voices for Change team at MPFT. All data was stored on password protected and encrypted computers in line with data protection requirements.



3.3 Data collection

Referral data

Non-identifiable routinely collected data from the L&D (n=7437) and RECONNECT Services (n=466), e.g., referrals, screening by protected characteristics such as, gender, ethnicity, age, were collected by Voices for Change and shared with the CHAD team.

Service user feedback

Service user feedback was received through anonymous survey's (n=22) from people with experience of using the services, anonymised notes of semi-structured interviews (n=11) conducted by the Voices for Change team, and typed feedback statements from people following their experience of engaging with the services (n=2).

Partner feedback

Staff from partner organisations (n=25) completed the feedback survey and included those working with both L&D and RECONNECT. In addition, two testimonies from partners were also supplied and incorporated into the findings.

Staff feedback

Anonymous survey feedback was received (n=27). In addition to this, summary feedback was obtained from the workshop. Informal feedback was also provided from staff through brief 'interviewer notes' at the end of two service user interviews, one log about service users engagement and Multi Disciplinary Team RECONNECT notes. One staff member collecting data also offered some insight into service users that declined to engage with the service.



3.4 Data analysis

The quantitative data was processed to determine engagement (survey) and referrals (Power BI). Socio-demographic descriptive statistics of those being referred for a service were summarised. Data was tabulated for exploratory descriptives.

The qualitative data was analysed using thematic analysis to identify patterns across the data related to engagement and issues that act as barriers to, or facilitators of, its success. Braun and Clarke's process of Thematic Analysis was followed through which "patterns are generated by the researcher/s through a rigorous process of data familiarisation, data coding, and theme development and revision" (Braun and Clarke, 2013; Braun & Clarke, 2020).

Data were familiarised through extensive reading, before it was coded and initial themes were identified. Themes were then reviewed to ensure they were data driven. The process allowed for themes to be reflective of participant opinion. All preliminary codes were identified independently by an experienced qualitative researcher (FM) and then verified by a second researcher (NE).

4. Findings

4.1 Referral data

Liaison and Diversion service

When considering referral data, the consent process needs to be considered and adds important context to these data presented. Consent is required before staff can screen or support anyone who is not currently in custody. If a custody referral arrives outside commissioned hours (7pm–8am) and the person has already been released without consent to contact, staff cannot record the referral, access the database, screen them, or proceed. In court, L&D can only screen walk-ins with their consent, while those held in cells can be screened without it. Outreach referrals are accepted only when consent has been obtained – whether from custody, court, out-of-hours consent to contact, or self-referral.

Of the 7437 records provided of referral into the L&D service, 2569 (34.5%) individuals consented to being referred into the L&D service and 4791 (64.5%) did not. Data was not provided for 77 (1%) of cases. The referral source of the consenting and non consenting cases are detailed in Appendix 4. The majority (78.8%) of referrals came from custody, with significantly more individuals not providing consent from this referral source.

Of those consenting to L&D services, over 80% have an identified mental health need and over 25% have a form of neurodiversity.

The overall number of referrals into the L&D service, for those who consented and those who did not, have been considered by socio-demographic descriptive statistics and mental health conditions for all cases (Appendix 5), and specifically focussing on gender by age and gender by ethnicity (Appendices 6 and 7). There were significantly more males and females who did not provide consent compared to those who did. Those in the older age group (age 70+) or with mental health problems were more likely to consent. While significantly more males and females aged <17 did not provide consent when compared to older age groups. Significantly more individuals did not provide consent for all ethnic groups except for mixed/multiple ethnic groups. We note caution with these differences given the significant amount of unknown data.

RECONNECT

Of the 466 records provided, 437 individuals consented to being referred into the RECONNECT service and 29 did not. RECONNECT service users need to consent to the referral to receive the service. The referral source of the consenting and non consenting cases are detailed in Appendix 8. Most referrals came from friends/family or via self-referral (29.8%), prison referrals (28.1%) and other RECONNECT services (23.2%).

Significantly more individuals provided consent when being referred from a community offender manager, friends or family or self, the L&D service, prison referrals, and other RECONNECT services.

The overall number of referrals into the RECONNECT service, for those who consented and those who did not, have been considered by socio-demographic descriptive statistics and mental health conditions for all cases (Appendix 9), and specifically focussing on gender by age and gender by ethnicity (Appendices 10 and 11). There were significantly more males and females providing consent compared to those who did not and significantly more individuals providing consent for all age groups except for those aged under 20 years and over 60 years. Many more individuals provided consent if they were white British or had mental health problems. Many more males aged between 20 and 49 years provided consent, as did females but to the age of 59 years. Equally, more white British males aged 20-29 years and 40-49 years and white British females aged between 20-49 years also provided consent.

4.2 Service user feedback

Of the 22 responses to the survey questions, most of the sample were males (59.1%) with 55% of the total sample being White British. Responses from service users covered all aspects of L&D (59%) and RECONNECT (41%) and all age groups from under 19 to over 70 years (Appendix 12).

From survey feedback, people engaging with the services were very positive about their experiences and the support provided. The majority of service users reported that they felt comfortable and safe using the service (86%), trusted the service to keep their information confidential (72%), had

a really good understanding of what the service could do for them (91%), understood why they had been referred (91%), trusted the service to do the best for them (91%), and felt confident that the service could help them with things they needed (86%). Equally, most service users also suggested they were satisfied with how the service was trying to support them (82%), had worked with someone in the service to develop a plan to meet their needs (86%) and had been put in touch with other services that were able to provide additional support (86%) (Appendix 13). This suggests that once someone is engaged, they go on to have a good experience.

The above highlights the majority are reporting a positive experience. There was only one instance of 'disagree' which was in relation to the statement 'I have worked with someone in the service to develop a plan to meet my needs'.

From service user feedback obtained during the interviews, one person mentioned being referred early in the service before plans were routinely developed. It may be that the same applied here, rather than that the plan was meant to have happened and did not.

The following themes have been developed using both survey and interview feedback from service users:

4.2.1 Service users value the level and nature of support from Health and Justice service workers

It was clear that those engaging with the service were highly satisfied with the support provided and grateful to the staff involved. As one participant summarised: *"I have been in and out of prison most of my life and this is the best the service I have ever had in my life."* (Courts).

Across the services, service users valued the nature of the support from the Health and Justice workers and how they interacted with them and made them feel (*"keeping me informed"; "giving me a voice"*). People were positive about the effort and care that staff put into *"understanding my situation"* (Courts), interacting and working with people. They reported feeling that the workers were *"fun, happy, positive", "friendly/easy to talk to", "sympathetic",* went *"above and beyond"* and had genuine care and concern for them, their situations and what happened next. Service users appreciated the *"level of support, it felt genuine care"* and the way Health and Justice workers were *"getting me to engage"* with the right guidance and *"support to stay out of custody"*.

Some of the feedback also highlighted the value and benefit that having a worker with lived experience specifically made to them, for example: *"My Support Worker sharing their lived experience with me gave me so much hope and inspiration"*.

Most of the responses mentioned that staff were available, accessible, reliable and consistent which meant a lot to them. For example: *"My worker was always available to me and would call me back if they could not take my call. I cannot fault the support I have had"* (RECONNECT). The connection between the service user and their support workers appeared valuable *"nothing [was] too much to ask, [they were] always there for me"* (Outreach). One participant talked about when their circumstances changed, they were able to rely on their support worker *"when I relapsed on alcohol they stayed in touch and reminded me of all of my appointments"* (Outreach).

For some (which may have depended on which Health and Justice service they were working with), being able to do home visits was also valued: *"[the] worker I was assigned to always came to my house which I really appreciated"*. Being flexible and working with service users in a space *"where I felt safe"* was important.

4.2.2 Helped to access further support to make positive changes

People accessing the services described how L&D service staff helped them to access a range of further opportunities for support. This included referrals to access a wide range of support, referrals, and/or assessments related to their health and wider circumstances, such as, GPs, dentists, drug and alcohol services, mental health, PTSD, therapy, and support for coercive control.



People were often unsure about how to access this support themselves: *"Got me registered with a GP. I didn't know how to go about this"* (Outreach). Therefore, the support workers often acted as a link between the individual and other services: *"[they] phoned people for me which was very helpful"* (Courts). This included Doctors, other health care providers and social services. The difference this made to people cannot be understated: *"Doctors – they spoke to them for me. I couldn't do it myself as I couldn't function. I wanted to die and I was planning my will"* (Outreach).

Participants also talked about the support workers signposting them to a range of organisations. This appeared to involve the support worker supporting the individual to access that support themselves: *"Took me to my appointments. If she did not do this I wouldn't have gone as I have anxiety and struggle to do these things alone"* (Outreach). In one example, a participant described how their support worker had helped them to contact drug and alcohol services and made it clear that they would not have done so without the encouragement received. This served as the catalyst for the individual to build their confidence and access a range of ongoing support and resources:

I am now working with the drug/alcohol service and have a good relationship with my support worker. From the support I have there, I built up the courage to attend my local Men's Club too. My support worker recommended a book around neurodiversity and alcohol use and I am identifying so much from this. If my worker from outreach hadn't pushed me to refer to this service, I wouldn't be getting all this on-going support to meet my needs (Outreach)

Participants also talked about their support workers providing practical support to help them develop wider opportunities for a better future. This included accommodation, and starting the *"ball rolling to get a flat"* (RECONNECT) and helping with a CV *"so I can look at employment when I feel ready"* (Outreach). Support workers helping to complete documentation was another form of practical help that was valued highly by people accessing the services.

In the court setting, reports written by L&D service staff were also praised and appreciated for helping people access positive outcomes and opportunities for their future: *"Your report to the probation after our conversation was very helpful in getting the result I needed to make positive changes in my behaviour and life"*. One service user was incredibly grateful to staff for *"setting me on the right path for healing"*.

Similarly, they also credited the service with them *"moving in the right direction with social services"* in relation to their children: *"I understand this is the one that will take the most time, but because of RECONNECT I am in a much better place with it than I was a few months ago"*.

4.2.3 Key areas for service enhancement

1. Promote it more as people don't know about it

Participants often talked about how they did not experience barriers themselves but highlighted that there may be barriers for other people. One of the main ones was that people may not be aware of the service, or how to access it: *"Well the only barriers are for people who do not know how to contact you or ask for help. The service needs to be more accessible so it can reach everyone who needs it"*.

There were calls for the service to be promoted so that more people could receive this type of help, especially as they felt had made such a difference to them: *"I had never heard of the service and it could be promoted more because it is so needed and helps a lot"* (Outreach).

As this participant explained, people may have reservations initially based on previous experiences: *"initially I thought 'this is just another service who will do nothing for me'. I am glad that this service was not like the rest and it has been amazing"* (Outreach).

There were broader concerns that previous or bad experiences can put people off accepting and engaging with support. One stark example discussed related to a nurse (from a partner organisation) who assessed an individual in custody and was not well-informed or understanding of mental health problems and neurodiversity:

The person who assessed [adult] in custody wasn't very kind...they were a nurse but did not acknowledge additional needs and told [adult] I were silly when they said they have bipolar. It is a miracle they even agreed for a case worker to come to the house because this initial experience really put them off. The people in custody need to be more sensitive and understanding if they want people to work with the service when they are in the community (Custody)

This example demonstrates the need to work with partner organisations to improve how they communicate with, and treat people, as this could hinder people's willingness to accept a referral and engage with L&D services, particularly if the individual is not aware that L&D is a separate/different entity.

It was also highlighted that people may be reluctant initially due to concerns about whether mental health challenges would lead to social services involvement and the possible implications for their children:

"I do think people with children are sometimes scared to accept help, especially about mental health as they are scared the children will get removed by social services" (Outreach).

2. *"Make sure that no-one goes without this service as it can be life changing"*

Service users also wanted the provision to be expanded so that more people could benefit from this type of support. The feedback here has obvious implications for staffing and attached resources.

The calls for *"more staff"* included more L&D workers, including peer support workers in prison, and support, time and recovery (STR) workers specifically. One response also suggested cover for workers if they are training or otherwise unavailable as they reported there had been times their support worker was unable to attend appointments with them.

For some, the only recommendation they had was for the support to last longer. Part of this was that people build up trust and a relationship with support workers, which took time: *"Just support lasting longer than 12 weeks"* (Courts). One service user with ASD found the short time frame of the support particularly challenging:

The service has stayed longer than they should have, and but I feel that the service is too temporary. [I] bonded with the worker which [I] find very difficult and [am] sad about [my] time with service coming to an end (Custody).

While some service users had commented on their support workers being able to help them access wider services (e.g., accommodation), this may be inconsistent across the service. Other service users reported wanting to be linked in with wider opportunities that could further support their futures, e.g., employment (*"Give me a job"*), a dentist, and housing (including permanent housing specifically): *"They said they think our services should have a direct link to housing"* (RECONNECT 2). Although it was recognised that might be challenging: *"My biggest issue is housing but this is a big ask for RECONNECT to cover"*.

L&D services could perform a link function with other services and organisations. For example, *"I would have appreciated advice around my legal situation, what to expect with sentencing etc."* (Custody). As the interviewer noted, L&D staff are not trained to give legal advice to people in custody, but there may be opportunities to work collaboratively with partners to address such issues.

4.2.4 Summary

Feedback was highly positive: most felt safe, informed, understood, and supported, and some developed plans and accessed additional services. Themes from surveys and interviews showed that users deeply valued the empathy, reliability, and genuine care provided by staff, including support workers with lived experience.

Support workers played a crucial role in helping people access healthcare, substance use services, mental health support, and practical needs like housing. Reports from courts about L&D services were highlighted as influential in achieving positive outcomes for service users.

Suggested improvements focused on greater promotion of the service, expanded staffing, longer support periods, improved partner-agency interactions, and stronger links to housing, legal, and wider community support.

4.3 Partner Feedback

Anonymous feedback was obtained from partner organisations working with both L&D and RECONNECT. Most staff in partner organisations that completed the survey had referred into the services (92%). Generally staff also reported that they understood the referral process (76%).

However, at 52%, fewer partners reported that they felt confident that they knew what the services had to offer. Only 36% indicated they had received training on what the services provide.

4.3.1 Barriers to referrals

Most staff in partner organisations (68%) reported they had offered a referral, but the individual had refused the support.

Service user reluctance

The majority responded to the follow up question about why the individual had refused.

The most frequent response was that the individual did not want the referral/did not want to speak to L&D. Within this, some partners highlighted that individuals may not give a reason: *"Some have just point blank refused the service"*. Others added that the individuals felt there was *"no point"*, and *"why bother"*. Related to this, one explained how time was also a factor as they did not expect to be there long enough to be seen: *"they stated they will be released before they get to be seen"*.

It was also highlighted that previous experiences could put people off being referred again: *"Previous engagement...did not feel beneficial"* and they had *"poor engagement in the past and [were] not supported"*. Other partners felt the referral was not required as the service user *"stated that they are already getting help so don't want it"* (in the community and/or through family) and so felt there would be nothing further to be gained from a referral to L&D: *"They said that they did not require any support - had all that they needed externally and with family"*.

One partner reported an individual's reluctance to be seen by L&D; yet a referral was still made due to mental health concerns. However, not needing support with mental health specifically was also highlighted by partner organisations (e.g., *"don't require mental health support"*) as a reason for not referring. It is important to highlight here that L&D is not just about providing mental health support, so there

is some need to look at how the purpose of the service is better communicated to partner organisations.

When service users were reluctant to be referred, one partner added they would encourage them to think about it. For those they had managed to convince, it had been beneficial: *"I have managed to convince some to see Liaison and Diversion and they have come out learning something from them"*. The suggestion that partner organisations are needing to 'convince' service users to be referred, again suggests that how partners communicate with people about being referred to L&D and the benefits of accessing the service are important.

Liaison and Diversion operating hours

Most staff from partner organisations that completed the survey (80%) reported that the availability of out of hours/L&D staff was a barrier to making a referral. This was also reflected in their open text responses. A clear concern for partners was the increased demand in custody compared to the provision available in that setting. Partners felt there were too few L&D practitioners meaning the practitioners were *"too busy"*.

Their working hours (Monday-Friday, 9-5) were contrasted with the 24-hour nature of custody, which was described as a *"missed engagement and opportunity"* for referrals: *"a shortage of practitioners as they get busy in custody and therefore cannot see all that are requested in a short workday 9-5, when police custody is a 24/7 facility"*.

The working hours of L&D practitioners also meant there was concern around mental health specifically, and a lack of support overnight: *“There are always mental health issues coming into custody throughout the night that we cannot deal with as there is no one to help deal with it”*. Considering these issues, it was generally agreed that a *“24-hour service would be beneficial”*. In the context of the busy workloads for L&D practitioners, one partner raised questions about how they prioritise who is seen first:

I find L&D helpful, although sometimes [they] tend to focus too much on individuals who are not that urgently needing assistance at the expense of those who are keeping quiet and definitely need assistance

Referral process

Feedback from partner organisations suggested that it is now taking longer for practitioners to see individuals *“since the service changeover with the lack of access to certain systems to gain information on detainees”*. Gaining the needed information for *“the referral process is not so much complicated but it is time consuming, it used to be much easier using the SUMS system to make the referral”*.

Partners felt that this slower process meant people could be waiting 4–5 hours to speak to a L&D practitioner, which hampered engagement. *“Lack of engagement”* by L&D practitioners was also framed in terms of

speaking to people through the hatch of the cell door which could mean that the individual assumes they are speaking with someone else from the police. As one partner described:

Often the detainee sees a pair of eyes through the hatch and thinks it's just a member of the police. Staff should be more proactive and either seeing people face-to-face or at least first contact should be having a door opened by custody staff so detainees can see who they are engaging with

There was also a suggestion to revisit the referral form due to the ‘RAG’ rating questions not adequately reflecting people’s situations:

for instance, [the form] says ‘has depression and anxiety but medicated’. There is no option for depression and anxiety but not medicated. Then you have suicidal in last 6 months, but no option for longer. Or says they are self-harming now, but no option for says they are going to self-harm

One final issue raised, and which perhaps highlights a discrepancy in understanding between L&D practitioners and some staff from partner organisations, related to the court process for people experiencing mental health challenges. One response to the survey questioned the understanding of L&D practitioners, commenting:

Liaison and Diversion practitioners in court do not understand the court process and therefore don't realise that just because someone is saying they have [mental health] problems, they still need to go before the court if the case has been listed. There have been instances when Liaison and Diversion have just said the individual needs to be taken away under a [mental health] order without having the charge put before the court

4.3.1 Positive outcomes

In contrast, two testimonies from solicitors expressed their thanks, gratitude and appreciation to L&D practitioners for their assistance in supporting service users for whom assessments of their mental health were needed in the court setting. As the excerpts below illustrate, the practitioners' involvement was described as vital in achieving the subsequent outcome for the individual:

[L&D] assessment and subsequent address to the court was crucial and made a big difference to the outcome that day. I would once again like to thank [L&D] for the invaluable help provided that day



[service user] refused to come into the court room today and this presented me with some difficulties as to how best to deal with the case in their best interests. If it was not for [L&D] assistance, I would not have been able to take the course I did, which was to deal with the trial without them being in the court room. The case proceeded today without the need for a further adjournment and resulted in my service user receiving a 2 year conditional discharge. Essentially, the outcome has resulted in my service user being returned to hospital to carry on with their treatment under Section 3 of the Mental Health Act

4.3.3 Summary

Overall, whilst most respondents had referred into L&D services, it was evident that not all partner organisations understood the services they offer, with most not receiving any training. This confusion sometimes led to potential referral opportunities being missed. A reluctance on behalf of the service users and the lack of clear guidance for partner organisation staff demonstrates the need for further work in this area.

Practical considerations like the operating hours of L&D and the system used for referring needs, also seemed to be a barrier for referrals, impacting both staff and service user experience of the service.

Despite this, it is clear, from court feedback that the service is valued and when service users feel able to engage L&D can offer the support needed.

4.4 Staff feedback

Health and Justice staff clearly have a strong understanding of the barriers to engagement as evidenced through the survey responses, the workshops and feedback. The following section details this feedback from staff under three headings:

- Barriers to engagement
- What we do well
- Suggestions for service improvement and addressing barriers

4.4.1 Barriers to engagement

Staff appeared to have a very good understanding of the barriers impacting engagement. One of the main issues reported by staff, and supported by previous evidence from service users and partner organisations was a lack of awareness or understanding about their services and the support available. Some staff felt that there was not enough promotion. Others also highlighted that the existing materials used to promote the services may not be accessible, attractive or easily understood by service users: *“much of the information provided to people such as leaflets/letters may not cater to both their reading age/comprehension and/or be appealing in design”*.

Several staff also identified challenges to contacting and keeping in touch with people, which included that people may not be able *“or ready”* to engage and then people are recalled to prison. It was emphasised that not everyone has phones, and for those that do, they may be unlikely to answer a withheld number out of concerns that it may be the police: *“for [neurodiverse] people, paranoid people, people who are fearful, it's police calling again on a withheld number etc”*.

Language barriers were also raised. A staff log of calls demonstrated some of the challenges with contacting/engaging with service users, with multiple attempts made and often going unanswered. Additionally, staff noted there are sometimes barriers related to memory issues and confusion, which impacts communication: *“[they] had no idea who I was, tried to explain many times and [they] continued to mix me up with lots of other people. Seemed quite confused”* and *“[service user] can't remember us, says has memory issues. Tried prompting but didn't get very far”*.

Staff highlighted that it can take time to build people's trust and confidence and that, for some service users, *“drug use impacts consistency”*. Staff empathised with people and understood that there can often be a lack of trust in professionals, and fear that they may be detained under the Mental Health Act, or that information would be shared with the police. It was explained that such concerns can mean people *“find it difficult to open up”*.

In addition, it was highlighted that service users may be given multiple appointments or be managing contact with different professionals and so *“need to prioritise”*. This was mentioned in relation to court, when time may be limited and the individual may focus on having time with their legal advisors. A lack of private space in some custody settings was also a barrier. In that setting, it was also highlighted that people may *“think we’re police”*: *“many service users assume that Liaison and Diversion is part of court rather than a separate NHS service which can impact engagement and subsequent feedback collation”*.

Communication between professionals and organisations was also suggested to be a barrier: *“Lack of knowledge and difficulty sharing information between professionals”*. For some staff, barriers with *“poor communication and management in HMP”* were mentioned. Here, sharing information was reported to be difficult and *“slow”*.

Staff indicated barriers from other services having *“insufficient understanding of the role and support that can be provided”*. One response described staff in the police also not explaining L&D documents properly to service users. This was also captured in the staff workshops, where it was highlighted that *“referrers are not clear about what we do”*. This is further evidenced from the partner organisations. In addition, it was noted that in their experience, police were not necessarily seeking consent for out of hours contact.

Practitioner reflections from time spent in custody also noted that police may not gain consent before making the referral:

Police don’t ask for consent as such – if they identify any risks within their risk assessment they will automatically put through a referral to L&D – it is then up to the L&D practitioners to talk to the client to see if they wish to engage in an assessment. Consent gained at this point

More broadly, staff felt that engagement was hindered by stigma and the lack of support on the wider determinants of health, such as the lack of housing, including people having no accommodation when leaving prison. It was acknowledged that such elements are beyond the control of the service, but it had a substantial impact on people then being able to engage in Health and Justice services:

If people’s basic needs are not being met, then of course they don’t have any patience or energy to expend on anything else – like mental health, work, addiction, etc.

services to support the most basic of needs such as stable accommodation, regular meals etc are scarce / have “closed the door” to individuals after multiple unsuccessful attempts to support

4.4.2 What we do well

Staff identified a range of positive aspects to their way of working. It should be acknowledged here that staff spanned different services across Health and Justice as well as different localities, therefore the findings may not apply equally to everyone.

Staff echoed the feedback from service users that, once someone is engaged, staff work well with them and provide person-centred *“adaptable and creative”*, trauma informed care that is flexible: *“when good contact is established – staff will be dependable and develop therapeutic relationships”*.

They also reported the importance of workers being *“transparent”* and *“honest”* with people and taking time to understand and work with service users to understand their needs and circumstances and to build relationships: *“being transparent with individuals, explaining our role and remit, listening to their experiences and validating their feelings and experiences”*. Placing the *“individual at the heart of it”* was important.

The dedication of staff came through in their responses, *“we are passionate and persistent with offering support”*, and *“the team will always try to engage an individual, to break down barriers and advocate for individuals”*.

Staff identified specific examples where they had identified ways to improve engagement with specific groups, including people with neurodiversity:

“Issuing neurodiverse fidget aids to very agitated service users”. For people experiencing digital poverty staff highlighted that their teams offer mobile phones to service users, for example, *“issuing mobile phones to service users to support engagement with services”*.

Outreach appointments were also identified as a positive aspect of the support, again mentioned by service users previously as a strength of the work Health and Justice services do. In addition, peer support workers were described as *“invaluable to the outreach team and to our clients”*. Staff with lived experience felt that drawing on their own experiences immediately helped build rapport with service users and supports previous findings.

In addition to the way of working, and again echoing the service user findings, staff reported the service works well in helping people to access further support for key areas including *“GP, Talking therapy and dental”*. Staff reported regularly providing referrals to onward support services, as well as providing material and information leaflets for services: *“Giving structured advice and access to onward support services”*.

Related to this, some staff also reported working well and collaboratively with other services and staff on behalf of an individual. One specific example was given by a court practitioner, explaining their team has a morning meeting, *“passing over service users from custody who are vulnerable”*

and that their team works well with HMP and other agencies, *“sharing information (with consent) around current vulnerabilities, engagement [and] plans”*.

A further element praised in some staff feedback related to the teamwork and support within their teams: *“we like to develop, we like to support staff and listen to new ideas”*. One team gave the example of running relevant training related to trauma informed care, motivational interviewing and solution focused therapy. In addition, learning from experienced colleagues also underpinned this example: *“we have weekly multi-disciplinary team where we discuss cases and challenges we experience at work. The meeting affords opportunity for support from experienced colleagues”*.

Another staff member described how within their team, they are always trying to learn more, to *“try to refine processes, and share knowledge in an agile way – e.g., using Teams Huddle functions to collate useful resources to access on the go”*.

4.4.3 Suggestions for service improvement and addressing barriers

Staff provided several suggestions for how *“gaining people’s confidence and trust”* could be strengthened, building on what already happens. Some practical aspects would improve the work they are already doing, for example providing a budget for coffee to allow practitioners and service users to chat together, seems logical and

would give them more time to get to know each other, understand their needs and build rapport. Contacting interpreters so that person has *“equal access to service provision”*, setting up a facility for automated reminders of appointments and ensuring all services can send text messages as well as/instead of ringing them were suggested (so they can see what suits the person best). Finally, *“expanding assessment to capture other social needs and interests”*, e.g., including housing.

Having more time with service users would also enhance their relationship and the support they can provide. For example, take the time to explain more to service users about what the service can and cannot do. Staff spending more contact days in prisons so that people become familiar with their names and faces over time *“let clients put names to faces”* and importantly, *“a longer period of interventions to allow trust to be built”*. The length of interventions was supported by service user feedback.

Court was described as a challenging environment where service users *“are often in a heightened state both before and after court”* which can present challenges for engagement with the service, and for obtaining feedback from service users about their experience. Concerns were raised from practitioners about seeking feedback from service users at that time. Therefore, further consideration is required about how feedback can be collected in this setting, and what type of feedback is required.

While having a QR code was also described as a valued and innovative practice to promote the service to people, it also felt *“inequitable to provide a QR code for feedback to be obtained due to a high number of people being in digital poverty”*. Developing a service user involvement strategy for each service type was suggested to collect feedback in a way that is equitable, feasible and realistic for that service, so that meaningful feedback is prioritised. Learning from the existing peer support workers was encouraged: *“get peer support workers together in a group to discuss what they feel works best and use this information to help with engagement”*.

Staff also suggested a notice board or similar: *“‘you said, we listened’ to feedback to service users that we are listening to their feedback and acting on it to help shape our services”*.

Whilst it was highlighted there is very little the service can do about the lack of housing and wider challenges people face, some suggestions were made to begin to address them: *“Collate evidence, and use to petition government, or to contribute towards other research happening – with organisations such as Shelter”* or *“employ a housing navigator full time on every outreach team”*. It was acknowledged that much of this goes beyond the scope of the Health and Justice service, and it has been highlighted as a priority area for service users.

When communicating about the support to service users make it clear that L&D are not part of the Criminal Justice System.

Suggestions at the staff workshop included have a clear visual difference, e.g., with their lanyards/IDs. It was also suggested to allow people to self-refer after release by giving them a plain language and clear letter, ensuring that plain language is used throughout, for example, simplifying posters/fliers, was recommended *“don’t use jargon and explain acronyms”*. Potentially having a short video that could give people clear and accessible information as well as via a QR code on an information sheet were suggested.

Further consideration of the language and terminology of ‘L&D’ and the extent to which that is understood and meaningful for service users would also help to give clarity. Within the court setting, staff reflected felt that:

“many service users don’t know what this means and how this can help them and therefore it is often easier and clearer to use terminology such as ‘mental health services’ and the like

Reflections from a practitioner from time spent in custody also echoed this, explaining that *“L&D still very much considered the mental health team within custody”*. However, that could lead to missed opportunities for referrals and engagement when other health needs other than mental health are identified. There were calls for more consideration and investment in hiring peer support workers across the services:

we need to promote more through hiring peers who are serving current sentences and can be employed to promote and get referrals. We also need to have more active peer support workers working within prison, not restricted to community

it was discussed that having a lived experience role within the courts, to act as a support/navigator role for service users who are being released would be extremely beneficial

Given that referrers may not be clear about what L&D do and the nature of support they provide, the staff workshop generated suggestions for how to address that. This included trying to better understand what people do and do not understand, and/or providing services with information about what the service does and does not do. Suggestions here included, written materials, meeting with services to clearly explain, and a short information video for referrers: *“continue with training around Health and Justice role to help police understand the impact of our service”*.

Taking this further, staff also pointed to a role for staff in terms of *“ongoing advocacy from the teams”* to bring together professionals for multi-disciplinary teams and *“holding other professionals accountable”*. In addition, sharing case study examples and *“setting up reflexive practice groups for Health and Justice staff”* was also recommended.

5. Summary and recommendations

Data collection

- Keep the focus on capturing service user, staff and partner feedback
- Address glitches with partner survey and include a question about which service they have interacted with
- Collect demographics for service user feedback
- Consistency with how staff and partner roles are described/captured
- Referral data/Power BI – there is a lot of ‘unknown’ data. Think about training around data reporting. Reducing the missing data would give a much more accurate picture of who is engaging.
- Consider appropriate ways to be able to obtain feedback from those not consenting to the referral. Approvals prevented this from happening for this project, but understanding the rationale from this group of people is very important and their feedback likely to be different to those consenting to the referral and disengaging later. For example, the need to further explore why such a high percentage of individuals; 64.5% did not consent to being referred into L&D.

Publicity

- QR codes to enable service users and partners to provide feedback; but also other methods i.e. paper and verbal feedback to account for digital poverty
- Simplifying leaflets and a video
- Consider hosting an event with police, courts, probation, SMS, housing etc. relating to ‘understanding L&D and

RECONNECT services'

- Getting staff with lived experience to support with a video
- Training to help police understand the role and impact of the service
- Making it clear that staff are part of an NHS service, separate to the police, when engaging with service users, e.g., wearing lanyards, clear face to face contact.

Further work with/training for partners

- Recommend further work with partners to improve their knowledge about what is provided and to clarify that it is about more than 'mental health'
- Improve their understanding of what L&D offer
- Support for those with neurodiversity and awareness, trauma support and to promote partnership working
- Share video about the service with partners and their teams
- Better understand the competing priorities of partner organisations and where possible align the support offered with partners to better support service users
- Further engagement with partners to review the RAG form and prioritisation process given partner feedback.

Practical considerations

- Building trust, and how to enhance work already being done, e.g., budget to buy service users coffee; more visible presence to build familiarity

- Further consideration is required about how feedback can be collected in court
- Linking into services like housing to give the for support service users to access some of the wider support needed

Longer term

- Consider service user strategy for each service
- Extending the length of intervention/support
- Increase the number of lived experience support workers
- Housing navigator in each outreach team
- Strategy targeting under 17s as they are less likely to consent to support
- Deep dive into different parts of the service to give a more detailed insight into different parts of the service and how they operate within their specific contexts, processes etc. to identify more specific recommendations for each
- Review the referral process and information sharing to ensure it is timely and streamlined.



6. References

- Belenko, S., Hiller, M., & Hamilton, L. (2013). Treating substance use disorders in the criminal justice system. *Current Psychiatry Reports*, 15(11). <https://doi.org/10.1007/s11920-013-0414-z>
- Bellis, M. A., Hughes, K., Ford, K., Sharp, C., & Hill, R. (2024). Associations between adverse childhood experiences and trust in health and other information from public services, professionals and wider sources: national cross sectional survey. *BMJ Public Health*, 2(1).
- Braun V, & Clarke V. (2013). Successful qualitative research: A practical guide for beginners. *Successful Qualitative Research*; 1–400.
- Braun V & Clarke V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol*. 1–25. doi:10.1080/14780887.2020.1769238
- Burch, E. and Rose, J. (2020). The subjective experiences of liaison and diversion staff who encounter individuals with autism. *Journal of Criminological Research Policy and Practice*, 6(2), 137–150. <https://doi.org/10.1108/jcrpp-11-2019-0067>
- Carswell, C., Noble, H., & Farrow, D. (2017). Barriers between offenders and primary health care after release from prison: a case study. *Practice Nursing*, 28(9), 386–389. <https://doi.org/10.12968/pnur.2017.28.9.386>
- Ford, K., Barton, E., Newbury, A., Hughes, K., Bezeczký, Z., Roderick, J., & Bellis, M. (2019). Understanding the prevalence of adverse childhood experiences (ACEs) in a male offender population in Wales: the prisoner ACE survey.
- Fox, C. (2008). A new approach to crime and justice. *Probation Journal*, 55(4), 405–406. <https://doi.org/10.1177/02645505080550040504>
- Goddard, D., Vries, K., McIntosh, T., & Theodosius, C. (2019). Prison nurses' professional identity. *Journal of Forensic Nursing*, 15(3), 163–171. <https://doi.org/10.1097/jfn.0000000000000239>
- Hean, S., Willumsen, E., Ødegård, A., & Åhgren, B. (2015). Weaving together different disciplinary perspectives in an exploration of integration between mental health and criminal justice systems in Norway. *International Journal of Integrated Care*, 15(5). <https://doi.org/10.5334/ijic.2078>

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., ... & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet public health*, 2(8), e356–e366.

Lennox, C., Mason, J., McDonnell, S., Shaw, J., & Senior, J. (2012). Information sharing between the national health service and criminal justice system in the united kingdom. *Journal of Forensic Nursing*, 8(3), 131–137. <https://doi.org/10.1111/j.1939-3938.2012.01138.x>

Office for National Statistics & National Centre for Social Research. (2022). Public Confidence in Official Statistics 2021. UK Statistics Authority. Retrieved from [ONS](https://ons.gov.uk)

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Services (Treatment Improvement Protocol (TIP) Series No. 57; HHS Pub. No. (SMA) 13–4801). Rockville, MD: Substance Abuse and Mental Health Services Administration

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances*, 24(5), 319–333.

Woodhouse, R., Neilson, M., James, M., Glanville, J., Hewitt, C., & Perry, A. (2016). Interventions for drug-using offenders with co-occurring mental health problems: a systematic review and economic appraisal. *Health & Justice*, 4(1). <https://doi.org/10.1186/s40352-016-0041-y>

Young, S., Adamou, M., Bolea, B., Gudjónsson, G., Müller, U., Pitts, M., ... & Asherson, P. (2011). The identification and management of adhd offenders within the criminal justice system: a consensus statement from the uk adult adhd network and criminal justice agencies. *BMC Psychiatry*, 11(1). <https://doi.org/10.1186/1471-244x-11-32>

Young, S., González, R., Fridman, M., Hodgkins, P., Kim, K., & Gudjónsson, G. (2018). The economic consequences of attention-deficit hyperactivity disorder in the scottish prison system. *BMC Psychiatry*, 18(1). <https://doi.org/10.1186/s12888-018-1792-x>

7. Appendices

Appendix 1

Statements included on the co-produced survey:

1. I have a really good understanding of what the service can do for me
2. I understand why I have been referred to the service
3. I feel comfortable and safe using this service
4. I trust the service to keep my information confidential
5. I trust the service to do the best for me
6. I feel confident that the service can help with the things I need
7. I have worked with someone in the service to develop a plan to meet my needs
8. So far, I am satisfied with how the service is trying to support me
9. The service had put me in touch with services that may be able to support me further

Appendix 2

Range of options on the co-produced survey to indicate 'Improvements or support which would be beneficial'.

- o Drug and alcohol support
- o Faster support after release from police station/prison
- o Housing
- o Mental health support
- o Information on the service and what it can do
- o Knowing what support is available to me
- o Access to neurodiverse clinics
- o LGBTQIA+ support/understanding
- o Financial support/support with debt
- o Physical Health
- o Stop smoking services
- o Information pack/phone numbers on what services are available
- o My carer/family member being involved
- o Healthy lifestyle resources
- o Help with using the internet
- o Using what I'm good at to help me
- o Help with adult literacy (reading and writing)

Appendix 3

Partner feedback survey questions:

1. Do you feel confident that you know what L&D service have to offer?
2. Do you refer into L&D services?
3. If not, why not?
4. Do you understand the referral process into L&D services?
5. Have you received training on what L&D provide?
6. Do you think any of these are potential barriers to making a referral? Please tick all that apply (from a drop down list)
7. Have you ever offered a referral and the individual has refused?
8. If so, did they say why?
9. Any other information?

Appendix 4

Summary of referral sources into the Liaison and Diversion service

Referral source	All cases - 7437		Consent – 2569			Non consent - 4791		
	n	% of all cases	n	% of consent	% from referral source	n	% of non consent	% from referral source
Adult L&D practitioner	111	1.5	56	2.2	50.5	55	1.1	49.5
Court referrals	437	5.9	203	7.9	46.5	234	4.9	53.5
Health service	13	0.2	6	0.2	46.2	7	0.1	53.8
Other	970	13.0	21	0.8	2.2	946	19.7	97.5
Custody referrals	5860	78.8	2258	87.9	38.5	3529	73.7	60.2
Youth referrals	3	0.0	1	0.0	33.3	2	0.0	66.7
Out of court disposal/diversion	1	0.0	1	0.0	100.0	0	0.0	0.0
Police Voluntary Attendee	16	0.2	7	0.3	43.8	9	0.2	56.3
Prison service	5	0.1	1	0.0	20.0	4	0.1	80.0
Self / family	20	0.3	15	0.6	75.0	5	0.1	25.0
Unknown	1	0.0	0	0.0	0.0	0	0.0	0.0

Note: Court referrals include: court cell detentions staff, court staff, judiciary/magistracy, other agency operating in magistrates court, probation services, solicitor. Custody referrals include police custody, police custody healthcare services. Youth referrals include: youth L&D practitioner, youth offending team

Appendix 5

Demographic details for gender, ethnicity and mental health overall and for those consenting and not consenting

	All cases - 7437		Consent – 2569			Non-consent - 4791		
Gender	n	% of all cases	n	% of consent	% of gender	n	% of non consent	% of gender
Male	4290	57.68	1856	72.2	43.3	2416	50.4	56.3
Female	1514	20.36	642	25.0	42.4	869	18.1	57.4
Non-binary	3	0.04	0	0.0	0.0	3	0.1	100.0
Unknown	1630	21.92	71	2.8	4.4	1503	31.37	92.2
Ethnicity	n	% of all cases	n	% of consent	% of ethnicity	n	% of non consent	% of ethnicity
White British	5423	72.9	1908	74.3	35.2	3447	71.95	63.6
Asian/Asian British	73	1.0	23	0.9	31.5	46	0.96	63.0
Black/Black British/Caribbean/African	74	1.0	17	0.7	23.0	57	1.19	77.0
Mixed/multiple ethnic groups	41	0.6	16	0.6	39.0	25	0.52	61.0
Other ethnic groups	57	0.8	11	0.4	19.3	45	0.94	78.9
Unknown	1769	23.8	594	23.1	33.6	1171	24.44	66.2
Age	n	% of all cases	n	% of consent	% of age	n	% of non consent	% of age
<17	825	11.1	139	5.4	16.8	676	14.1	81.9
18-19	347	4.7	121	4.7	34.9	223	4.7	64.3
20-29	1716	23.1	634	24.7	36.9	1065	22.2	62.1
30-39	2166	29.1	785	30.6	36.2	1360	28.4	62.8
40-49	1441	19.4	505	19.7	35.0	921	19.2	63.9
50-59	706	9.5	290	11.3	41.1	405	8.5	57.4
60-69	177	2.4	69	2.7	39.0	108	2.3	61.0
70-79	55	0.7	26	1.0	47.3	29	0.6	52.7
>80	4	0.1	0	0	0.0	4	0.1	100.0
Mental Health	n	% of all cases	n	% of consent	% of Mental health			
None	395	5.3	391	15.2	99.0			
Yes	2098	28.2	2079	80.9	99.1			
Unknown	4944	66.5	99	3.9	2.0			

Appendix 6

Demographics – gender by age group for those consenting and not consenting

Gender by age group	Consent				No consent			
	Male	% male	Female	% female	Male	% male	Female	% female
<17	109	5.9	24	3.7	438	18.1	74	8.5
18-19	82	4.4	33	5.1	104	4.3	45	5.2
20-29	459	24.7	159	24.8	505	20.9	188	21.6
30-39	564	30.4	198	30.8	645	26.7	243	28.0
40-49	345	18.6	147	22.9	428	17.7	214	24.6
50-59	218	11.7	67	10.4	211	8.7	83	9.6
60-69	54	2.9	13	2.0	63	2.6	18	2.1
70-79	25	1.3	1	0.2	18	0.7	4	0.5
>80	0	0.0	0	0.0	4	0.2	0	0.0

Appendix 7

Demographics of gender by ethnicity for those consenting and those not consenting

Age	<17	18-19	20-29	30-39	40-49	50-59	60-69	70-79	>80
Male consenting (not consenting)									
White British	88 (297)	52 (73)	345 (348)	406 (434)	249 (297)	158 (155)	39 (48)	19 (14)	0 (4)
Other ethnicities	2 (6)	3 (2)	17 (25)	21 (33)	6 (11)	0 (2)	1 (1)	0 (0)	0 (0)
Female consenting (not consenting)									
White British	16 (58)	28 (35)	121 (130)	155 (174)	112 (162)	48 (59)	10 (15)	1 (4)	0 (0)
Other ethnicities	0 (0)	0 (1)	8 (10)	3 (3)	5 (5)	0 (0)	0 (0)	0 (0)	0 (0)

Appendix 8

Summary of referral sources into the RECONNECT service

Referral source	All cases - 466		Consent - 437			No consent - 29		
	n	% of all cases	n	% of consent	% of referral source	n	% of non-consent	% of referral source
Community Offender Manager	42	9.0	40	9.2	95.2	2	6.9	4.76
Friends or Family or Self	139	29.8	126	28.8	90.6	13	44.8	9.35
Liaison and Diversion	21	4.5	17	3.9	81.0	4	13.8	19.05
Other not listed	13	2.8	13	3.0	100.0	0	0.0	0.00
Prison referrals	131	28.1	126	28.8	96.2	5	17.2	3.82
Other RECONNECT service	108	23.2	104	23.8	96.3	4	13.8	3.70
Proactive RECONNECT identification	5	1.1	5	1.1	100.0	0	0.0	0.00
Voluntary Sector	7	1.5	6	1.4	85.7	1	3.4	14.29

Note: Prison referrals include other prison or IRC staff excluding probation, prison offender manager, prison or IRC healthcare, prison or IRC substance misuse service

Appendix 9

Demographic details for gender, ethnicity and mental health overall and for those consenting and not consenting

	All cases - 466		Consent - 437			Non consent - 29		
Gender	n	%	n	% of consent	% of gender	n	% of non consent	% of gender
Male	254	54.51	246	56.29	96.85	8	27.59	3.15
Female	212	45.49	191	43.71	90.09	21	72.41	9.91
Ethnicity	n	%	n	% of consent	% of ethnicity	n	% of non consent	% of ethnicity
White British	226	48.50	216	49.4	95.58	10	34.5	4.42
Asian/Asian British	3	0.64	3	0.7	100	0	0.0	0.00
Black/Black British/Caribbean/African	3	0.64	3	0.7	100	0	0.0	0.00
Mixed/ multiple ethnic groups	4	0.86	4	0.9	100	0	0.0	0.00
Other ethnic groups	1	0.21	1	0.2	100	0	0.0	0.00
Unknown	229	49.14	210	48.1	91.70	19	65.5	8.30
Age	n	%	n	% of consent	% of age	n	% of non consent	% of age
<20	5	1.07	5	1.1	100	0	0	0.00
20-29	87	18.67	81	18.5	93.10	6	20.7	6.90
30-39	179	38.41	171	39.1	95.53	8	27.6	4.47
40-49	128	27.47	117	26.8	91.41	11	37.9	8.59
50-59	51	10.94	47	10.8	92.16	4	13.8	7.84
60-69	12	2.58	12	2.7	100	0	0	0.00
>70	4	0.86	4	0.9	100	0	0	0.00
Mental Health	n	%	n	% of consent	% of mental health			
None	223	47.85	198	45.3	88.79			
Yes	243	52.15	239	54.7	98.35			

Appendix 10

Demographics – gender by age group for those consenting and not consenting

Gender by age group	Consent				No consent			
	Male	% male	Female	% female	Male	% male	Female	% female
<20	5	2.0	0	0.0	0	0.0	0	0.0
20-29	47	19.1	34	17.8	3	37.5	3	14.3
30-39	88	35.8	83	43.5	1	12.5	7	33.3
40-49	64	26.0	53	27.7	4	50.0	7	33.3
50-59	28	11.4	19	9.9	0	0.0	4	19.0
60-69	12	4.9	2	1.0	0	0.0	0	0.0
>70	2	0.8	0	0.0	0	0.0	0	0.0

Appendix 11

Demographics of gender by ethnicity for those consenting and those not consenting

Age	<20	20-29	30-39	40-49	50-59	60-69	>70
Male consenting (not consenting)							
White British	0 (0)	25 (3)	45	37 (3)	13	5	0
Other ethnicities	0 (0)	0 (0)	1 (0)	1 (0)	0 (0)	0 (0)	0 (0)
Female consenting (not consenting)							
White British	0 (0)	18 (1)	40 (2)	25 (10)	7 (0)	0 (0)	1 (0)
Other ethnicities	0 (0)	0 (0)	6 (0)	2 (0)	1 (0)	0 (0)	0 (0)

Appendix 12

Service user feedback demographics

Survey sample (n=22)

Gender	n
Female	5
Male	13
No response	4
Total	22

Ethnicity	n
White	4
White British	12
White/mixed Caribbean	1
White mixed British	1
No response	4
Total	22

Service type (file name)	n
Courts	4
Custody	4
RECONNECT	9
Outreach	5
Total	22

Age groups - Age range = 14 – 60 years

Age groups	n
13 – 19	1
20 – 29	2
30 – 39	4
40 – 49	3
50 – 59	3
60 – 69	2
70+	0
No response	7
Total	22

Appendix 13

Service user feedback

- “I feel comfortable and safe using this service”
 - o Everyone agreed
 - 19 strongly agreed, 3 agreed
- “I trust the service to keep my information confidential”
 - o Everyone agreed
 - 16 strongly agreed, 6 agreed
- “I have a really good understanding of what the service can do for me”
 - o 20 people agreed
 - o
 - 16 strongly agreed, 4 agreed
 - o 2 neither agreed nor disagreed
- “I understand why I have been referred to the service”
 - o 20 people agreed
 - o
 - 16 strongly agreed, 4 agreed
 - o 2 neither agreed nor disagreed
- “I trust the service to do the best for me”
 - o 20 people agreed
 - o
 - 15 strongly agreed, 5 agreed
 - o 2 no response
- “I feel confident that the service can help with the things I need”
 - o 19 agreed
 - o
 - 15 strongly agreed, 4 agreed
 - o 1 neither agreed nor disagreed
 - o 2 no response
- “So far I am satisfied with how the service is trying to support me”
 - o 18 agreed
 - o
 - 14 strongly agreed, 4 agreed
 - o 2 neither agreed or disagreed
 - o 2 left no response
-
- “The service had put me in touch with services that may be able to support me further”
 - o 19 agreed
 - 13 strongly agreed, 6 agree

- o 1 neither agreed nor disagreed
 - o 2 no response
-
- "I have worked with someone in the service to develop a plan to meet my needs"
 - o 19 agreed
 - 15 strongly agreed, 4 agreed
 - o 2 no response
 - o 1 disagreed (discussed below)