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# Prison Health Discharge Planning – Evidence of an Integrated Care Pathway or the End of the Road?

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*Improvements in offender healthcare are key to the current UK Government's reform of the criminal justice system and the aims of reducing reoffending and protecting the public. Current approaches to offender health care emphasise the importance of 'continuity of care'. Reference to the 'offender health pathway' suggests the existence of seamless delivery and experience of care; however, evidence suggests these remain some way off. This research explores prison health discharge planning in four North East prisons and uncovers elements of good practice, but also a number of challenges the prisons continue to face in their attempts to improve clinical pathways for prisoners being released or transferred, including institutional, staffing and prisoner issues. These challenges need to be acknowledged and addressed if robust discharge planning and continuity of care at the end of the offender health pathway is to be achieved.*

**Keywords:** Prison health, discharge planning, continuity of care, offender health pathway.

## Introduction

Prison health discharge planning is key to the current UK Government's reform of the criminal justice system and the aims of reducing reoffending and protecting the public. *Breaking the Cycle: Government Response* argues '[o]ur priorities are to get offenders off drugs and alcohol for good; address offenders' mental health problems; get offenders into work; and reduce barriers to resettlement' (Ministry of Justice, 2011: 6).

Prison discharge planning and continuity of healthcare is an important part of the offender health pathway (from arrest and prosecution to sentence, including prison and release) given the widely recognised link between offending, reoffending and wider factors, including health (Social Exclusion Unit, 2002). However, issues around prisoner health are substantial, and every stage of the offender health pathway is problematic as prisoners tend to go from a state of poor health in the community, to limited and patchy custody diversion schemes (Dyer, 2012), to limited healthcare in prisons, to problematic prison discharge planning, and finally to poor health when released back into the community.

Offender pathways, such as Farrington's (1992) criminal careers, have a beginning, a middle and an end. They can be straight or winding; can 'bifurcate', as per Complexity Theory (Dyer, 2011); and take one route or another depending on what does or does not happen along the way. Offender pathways have a destination, and it is useful to explore

what positive ending we are aiming for (essentially an end to criminal behaviours) and what can get in the way or lead us 'off track'.

The Government acknowledges that in order to achieve the aims of reducing reoffending and protecting the public, barriers to resettlement must be reduced. In terms of the offender health pathway, a substantial barrier is the discharge planning process itself. Despite this, much of the current focus of offender health policy concentrates on the start of the criminal justice pathway, in particular around the concept and practice of custody diversion for mentally disordered offenders at police or court stage (Bradley, 2009; Ministry of Justice, 2010; HM Government and Department of Health, 2011), with little detail about the end of the pathway, prison release and resettlement. It is this part of the pathway that the majority of this article will concentrate on, before returning to the broader picture in the discussion section.

### **Policy context**

Prisoners experience poorer levels of health and wellbeing compared with the general population. Over 80 per cent of prisoners smoke (Prison Health Policy Unit and Task Force, 2002). Almost 25 per cent of prisoners report having injected drugs, and of these 20 per cent have Hepatitis B and 30 per cent have Hepatitis C (Prison Health Policy Unit and Task Force, 2002). Male prisoners, in England and Wales, have higher rates of sexually transmitted diseases compared with the population as a whole. Prisoners are fifteen times more likely than the general population to be HIV positive (Stewart, 2007). According to the Office for National Statistics study (Singleton *et al.*, 1998), 90 per cent of prisoners have a mental health problem. Approximately 10 per cent of prisoners will self-harm during incarceration with the likelihood increasing with the length of time in custody (National Institute for Clinical Excellence, 2004; Ministry of Justice, 2011). To add to the complexity of the problem, the health needs of offenders are often multiple and overlapping. For example, the same offenders often have mental health and substance misuse problems, and substance misuse issues and communicable diseases (Williamson, 2007). Evidence indicates that older prisoners in particular experience health issues and health inequalities (Prison Reform Trust, 2003; North East Offender Health Commissioning Unit, 2010). An HM Prison Inspectorate Study (1999–2000) found that 85 per cent of older male prisoners in the project sample reported at least one chronic illness or disability, with common conditions including mental health issues, cardiovascular problems, musculo-skeletal problems and respiratory conditions (HM Inspectorate of Prisons for England and Wales, 2004).

In the last decade there has been an increased awareness of the need to improve prison healthcare to address a number of historical weaknesses in policy, practices, processes and structures. Despite progress being made, there remain a number of issues to address in order to improve healthcare and to overcome an historic focus on acute services which respond to short-term problems, rather than interventions designed to address longer term public health-related priorities (Viggiani, 2007). In particular, there remain concerns that the quality of pre-release planning continues to be variable, requiring improvement to be effective (Williamson, 2007; Fazel and Baillargeon, 2010).

The transition from prison to the community is particularly fraught with problems (Meehan *et al.*, 2006; Pratt *et al.*, 2006; Farrell and Marsden, 2008; Hartfree *et al.*, 2008; Sainsbury Centre for Mental Health, 2008; Lennox *et al.*, 2012) and a range of negative

health outcomes are associated with prison release. For example, prisoners recently released from prison are eight times more likely to commit suicide than the general population (Pratt *et al.*, 2006; Sainsbury Centre for Mental Health, 2008). Accidental overdose is also an issue post-release from prison. A meta-analysis of studies into deaths of prisoners up to 12 weeks after release identified an increased risk of drug-related death among ex-prisoners. These risks remains elevated until at least the fourth week after release (Farrell and Marsden, 2008; Merrall *et al.*, 2010).

Issues around prison release and resettlement are long-standing. In 2005, the House of Commons Home Affairs Committee in its *Rehabilitation of Prisoners* report argued:

[t]he Prison Service's efforts to date regarding resettlement of prisoners have been very much ad hoc. . .when prisoners are released, social services and community support agencies are far from pro-active in identifying them, and indeed there is evidence that prisoners are actively deprioritised. (106–107)

Attempts to improve prison release have included the introduction of the UK cross-government National Reducing Re-offending Delivery Plan (National Offender Management Service, 2005) which outlined a commitment to improving resettlement across seven pathways as identified by the Social Exclusion Unit's report *Reducing Re-offending by Ex-Prisoners* (2002). Pathways include: accommodation; skills and employment; children and families; finance, benefit and debt; attitudes, thinking and behaviour; drugs and alcohol; and health. In relation to health, the focus has very much been on offender mental health, which reflects priorities in terms of the size of the prison population with mental health problems, links with reoffending and protecting the public (HM Government and Department of Health, 2011), but has meant the development of physical health pathways, chronic or acute, and often co-morbid with mental health issues, has been neglected. The Offender Mental Health Care Pathway (Department of Health and National Institute of Mental Health in England, 2005) aimed to provide guidance for practitioners and commissioners in order to meet the needs of offenders from arrest to prison release, and includes sections on sentence planning, pre-release healthcare planning, unplanned release, prison transfers and aftercare.

Specifically in relation to continuity of healthcare during transfer and release, the Care Quality Commission and Inspectorate of Prisons report that Primary Care Trust (PCT) commissioners of prison healthcare 'should particularly address the continuity of prisoners' health care during transfer and release, which is inadequate and seems to be getting worse rather than better' (2010: 4).

Similarly, in relation to prison health discharge planning in particular and offender health pathway management in general, the recent Department of Health consultation document *Our NHS Care Objectives: A Draft Mandate to the NHS Commissioning Board* states:

The Government aims to promote community safety by ensuring that offenders of all ages can access health and social care services, appropriate to their needs, and in line with standards set for the rest of the population. [T]here is scope to ensure that offenders' health and wellbeing needs are met by improving the transition from custodial to community healthcare services. (2012a: 25)

## **Project - Mapping the Clinical Pathway from Prison Healthcare to Community Healthcare**

This project was commissioned by the Head of Healthcare at two North East prisons, and the North East Offender Health Commissioning Unit, as part of a health needs assessment and audit of current service delivery. It was designed to support the development of an effective clinical pathway for inmates across the North East prison estate. Continuity of care is concerned with the quality of care over time and can be viewed from the perspective of either patient or provider. This project focused on continuity in the delivery of care (rather than the experience of care). From a provider perspective, the focus is on models of service delivery and improved patient outcomes (Gulliford *et al.*, 2006). The aim was to explore current prison health discharge planning practice, identify gaps and weaknesses and suggest recommendations for improvement.

Four prisons were included in the study: a male high security dispersal prison, a male category B local prison, a category C male training prison and a category C and D male resettlement prison.

### *Method*

This study used a qualitative exploratory design, including a literature review to contextualise the research and to provide a benchmark for subsequent findings, and interviews and focus groups with seventeen key staff responsible for the development and delivery of pathways. Interviewees worked in a variety of healthcare, discharge or transfer roles, and included Heads of Healthcare and health-care staff: GPs, nurses, nursing assistants and healthcare support workers, members of the Mental Health In-Reach Teams, pharmacy and CARATs (Counselling, Assessment, Referral, Advice and Throughcare) staff. The interviews explored existing institutional discharge and transfer policy and practice; their effectiveness at ensuring equivalence of care; the strengths and weaknesses of current pathways arrangements; and possible improvements and priority areas where improvements are most needed.

Interviews were conducted face to face or by telephone. Where possible, interviews were recorded. When security requirements prevented recording, notes were made and written up immediately afterwards. The problems with recording mean that the data are presented without quotations. The focus of the data was on release from prison but, of course, this meant that the health situation of prisoners while in custody also needed to be considered.

### *Findings*

Overall, the findings described a mixed picture. Each of the four prisons demonstrated areas of good practice; however, all faced challenges in the delivery and management of clinical pathways; and finally each exhibited a commitment to improve clinical pathways where necessary. Challenges were a result of institutional issues, including the requirements of prison operation and security, the extent of collaborative working and the historical legacies of healthcare services and approaches; staffing issues which included available time and resources; and prisoner issues, each of which is discussed in more detail below.

### *Strengths*

Following publication of the National Reducing Re-offending Delivery Plan (National Offender Management Service, 2005) and identification of the seven resettlement pathways described earlier, health pathway-related activities were informed across all prisons by the publication of Prison Service Order (PSO) 3050 (HM Prison Service, 2006), also supported by the annual publication of the Department of Health *Prison Health Performance and Quality Indicators* (Department of Health, 2012b). PSO 3050 places an obligation on prisons to ensure continuity of care. For those being released, the order requires prisons to help inmates to register with a GP; complete relevant paperwork to secure exemption from prescriptions charges; arrange follow-up appointments in the community; provide information about GP practices, walk-in centres, NHS Direct and drug treatment provision in areas immediately local to the prison; and ensure that prisoners with significant mental health problems are referred to Community Mental Health Teams when required.

Furthermore, PSO 3050 stresses the need for prison healthcare staff to liaise with community-based healthcare providers to identify appropriate referral routes and ensure an appropriate pathway is created between prison and community healthcare provision. To comply with Order 3050, healthcare staff should also liaise with staff responsible for securing accommodation for offenders on release if inmates have an on-going health issue.

This study found that in order to comply with Prison Service Order 3050, prisoners across all four North East prisons had a healthcare appointment wherever possible, prior to release or transfer, with either a nurse or GP. The precise timing of this appointment varied between prisons but generally took place on the day of, or several days prior to, release or transfer. Prisoners being released were provided with a written summary of their medical needs and treatments to present to their community-based GP and were provided with details (sometimes verbal) of other relevant community-based services such as walk in centres and pharmacies. Prisoners taking medication were given a supply of medication sufficient to last until they could access community-based provision.

There were examples of good practice in all four prisons in relation to the management and delivery of discharge planning. There had been a recent improvement in patient monitoring as a result of the introduction of 'SystemOne Prison', an electronic patient data software package. SystemOne is a national prison healthcare IT system which as of April 2011 was installed in all prisons and young offender institutions across England. It enables healthcare staff to more accurately capture, store and retrieve patient details to inform the creation and management of appropriate clinical pathways for released and transferring prisoners.

Management of clinical pathways and discharge planning has also been improved across the four prisons by the introduction (or planned introduction) of specialist clinics or staff roles to better monitor prisoners and plan for the release of prisoners with a range of conditions including asthma, diabetes, heart disease and epilepsy. The male high security dispersal prison had plans to supplement specialist clinics with the creation of Chronic Disease Managers, who will co-ordinate the care and clinical pathways of prisoners with chronic conditions.

The data highlighted the importance of collaborative working across professions and organisations in supporting the delivery of clinical pathways. Respondents believed

that clinical pathways for prisoners released into Multi-Agency Public Protection Arrangements (MAPPA), designed to monitor and support violent and sexual offenders, tended to be well developed, with healthcare staff linking with community providers to ensure that prisoners can access and attend provision post-release, in line with the conditions of their MAPPA arrangements.

The findings from the research also illustrated the importance of collaborative working, beyond MAPPA, to achieve effective discharge planning and clinical pathways, particularly for patients with more serious, on-going and/or chronic conditions. Across the four North East prisons, healthcare staff (working with others within and outside their prisons) planned the release or transfer of inmates with more serious, on-going conditions at an early stage whenever possible, developing links with community-based providers several weeks in advance to organise post-release care. Planning could involve face-to-face meetings and visits to prisons by community-based services. Prisoners with complex needs were also moved to prisons closer to their release address when possible. Based on information available on SystemOne, the category C male training prison had developed a new document for prison transfer, containing details of prisoner's health needs, which is sent to the receiving prison prior to the prisoner's arrival, to enable the receiving prison to better plan care in advance.

The proportion of inmates without a fixed address on release is significant (though this did vary substantially between institutions). However, some types of prisoners (e.g. those released under MAPPA arrangements and/or with chronic conditions) generally had a fixed address or hostel accommodation. It was therefore possible for healthcare staff to contact community-based providers to make appointments for these prisoners and provide them with the information they needed to attend, or for hostel staff to assist released prisoners to access community health services.

The project also identified evidence of health-promotion activities in each of the prisons studied. However, the extent of these activities varied and possible improvements to health promotion are discussed below.

### *Challenges*

Despite the examples of good practice identified above, the findings clearly pointed to a number of challenges the prisons continue to face in their attempts to improve clinical pathways for prisoners being released or transferred. Challenges occur at an institutional, staffing and prisoner level and were often mutually reinforcing.

At the institutional level, the factors discussed above which were helping prisons to create effective clinical pathways were balanced by other factors making their creation more difficult. For example, the male high security dispersal prison releases very few inmates and transfers relatively small numbers of prisoners at any one time. In theory, this should offer an ideal environment in which to create effective clinical pathways, being less pressured and allowing staff the time to focus on individual cases. However, in practice this potential was often compromised because of security-related transfers, which could occur very quickly and without warning, so that healthcare staff had little or no time to organise a transfer package.

Issues around the time available to create a clinical pathway for prisoners were also experienced by the busy Category B local prison. This prison experienced a rapid turnover



of inmates, many of whom it held for very short periods, giving staff little time to plan for discharge or transfer, and making it difficult to ensure that all prisoners were discharged in line with all PSO 3050 requirements.

Also at the institutional level, prison regimes and resources could make the creation of effective clinical pathways difficult. Respondents reported that balancing access to healthcare with a range of other institutional priorities (including work, mealtimes, recreation and the separation of vulnerable and 'normal location' prisoners) limited the time that was available to healthcare staff to spend with prisoners to develop clinical pathways. In addition, at one institution the delivery of the Integrated Drug Treatment System (IDTS) absorbed a substantial amount of healthcare time and resources, further reducing capacity potentially available to develop clinical pathways.

At the staffing level, a lack of institutional level management and coordination left some staff feeling unsupported. Individual staff appeared to have a clear understanding of the need to develop appropriate clinical pathways; however, several felt that more institutional-level guidance and strategic management would help to ensure standardised institutional approaches to the management of these pathways.

In addition, each institution had previously struggled, to varying degrees, to recruit and retain a full roster of healthcare staff, and a small number of posts remained unfilled at the time of this research. This made a focus on proactive discharge planning more difficult by increasing caseloads and decreasing resources. Limited resources meant that staff tended to focus on reacting to emergency or un-planned situations. In addition, the capacity of secondary mental health services (In-reach teams) appeared to be particularly pressured in the high security dispersal prison and the category C training prison.

The patient information system (SystemOne), and the introduction of other processes into the prison environment, such as the Care Planning Approach, have supported improved information management and information sharing. However, the data suggested that staffing levels, the number of functional departments within prisons, and time constraints, mean that integration and information-sharing between healthcare and other prison departments could sometimes be informal and fragmented. Consequently, at times inmates were transferred or left prison without some of the staff involved in their treatment being made aware or contributing to their on-going care. Furthermore, despite the introduction of SystemOne, patient records were still occasionally incomplete, with important details not entered onto the database and therefore not accompanying transferring prisoners.

Several interviewees expressed concerns that individual staff working in prison healthcare tend to have generic roles, rather than have expertise in one or a small number of specialist areas. This lack of specialism is linked to prisons having only relatively small numbers of inmates with a particular condition, resulting in there being little rationale for employing specialist staff. However, a lack of specialism can result in staff having weak links to sources of external information, expertise and knowledge. In addition, lack of knowledge can result in staff requiring the support of colleagues which, in turn, prevents the latter from focusing on other issues, including discharge planning. For example, mental health staff are often required to advise on prisoners mental state, as non-mental health staff felt they lacked the knowledge to judge this themselves, when perhaps with further training, information and guidance, non-mental health staff could have a greater role in identifying problems and triaging patients, consequently freeing-up mental health specialists to focus on discharge planning for those prisoners with a

mental health need. Concerns were also raised about knowledge gaps around a number of chronic conditions, including coronary heart disease. These issues may result in staff failing to engage appropriately with inmates with these conditions, with implications for development of appropriate release and transfer planning.

In terms of inter-agency working, healthcare staff regularly liaise with community-based services to develop clinical pathways for released prisoners, and that this can support effective discharge planning and clinical pathways. However, partnership working with community-based agencies is not always straightforward. It can require several phone calls to successfully contact community-based staff with whom to discuss transfer of care, although in many cases healthcare staff do know who to contact and community services respond positively to requests from prisons to engage with prisoners as they are released. The main challenge for healthcare/mental health staff is the time it takes to contact the right individuals/teams within the community organisations and develop working relationships. This problem is further complicated for two of the prisons involved in this research because they release their inmates nationwide which requires staff to develop links across Britain.

At the individual-prisoner level, healthcare staff reported that some inmates lack an interest in their health or the motivation to engage with healthcare in prison or in the community to address their health issues. This can often be linked to a perception that they have no alternative to a life characterised by re-offending and imprisonment. Lack of engagement from inmates results in it being extremely difficult to identify their healthcare needs and thus establish appropriate clinical pathways for these inmates. Linked to engagement and motivation are difficulties facing those inmates who do wish to act upon health promotion information they receive and make positive choices. Aspects of the prison regime (such as food and access to the gym) may make it difficult to follow advice about eating healthily and taking exercise, despite healthcare and gym staff working together to provide a care package to inmates whenever this is possible. A substantial proportion of inmates have no fixed address upon release, making it extremely difficult for these inmates to register with a GP. As was noted in the introduction, it is very difficult for healthcare staff to create a pathway for these inmates, as they cannot provide them with details of local GPs and services as they do not know where these inmates will live upon release. However, for those inmates who do know the general area they plan to live following release, staff are able to provide information about local services, even if they cannot make GP appointments for them.

## Discussion

The offender health pathway and particularly continuity of care along the pathway is important because: offenders in general suffer poorer levels of health; health problems are often associated with public health issues, offending, re-offending and a revolving door of imprisonment and short-term ineffective service use. The identification of health issues at any point during contact with the criminal justice system offers an opportunity for treatment; and best efficacy and outcomes result from uninterrupted treatment and support (Brooker and Ullman, 2008, 2009; Fazel and Baillargeon, 2010). To improve prison health discharge, pathways require changes at institutional, staffing and individual levels. It is to these issues we now turn.

Current policy relating to offender health care encourages us to think about it in relation to ‘continuity of care’. Reference to the offender health pathway suggests the existence of a seamless delivery and experience of care. However, evidence (both from this project and wider research, for example Williams, 2009; Lennox *et al.*, 2010, 2012) points to the contrary, organisations continue to work in silos; or where there is evidence of inter-agency working, episodes of care during contact with the criminal justice system are themselves treated as silos with minimal if any links with the next part of the pathway. For example, the provision of healthcare at police stations, issues around custody diversion and support for offenders with mental health problems at court and prison healthcare are in the main treated as discrete periods within which care must be provided, issues considered and problems resolved, but between which there are few links made (Peay, 2007, 2010; Dyer, 2012).

This project identified evidence that prison healthcare staff were aware of the difficulties caused by working in silos and recognised the importance of continuity of care. However, pressures of time, staffing and competing institutional demands, a lack of ‘specialism’, the complexity of community services and a potentially large geographical resettlement area meant that developing links between prison and community healthcare providers was not always straightforward or successful.

Addressing problems with links between prison and community is important because, in the same way that hospital discharge planning aims to prevent local hospital re-admissions (Balaban *et al.*, 2008; Jack *et al.*, 2009; Shepperd *et al.*, 2010), continuity of care, as supported by prison health discharge planning, could play an important role in the aim to reduce re-offending or prevent the revolving door of prison release and re-arrest for those whose offending behaviour is associated with their health issues (House of Commons Home Affairs Committee, 2005; Centre for Mental Health, 2011). However, in terms of health care provision, the prison environment is unique. A key issue identified by this research project is that health care professionals working in prisons must work within the bounded reality dictated by wider institutional process and practice.

That said, there are a number of recommendations (supported by interviews undertaken for this project and wider research, e.g. Fraser *et al.*, 2009) prison healthcare commissioners and providers could consider, including supporting staff to develop community links by encouraging specialist interests and areas of expertise, condition-related clinics and clinical pathways targeted at key conditions. At an institutional level, implementation of a ‘whole prison’ approach would mean that health-related discharge and transfer planning becomes the responsibility not only of healthcare, CARATS and In-Reach Team staff, but also personal officers, prisoners themselves, prisoners’ families and external organisations delivering healthcare. This is an important approach, particularly for those with dual-diagnosis who may need the input of multiple services and therefore require multi-agency coordination and cooperation. Planning for discharge would become a central and therefore a shared responsibility, beginning at the point of reception and ending with a standardised approach to health-related discharge planning including the development of effective pathways for prisoners who are released outside of the prison’s geographic region. This might also include greater recognition of the role the Probation Service could play, for those offenders who are released into probation supervision, in linking offenders up with health services in the area that they are released into. At the prisoner level, introduction of the ‘whole prison’ approach might also include improved institutional health promotion which may help individuals engage proactively

and better understand their own health issue, and activities they might undertake to support their own health. This in turn may encourage prisoners to care about their health and wellbeing, and engage more positively with staff, pre and post prison release.

These changes might improve prison health discharge planning but not necessarily solve the problems surrounding continuity of care across the offender health pathway from arrest to sentence. This is the real challenge, and one possible solution has been offered in relation to the management of offender mental health. 'Care Management' is a role Bradley (2009) envisaged the new Criminal Justice Mental Health Teams (essentially more comprehensive custody diversion schemes) would undertake. He argued 'The importance of ensuring continuity of care should not be underestimated . . . [however] . . . Continuity can be greatly compromised by the number of different agencies that the offender may need to pass through' (2009: 133). There is no one person currently responsible for looking at, taking charge of and coordinating the 'bigger picture'. The new teams would therefore:

be responsible for ensuring continuity in an individual's mental health care when they are in contact with the criminal justice system. . . drawing together all the complex threads of a person's care from a diverse range of agencies (including criminal justice system and voluntary sector sources). The team would also have an overview, through periodic reviews of a person's case, to identify potential gaps in service provision. (2009: 135)

Such an approach to Care Management would help tackle the key difficulties in discharge planning encountered by prison health staff in the study of North East prisons. Care Managers would have an overview of the individual offender health pathway, including the services and support necessary to meet health needs. They would provide a 'single point of contact' for prison health staff, and be responsible for identifying community links and co-ordinating inter-agency working and a seamless transfer of care. So the introduction of Criminal Justice Mental Health Teams could be particularly beneficial at the point of discharge from prison.

While there is evidence to support positive outcomes of Care Management (Jarrett *et al.*, 2012), it is not clear if this recommendation will be adopted by the national network of 101 local Liaison and Diversion services (Criminal Justice Mental Health Teams) set up in June 2011 by the current Government. However, this 'Care Management' role is one which could be extended to include all offender health issues, including physical health, mental health, learning disability and substance misuse. A number of roles already exist which might have fulfilled this function, including: Care Programme Approach (CPA) care co-ordinators (mental health complex care); case managers (general health complex care); key workers (health and social complex care); and offender managers (management and supervision of punishment and rehabilitation for those serving a community order or prison sentences of twelve months or more). However, these services do not appear to bridge the health/criminal justice pathway.

This research explored prison health discharge planning in four North East prisons and uncovered a number of challenges the prisons continue to face in their attempts to improve clinical pathways for prisoners being released or transferred, including institutional, staffing and prisoner issues. These challenges need to be acknowledged and addressed if robust discharge planning and continuity of care at the end of the offender health pathway is to be achieved. Introduction of the 'whole prison' approach' or Care Management could improve health outcomes by ensuring that people do not return to the community with

health problems equal to, or greater than, those that they faced when they first entered the criminal justice system, and consequently potentially impact on the risk of re-offending.

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