**Accessing and engaging with primary healthcare services following discharge from forensic secure services: the perspectives of service users and mental health practitioners**

By Emily Samuels1\* and Nicola Moran1

1International Centre for Mental Health Social Research (ICMHSR), Department of Social Policy and Social Work, University of York, York, YO10 5DD, England, U.K.

\*Correspondence to: emilysamuels@hotmail.com

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Biographies:

Emily Samuelsis a mental health social worker in Forensic Services. She provides psychosocial interventions to individuals who are transitioning from custody to the community. Emily started her research journey as part of her postgraduate degree with the University of York and Think Ahead and hopes to continue contributing to the growing body of research in the field of forensic mental health.

Nicola Moran PhD is a Research Fellow at the International Centre for Mental Health Social Research at the University of York, England. Nicola is a qualitative social science researcher with almost 20 years’ experience of research in health and social care. Nicola has worked on projects across the UK, Europe and the USA. Much of Nicola’s work focuses on evaluations of new interventions in health and social care. Her research interests are primarily around mental health, unpaid carers, and criminal justice.

**Accessing and engaging with primary healthcare services following discharge from forensic secure services: the perspectives of service users and mental health practitioners**

**Abstract:**

*Purpose:*

Physical health inequalities and mortality rates are higher amongst individuals with severe mental illness (SMI), including among forensic populations, than the general population. This study explored the experiences of individuals accessing primary healthcare following discharge from secure services, and the practitioners who support them.

*Method:*

Face-to-face qualitative interviews were conducted with service users (n=4) and mental health practitioners (n=4) within a forensic community mental health team in one NHS Trust in England in 2019. Data were analysed using Interpretative Phenomenological Analysis.

*Findings:*

Four super-ordinate themes emerged: perceived importance of physical health, agency, responsibility and relationships. Service users mostly saw themselves as passive recipients of healthcare and prioritised their mental health over their physical health. Close working relationships meant that mental health practitioners were often the first contact for service users with any health issue and thus felt a sense of responsibility for their physical healthcare. Service users who did access primary care reported that consistency of professional, feeling understood and listened to without judgement or stigma were important.

*Originality:*

This study highlights some of the unique challenges in forensics around improving physical health outcomes for individuals with SMI.

*Practical implications:*

Interventions for service users that include practicalities and strategies to facilitate independence in physical health care, and collaborative working between primary care and forensic mental health services, are encouraged.

**Keywords:** physical health, SMI, forensic mental health, accessing primary healthcare, service user, practitioner

**Article classification**: Research paper, empirical research.

**Introduction**

Forensic mental health services provide care and support to individuals with severe mental health illness (SMI) and a history of criminal offending (NHS, 2021). Individuals who are receiving treatment from forensic services are likely to spend a significant amount of time in secure hospitals with data reporting an average length of stay of 10 years in England (Sampson *et al.,* 2016*)*. Mental health professionals in secure hospitals are encouraged to take a proactive approach for assessing physical health and promoting physical health interventions with their patients (Haddad *et al*., 2016). However, when deemed mentally well enough to be discharged, individuals face the task of recovery and reintegration into society. A central feature of this is the reclamation of autonomy and control over their lives, including increased independence in looking after their own physical health, such as accessing and engaging with primary healthcare services such as the General Practitioner (GP).

The physical health of individuals discharged from forensic inpatient services is a particularly relevant consideration due to the premature mortality rate of those with SMI who are likely to die, on average, 15 to 20 years earlier than the general population (World Health Organisation, 2018). Of all the causes of this mortality gap, suicide is among the less common; excess mortality is predominantly the result of physical health conditions such as cardiovascular, respiratory or malignant disease (Ashworth *et al.,* 2017). For example, a meta-analysis found that, compared to a matched general population, patients with SMI have a 53% higher risk for having cardiovascular disease (CVD), a 78% higher risk for developing CVD, and an 85% higher risk of death from CVD, which helps to explain the shorter life expectancy of those with SMI (Correll *et al*., 2017). Crucially, these deaths are often both premature and preventable; NHS England’s Mental Health Taskforce (2016) highlighted that for people with SMI, two in three deaths are from physical illness that can be prevented. Indeed, research indicates that excess mortality due to physical health conditions in people with mental illness increases over time, despite overall advancements in healthcare (Erlangsen *et al*., 2017). Increased recognition of this relationship has led to mental health services beginning to address or advocate for the physical health of their service users (O’Donoghue, 2021).

The relationship between mental and physical health is multi-faceted. Ashworth *et al.* (2017) highlight several risk factors such as smoking, lower levels of exercise and obesity that detrimentally impact on health and subsequently increase the rates of physical health conditions which are exacerbated or perhaps even instigated by medication. Moreover, the common co-occurrence of SMI and substance use can leave individuals with serious mental illness at increased risk of infectious diseases (Hughes *et al.*, 2016). A systematic review by Carney *et al*. (2021) similarly found relatively poor physical health among young people in inpatient units compared to the general population. Behavioural risk factors for physical health conditions can also vary by mental health diagnosis (Firth *et al*., 2019). Even when compared to the general patient population, those with SMI ‘are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease’ (Public Health England, 2020).

Factors specific to the forensic inpatient environment include low vitamin D levels (Every-Palmer and Souter,2015) linked to too little time outdoors, diet, limited options for exercise and effects of medications. Low vitamin D levels have been associated with a range of long-term conditions such as diabetes, cancer and cardio-vascular disease. Further, the weight of evidence suggests that those on antipsychotic medication are at clinically significant risk of reductions in bone mineral density which contributes to osteoporosis and increased susceptibility to fractures (Crews and Howes, 2012).

Research by Ivbijaro *et al*. (2008) tested the efficacy of introducing primary-care into inpatient services to help combat poor physical health and found that the GP service within the inpatient service achieved its targets on the majority of clinical indicators. Moreover, the study concluded that primary care professionals are best placed to monitor the physical health of patients with SMI. This links to DE Hert *et al.*’s (2011) explanation that SMI patients can be less capable of caring for themselves and interpreting the physical signs of ill health, therefore the responsibility can fall on the mental health workers who can be the only link SMI patients have with health services in the community. Tyler *et al.* (2019) highlighted that the transition from inpatient to community services was an especially vulnerable time period, laden with additional risks to an individual’s wellbeing, and that continuity of care was important. However, they did not explore the challenges around physical health and healthcare.

A study that did focus on physical health outcomes after discharge (Fazel *et al*., 2016) highlighted the unacceptably high mortality rate and proposed that factors such as poor access to physical health services, poor insight from patients and stigma stemming from professionals and wider society could contribute to the high levels of physical illness. Whilst the importance of developing strategies for reducing risk were emphasised, there was no unpicking of individual experience which could be fundamental to the development of effective strategies. Moreover, it was proposed that the forensic population is no different to the general psychiatric population. However, this finding is in opposition to the discourse around ‘recovery’ in the forensic mental health community which appears to be particularly complex. Simpson and Penney (2011) summarise the forensic population as having ‘unique rehabilitative needs’. For example, individuals are often laden with an ‘offender-patient’ status and this idea of being ‘forensically labelled’ can increase exposure to stigma (West *et al*., 2015; Livingston and Rossiter, 2011). Moreover, Livingston and Rossiter (2011) identified that forensic labelling can create situations where people feel powerless, devalued and oppressed. Social supports and networks become limited, individuals are less able to connect with their community and therefore their capability to access primary healthcare services diminishes.

Studies in non-forensic settings have also found that patients with SMI require a different approach than the general population to looking after their physical health. For example, van Hasselt *et al*.’s (2013) qualitative study with service users and carers identified a lack of structural collaboration between mental health practitioners and GPs and SMI patients’ difficulty in identifying and expressing physical health needs. Similar systemic barriers were identified by Schmutte *et al.* (2009) who ascertained perceptions of service users from both an inpatient and community perspective. In addition to such systemic barriers, participants expressed limited knowledge and self-efficacy regarding their physical health outcomes. A powerlessness in improving their health pervaded the results as an important psychological barrier. In both of the above studies however, service user experience appeared to be situated within the context of non-specialised mental health services. Mezey *et al*. (2010) explored perceptions of recovery with individuals in a forensic psychiatric service and whilst physical health was identified as a domain of recovery, along with social inclusion, autonomy and self-esteem, there was no direct focus on physical health. Whilst discharge from secure hospital was identified as a potential destabiliser, we are left to speculate about the impact this might have on physical health outcomes and, crucially, the experience of individuals within forensic services.

To begin to address the high mortality rates, to improve the quality of physical health and to contribute to an individual’s overall ‘recovery’, the specific experience of individuals who have been discharged from forensic inpatient services and are labelled as ‘offender-patients’ needs to be understood, with an explicit focus on physical health. Therefore, this study sought to explore the experiences of service users accessing and engaging with primary health care when transitioning from secure services to the community. As responsibility for physical health can often fall on the shoulders of mental health professionals who can be the only link with physical health services (DE Hert *et al*., 2011), the study also sought to understand the experience of practitioners involved in supporting service users’ access to primary healthcare services. The research question was thus two-fold: ‘What are the experiences of service users accessing primary health care when transitioning from forensic secure services to the community?’ Additionally, ‘What are the experiences of mental health professionals who support service users’ access to primary health care services?’

**Methods**

*Research design*

The study utilised a qualitative research design to explore the views and experiences of service users and practitioners and generate rich data (Denzin and Lincoln, 2011). Interviews were semi-structured with a topic guide allowing for the same core questions to be asked of all participants whilst including scope for them to raise other issues they felt relevant (Taylor *et al*., 2015). Interviews were conducted face-to-face, rather than by telephone, in order to build rapport with a potentially vulnerable group being asked questions on a sensitive subject (Irvine, 2011).

*Eligibility and recruitment*

The sample consisted of mental health practitioners working within a forensic service in one NHS Trust in England and service users from the same service. The service consisted of 72 staff members and approximately 250 service users, including both those living in the community and those transitioning from inpatient settings. To be eligible, service users had to have been living in the community for at least three months following discharge from a medium secure hospital to give them some time to have transitioned into community living, and practitioners had to confirm that they felt the service users were well enough to take part and were not at risk of recall to hospital - again to ensure as far as possible that they were stable in their recovery. Practitioners were eligible if they worked in the forensic service and had experience of supporting multiple service users during transition from inpatient to community settings and supporting service users to live in the community. All participants had to be at least 18 years old.

Practitioners were introduced to the study via the researcher attending team meetings and distributing information sheets.  A recruitment email and study information sheet were also circulated to the team via admin. The first stage of recruitment focused on service users. Practitioners were asked to identify service users who met the criteria for the study. Practitioners were asked to utilise their professional judgement and that of the multi-disciplinary team around the person to make decisions on the suitability of the service user in terms of mental health and risk of recall. Service users were provided with an information sheet by their practitioner which indicated that those wishing to find out more about the study should contact the researcher whose details were included. Service users could instead complete a consent to contact form which was returned to the researcher via the practitioner. Four service users volunteered to participate.

Practitioners were invited to contact the researcher directly if they were interested in taking part themselves. Four practitioners volunteered to participate.

*Procedure*

Upon being contacted by a potential participant, the researcher discussed the study with them and invited questions. A time and date for the interview was then agreed. Interviews took place in a private room at the team community base or, where appropriate, at the homes of service users, with the researcher following the Trust’s lone-working policy. Participants were required to sign a consent form.

Topic guides were informed by the literature, conversations with the clinical lead of the forensic service and discussions at a physical health forum for forensic services. The topic guide for service users gathered information about their physical health and included questions such as: ‘If you were to have worries about your physical health, what steps would you take and who might you contact?’; ‘What are the differences in your physical health care since being in the community in comparison with being in hospital?’; ‘How able do you feel to carry out the advice that you may have received about your physical health?’. Practitioners were asked questions such as: ‘Can you tell me about any experiences you have had supporting service users in the community to access primary healthcare services such as the GP?’; ‘What do you think are some of the barriers for service users accessing these services?’ and ‘How able do you feel to have conversations about physical health with the individuals you support?’. Pilot interviews were conducted and the topic guides tweaked accordingly. The pilot data was not included in the analysis. Data were collected in spring/summer 2019.

Interviews were audio-recorded (with consent) and transcribed and anonymised by the researcher. Interviews lasted approximately 60 minutes.

*Ethical implications*

The researcher was employed as a social worker within the same forensic team and thus practitioners may have been concerned that confidentiality could be compromised. The recruitment materials emphasised that the research was being undertaken as part of a University Master’s degree and the researcher was acting in their role as Master’s student. It was also made clear that all responses would be fully anonymised and participation would be confidential.

To maintain the confidentiality of service users’ personal data during recruitment, practitioners were asked to identify eligible participants from their caseloads and provide them with the information sheet. Practitioners were not made aware of which individuals took part in the study. Further, service users from the researcher’s own caseload were not approached. Service user participants thus were not known to the researcher and practitioner participants were colleagues of the researcher based in different buildings and were not close colleagues. To ensure there was no undue influence in participating, participants were reminded at the start of the interview that participation in the study was voluntary, would have no impact on their employment or the services they received now or in the future, and that all information given would be anonymised and kept confidential unless there was a disclosure of harm.

It was acknowledged that participants could become distressed during the interview and thus they were informed that they could withdraw from the study at any point. During the interview, signs that the participants were becoming distressed were monitored and the opportunity to pause or stop the interview would have been made available if required. If a disclosure of harm to self or others was made, confidentiality would have been broken and relevant professionals alerted. This was made explicit in the information sheet and consent form for both practitioners and service users.

Study approvals were granted by an NHS Research Ethics Committee (ref: 19/WA/0098), the NHS Health Research Authority (IRAS ID: 256451) and the local Trust research and development office.

*Data analysis*

Data was analysed using Interpretative Phenomenological Analysis (IPA) which offers a systematic approach to understanding the lived experience of participants (Smith, 2004) in relation to the wider social, cultural and contextual context (Larkin *et al*., 2006). IPA requires that the researcher closely engages with the minutiae of the accounts produced by each participant before general claims can be made (Smith and Osborn, 2007) and focuses on the interpretation of meaning within its context. During analysis notes were added to each transcript under colour-coded headings - descriptive, linguistic and conceptual - starting with descriptive analysis and moving to interpretative analysis (Reid *et al*., 2016). Emergent themes from each transcript were identified. To assist interpretation and check potential researcher bias, a sample of transcripts was analysed by the two researchers working independently and reflecting on their own perceptions (Smith, 2004); additional emergent themes were identified, and discrepancies were discussed and resolved. Finally, a structure illustrating relationships between themes in each transcript was developed and a list of quotes per theme was established and re-read. The narratives were analysed across all transcripts and written up (Larkin *et al*., 2006). Pseudonyms were allocated to preserve anonymity.

**Results**

*Sample*

Eight interviews were conducted with four service users living in the community following discharge from a forensic medium secure inpatient hospital and four practitioners working in the forensic community service. The practitioner participants were community psychiatric nurses (n=2) and support workers (n=2) who had worked in forensic services between two and six years. The service user participants had been living in the community between three and twenty years. No relevant differences were observed between service user participants who had been living in the community for longer or shorter periods of time.

*Findings*

Four super-ordinate themes emerged from analysis of the data, though not all themes emerged for both service users and practitioners: perceptions of the importance of physical health (service users and practitioners); agency (service users); responsibility (practitioners); and relationships (service users and practitioners).

*Theme 1: Perceptions of the importance of physical health*

Practitioners described how physical health appeared to be a relatively low priority for service users.

*‘They’ll say “I will do it” [register/go to the GP] and then they might say “I forgot”, or “I couldn’t be bothered.”’ (Mike, practitioner)*

Helen, another practitioner, described her experience of service users trying to barter with her when it came to visiting the GP which suggests that their intrinsic motivation to look after their physical health was low.

*‘[They say] “if you give me a lift and take me somewhere else afterwards I’ll go” [and I remind them that] actually the goal is that you’re checking in on your physical health for yourself, not for the staff member asking you to.’*

Helen appears to be describing a balancing act that she tries to manage, with the potential risk to the service user’s health if GP visits are not maintained (and thus the pull to engage in negotiation with the service user) on one side and the perhaps longer-term risk to the service user’s physical health if such negotiation encourages the service user to perceive their physical health as less important in its own right.

However, whilst there appeared to be a level of recognition of physical health amongst service users, mental health remained a priority:

*‘If it was physically [a physical health concern], I would try and manage it myself and just get on with it. I’m most concerned about my mental health.’ (Mark, service user)*

The importance of physical health was apparent only in relation to the role it played in keeping service users mentally well. The fear of mental illness was portrayed as more prominent than fears of physical health problems. Stacey, a service user, highlighted her fears of relapsing. The repetition of the word ‘horrible’ emphasises her aversion to this.

*‘I wouldn’t like to be mentally ill again or relapse. I don’t like being ill. It’s horrible, horrible it is. If you’ve suffered it then you know what it feels like.’*

Practitioners noted that concern for physical health among service users increased in relation to the side-effects of psychiatric medication, particularly when this involved weight gain:

*‘Identity I think is an issue – people looking at themselves, people can show you pictures and say that used to be me and you’re thinking ‘I can’t recognise them’…. people attribute the drugs that we give them with causing raised blood pressure and people to put on weight. They are rightly concerned about that.’ (Mike, practitioner)*

Helen, a practitioner, highlighted the significant impact of secure mental health care on an individual’s physical health and noted how physical health can plummet down the list of priorities in the face of acute mental health care:

*‘If you’re acutely psychotic and potentially a risk to others, the main goal is going to be reducing that psychosis … that means no leave off the ward, so minimal exercise …you’re drugged up to the eyeballs with stuff that increases your appetite and you can’t move and you’re fed four times a day and people’s weight balloons.’*

Helen’s use of emotive imagery i.e. ‘drugged up to the eyeballs’ foregrounds the intense experience of being in an acute hospital and the dramatic physical change that individuals can experience. Helen described an unrelenting set of imposed structures and limitations which prove to have lasting effects on people’s physical health. She explained the difficulty of managing risk and severe mental health difficulties whilst protecting physical health:

*‘In forensic mental health the risk is so great. Sometimes you see extreme measures to manage mental health, but it has such devastating impacts on physical health which carry on potentially for the rest of people’s lives. It’s really hard to find a balance without neglecting physical health.’*

*Theme 2: Agency*

Service users described how primary-care services would take an active role in initiating contact with them. Stacey explained how she would attend the GP surgery whenever ‘*they write to me or phone me’* and Mark commented that ‘*they usually phone me when I need to go’.*

It appeared rare that service users would take an active role in seeking support from their GP. Their language in the interviews was structured with a passive voice that revealed the accepting and compliant nature of the exchange. This was also evident in how they talked about their contact with the mental health team. For example, Nigel, who more readily voiced his physical health concerns to the mental health team, still took a back-seat:

*‘You cooperate with the [mental health] team, get their advice.’*

The word ‘cooperate’ illustrates the lack of agency Nigel perceives himself to have. It also demonstrates the significant amount of trust held in the mental health team. In response, practitioner participants described some of the strategies used to facilitate access and engagement with primary healthcare services. For example, Helen reported using graded exposure approaches. She described her process of increasing responsibility and confidence:

*‘If they’re not sure how to set up an appointment I’ll do it with them a couple of times… and then next time I’ll say, ‘you have a go now with me here and see how you get on.’’*

*Theme 3: Responsibility*

Practitioners in the mental health team had conflicting perceptions of their role, in terms of the extent to which they perceived their duty of care to extend to physical health and also how this could be balanced with facilitating service users’ independence. Helen described her experience of practitioners identifying more closely with mental health, often to the detriment of physical health needs:

*‘It’s something that can be overlooked in mental health with the attitude of “I didn’t come into mental health to do physical health.”’*

She also highlighted a particular tension between promoting independence with service users and ensuring physical health is attended to:

*‘It’s a difficult balance between shoving our views on people as opposed to what they want to do. There’s no nice way to go about knocking on someone’s door and saying “we’ve noticed that you’ve put on a lot of weight and you’re really unfit, come and have a walk”.’*

Mike highlighted the importance, for him, of acknowledging his professional limitations. He agreed that practitioners should have responsibility for holistic care however emphasised:

*‘I think we need to understand that we’re not experts in the field, GPs are …I still say ‘get to your GP and go regularly.’’*

Mike described an experience with a service user who was supported to go to the GP for physical health checks and was diagnosed with cancer. Through use of an elongated pause, he hints at the serious consequences for the service user’s health, in this instance, if mental health practitioners had carried out checks and not shared them with the GP:

*‘But if we, who were not physical health professionals had not advised her to go to the GP and had just done routine blood tests and hadn’t necessarily shared those with the GP and just done them as an exercise… [dramatic pause]’*

Similarly, another practitioner, Ben, noted the importance of ensuring that somebody kept abreast of physical health complaints:

*‘We had to bring a guy off medication because it was affecting his heart. He wouldn’t have got it done [attending the GP for physical health checks] you know, he could have easily had a heart attack.’*

*Theme 4: Relationships*

Service users emphatically described the positive relationships they had developed with their General Practitioner.

Rosie highlighted the trust she had in her GP and the importance of being open about her mental health and forensic history.

*‘There’re no secrets between me and my GP, she knows why I was at [forensic inpatient hospital], she knows what I’ve done, she knows what I go through… she needs to know certain things…there’s no point someone trying to look after me that doesn’t know things about me… she needed to know that I self-harmed.’*

Nigel explained that he felt able to be open with his GP because of the consistency of seeing the one doctor:

*‘I wouldn’t like to keep on sharing my problems or what I’m saying to everybody.’*

It is important to highlight that all service users were able to see the same GP for a number of years. Therefore, consistency was highlighted as an important factor in the development of a positive relationship. Mark highlighted that this familiarity allowed for the development of trust in the GP:

*‘I’ve been with him for so long like he knows my symptoms and everything.’*

Rosie explained the adjustments her GP surgery had made to ensure her experience was manageable:

*‘If I can’t wait in the waiting room, if it’s too busy or if there are loads of kids jumping around and it’s causing me too much anxiety, I can go to the receptionist and the doctor will actually come and get me.’*

Moreover, the relationship she developed became so important to her that being able to stay with the same GP was a factor when she had to move house:

*‘When I found out I had to move I was getting upset because I thought I was going to lose my doctors.’*

However, a disproportionate focus on risk in other primary-care services could have a detrimental effect on a service user’s likelihood to engage. Rosie described a negative experience when being escorted to a general hospital from a psychiatric hospital due to physical health concerns. She attributed her poor treatment to being identified as a ‘mental health patient’ and recalled being asked invasive questions about her risk history: *‘Why are you in hospital? What have you done?’* This led Rosie to declare:

*‘I would rather go for a year, back into [forensic inpatient hospital] and spend a year [as opposed to going back to general hospital].’*

This provides an insight into Rosie’s experience of stigma from her offender-patient label. Such a sense of distrust can arise, and the stigma and sense of risk can be magnified and misconstrued, without effective communication between services, as illustrated by practitioner Helen:

*‘We are managing risk, but then the sense of stigma and the sense of paranoia and risk escalates because of maybe a miscommunication.’*

Such stigma could be a barrier to an effective working relationship. Mike, a practitioner, recalled experiences whereby GPs seemed unnerved by the level of perceived risk:

*‘The GP feels that there’s too much risk or has asked, ‘Will you sit in with us?’ because they’re frightened that the patient might ‘kick off’.’*

Forensic practitioners thus highlighted the importance of building up relationships with primary care practitioners and services:

*‘It’s nice to be all singing from the same hymn sheet… informing and working with primary care as to the nature of the clients we work with.’ (Ben, practitioner)*

In addition, practitioners highlighted the long-term relationships that they were able to develop with service users due to the enduring support and involvement of forensic services:

*‘You are a constant part of their lives a lot of the time.’ (Paul, practitioner)*

The importance of this relationship was evident for service users who reported that the forensic team would often be their first port of call if they had concerns about their physical or mental health:

*‘My team, my nurse, my doctor – they’re good to me, they solve things, sort things out for me you know.’ (Nigel, service user)*

The words ‘solve’ and ‘sort things out’ elicits a sense of trust Nigel has in his mental health team to effectively deal with concerns he might have. However, it again highlights the passivity and subsequent lack of agency. Moreover, Paul, a practitioner, described an occasion whereby a service user who had concerns about his physical health only seemed comfortable in approaching the mental health team:

*‘One of our guys turned up here one day, said he wasn’t feeling great, could he see one of our doctors… he had travelled up from [place name] because he did not want to go to his GP, he wanted to come here.’*

The possessive pronoun ‘our’ in ‘our guys’ highlighted the close working relationship between practitioner and service user; it suggests a paternal approach to care and evokes a sense of responsibility for the service user.

**Discussion**

Within existing literature, poor physical health for people with SMI has in part been attributed to decreased health awareness (DE Hert *et al*., 2011; Fazel *et al*., 2016). In the current study there appeared to be a general recognition of physical health and its importance. However, the majority of service user participants expressed that their priority was their mental health and their concern or motivation to act increased when physical health issues were at risk of compromising mental stability. Therefore, it is important to instead consider ‘decreased health awareness’ specifically in relation to the forensic context.It appears that balancing mental and physical health is a difficult task; practitioner participants highlighted that when managing risk was at the forefront of treatment, physical health could often be compromised. This was due to side-effects of antipsychotic medication and the limiting factors of inpatient environments; the impacts of which appear hard to shake following discharge into the community. It is understandable that service users who are subject to legal conditions imposed by the Ministry of Justice and those who are aware of the risk of returning to secure inpatient hospital if they should relapse are likely to place a higher importance on their mental health.

Furthermore, the findings demonstrate how service users often perceive themselves as passive recipients of healthcare. It is possible that the barrier may be poor insight into their own agency and increase in autonomy following discharge not, as Fazel *et al*. (2016) suggests, poor insight about the need for physical health care. The findings build on those by Schmutte *et al*. (2009) who outlined an underlying sense of powerlessness expressed by participants; the ability to improve physical health was seen as beyond their control and in the hands of others. Crucially, Schmutte *et al*. (2009) noted that any effort to improve physical health will need to address self-efficacy as a foundation. The findings of the current study show promising evidence of practitioner participants’ attempts to increase the confidence and facilitate the independence of service users. They acknowledge that many of the practical elements involved in accessing a GP such as registering, making an appointment, travelling to the surgery and waiting for appointments can be difficult and overwhelming. Overcoming such obstacles appears to have been most effective when practitioners empowered service users using a graded exposure approach.

It is apparent that mental health practitioners feel a sense of responsibility for the physical healthcare of individuals living in the community following discharge from secure hospital. This reflects O’Donoghue’s (2021) assertion that mental health services have taken on some responsibility for addressing the physical health of their service users. Whilst there is a danger that this sense of responsibility will inadvertently lead to the continued passivity of service users, there is an acknowledgement within the findings that this provision of holistic care has its limitations and should not replace the input of primary healthcare services. This supports Ivbijaro *et al.* (2008) whose findings highlighted that primary care professionals are best placed to monitor the physical health of those with severe and enduring mental health difficulties.

Positive relationships with primary healthcare services such as the GP are important for ensuring ongoing access and engagement for service users. The particular components of the relationships that were identified as helpful included consistency of seeing the same GP; feeling able to be open about forensic history without judgement; and feeling understood and listened to. This echoes the findings of Birkhauer *et al.* (2017) who highlighted that patient outcomes and quality of life were significantly improved when service users had higher levels of trust in the working relationship. However, consistency in seeing the same GP might be difficult to achieve considering the decline in relational continuity: for example, the number of patients able to see their preferred GP in England fell by 27.5% between 2012 and 2017 (Royal College of General Practitioners, 2019). However, this is an example of where effective communication and coordination between mental health and primary care services could be especially useful. An open dialogue between the services could allow for information sharing and an understanding of the importance of relational continuity with this particular population.

The study highlighted how, despite being registered with a GP, service users depend primarily on mental health practitioners who are often their first port of call for any health issue. This echoes DE Hert *et al.*’s (2011) findings that responsibility does often fall heavily on the shoulders of mental health workers who will be the sole link to health services. The forensic service can often remain a constant source of support throughout turbulent periods of significant transition for the service user. Understandably therefore, it is clear how service users develop a level of trust with their mental health team that can be hard to replicate with primary care services that are unfamiliar. Whilst in the short-term this allows mental health practitioners to ensure physical health checks are complete, this could hamper the long-term journey to recovery for service users. The idea of recovery, as Mezey *et al.* (2010) outline, centres around reintegration into all levels of society, regaining independence and ‘simply being able to lead an ‘ordinary’ life’ (p.687).

This has been made more difficult with Covid-19 and the restrictions placed on face-to-face contact. More mental health care has moved to telehealth or virtual meetings (O’Donoghue, 2021) which makes it more difficult for mental health practitioners to monitor physical health and support service users to increase their physical activity and also for patients to see a GP. Concerns around physical health for this population will be further increased for those experiencing long Covid.

The findings also demonstrate that stigma and misconceptions of risk were a barrier for access and engagement as outlined by Fazel *et al.* (2016). This is also in support of West *et al.* (2015) and Livingston and Rossiter (2011) who highlighted how the experience of being ‘forensically labelled’ could increase the likelihood of service users being subject to stigma and discrimination. It is apparent that without effective communication between services, the sense of risk surrounding those with an ‘offender-patient’ label can be magnified and misinterpreted which can have a detrimental impact on a service user and their likelihood to engage with primary healthcare. In fact, the ability to be open about one’s forensic history and still feel accepted, heard and understood by the healthcare professional, proved to be especially powerful. The delicacy of the situation requires that primary-care and forensic mental health services are conscious of the role that they must each play in order for the access and engagement of service users in primary care to be productive and physical health outcomes to be improved.

*Limitations*

Given that this was a qualitative study with a small sample size and participants all recruited from the same forensic service, the results are not representative. However, the findings do illustrate the experiences and issues raised by a sample of practitioners and service users around looking after physical health needs following discharge from a secure hospital into the community.

The potential for researcher bias was an important consideration. The researcher worked within the same service and, although none of the participants were involved professionally with the researcher, participants could potentially have felt the need to censor or restrict their responses. Furthermore, whilst due effort was taken to ensure participation was voluntary, some pressure to participate could have been perceived by service user participants as they were informed about the study by their practitioner.

In an attempt to ensure service users were stable in their mental health to minimise any distress arising from the interview, service users were only eligible if they had been living in the community for at least three months. Consequently, the study was not able to explore the perspective of service users who were newly discharged and in the midst of transitioning to the community; this could be an area for further research. In addition, future research could seek the perspectives of primary healthcare professionals who may provide care and treatment to service users who have been discharged from forensic secure services. Future research could also explore whether the findings would have the same emphasis on the priority of mental health over physical health if recruitment to the study was via physical, rather than mental, health services.

*Implications for forensic practice*

* The positive relationship between service user and mental health practitioner should be used to facilitate service users’ long-term independence in checking and managing their physical health. Practitioners need to hold an awareness of the psychological barriers the population are likely to experience, including a pervasive sense of powerlessness and a struggle to assimilate an increase in agency that may accompany discharge from an inpatient environment. In order to address this, appropriate self-efficacy enhancing interventions could be explored, which may include fixed-term interventions that utilise graded exposure approaches.
* Changes at the system level in service structure, delivery and culture must also be facilitated (Firth *et al*., 2019). For example, it is clear that the perceptions of risk attached to those with the label ‘offender-patient’ can be detrimental; and negative experiences can make it unlikely that individuals will be motivated to engage in services that are hostile or noticeably wary. Therefore, it is important to ensure that primary-care services and practitioners who are supporting service users with a forensic history receive an adequate amount of information, support and guidance. This could include thorough summaries which feature accurate and up-to-date risk assessments, a named point of contact in the forensic service and introductory consultations with service users and forensic service staff. It is important to include all staff in the primary care setting who are likely to communicate with service users, including administrators and receptionists who should be involved in information sharing and have access to relevant training.

**Conclusion**

This study sought to understand the specific experiences of forensic service users accessing and engaging with primary care services in the community following discharge from a medium secure hospital, and the views of the forensic mental health practitioners who support them. Interviews with four service users and four practitioners from one NHS Trust in England highlighted that the treatment of acute SMI and management of risk meant that support for physical health needs could be significantly compromised. The structures of secure care have a lasting effect on physical health which can be difficult to shake. Positive relationships between service users and primary-care professionals and between primary-care and mental health services are important to support engagement. Continuity of GP (where possible), the provision of detailed risk assessments from forensic services, and initial meetings between the service user, forensic team and GP could all be helpful in understanding risk, reducing stigma and encouraging trust and openness. There was concern that mental health teams should not replace the role of primary healthcare services which remain best placed to monitor physical health. Rather, forensic practitioners are best placed to facilitate service users’ access by working closely with primary-care and employing strategies that address service users’ perceived lack of agency.

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