

Challenging Inequality? Vertical Interventions to Horizontal Problems? A Study of a Healthy Living Centre within Lincolnshire Probation

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Discussion

- This paper seeks to explore and gain your comments on the nature of community OR practice through the case study of our research within a healthy living centre in Lincolnshire probation in particular:
- How COR helps in unravelling the multiple levels that impact on interventions
- How COR seeks to help policy makers and practitioners with their 'wicked' problems and potential solutions of how to act

The Problem – is the problem!

Health inequalities – ‘wicked issue’ – ‘cuts across boundaries of theory and practice’ – ‘problems symptoms of other problems’
Blackman (2006)

Are vertical interventions the targeting of ‘hard to reach and vulnerable groups’ – the solution to widening inequalities?

Research Context: Health Inequalities

- Health Inequalities not a new issue – Chadwick 1842 life expectation of ‘gentleman’ – 45 – labourer 18
- Black Report – 1980. First real opening of debate and analysis – interaction between the structural and cultural/behavioural causes of health inequalities
- Acheson Report 1998 – Governmental recognition to support change that was beyond ‘the control of the individual’ act on inequality
- 351 Healthy Living Centres - governmental response and complementary initiative to Acheson Report and Saving Lives – Our Healthier Nation
- Healthy Living Centres – ‘platforms for innovation’ – provide structures that affected one cluster explanation of health inequalities – *service accessibility and appropriateness*
- Lincolnshire Probation’s HLC - most unique model of the 351 HLCs
Vertical intervention to address problems of those at extreme of inequality

The story so far ... examples from the literature

- Social Exclusion Unit (2002) – estimated half of all prisoners had no GP before custody – catalogue of service failure and health inequalities in the prison community, with a circle of social exclusion, poor health and offending
- Sattar (2001) – offenders in the community had a *higher* mortality rate than those in prison and the general population
- Death rate 1997:
 - 449.5 per 100,000 offenders in the community
 - 258.8 per 100,000 general population
 - 189.8 per 100,000 prisoners
- Mair and May (1997) – sample study of 1213 offenders on probation – 49% indicated that they had or expected to have long-term health problems
- Overlaying of problems and inequality: Health and propensity for crime - Bennett's (1998) study of drugs and crime found that almost half of arrestees (46%) reported that their drug use and crime were connected

Offender Health – Identifying The Gap in Research and Practice

- **Very little specific to the health needs of offenders on community sentences compared to increasing evidence base of those in custody (Offender Health Care Strategies 2005 – ‘little evidence of research into health services for offenders outside of custody’)**
- **Concentration on certain health issues already identified as pertinent to offenders such as substance and alcohol misuse**
- **Very few studies that include qualitative data on offender views on health and health services**
- **Limited health initiatives for offenders living in the community to research and evaluate.....**
- **Lincolnshire Probation’s HLC exceptional opportunity to research:**
 - Alternative service models and structures for offender health – vertical approaches to equity**
 - Understanding of offender health profiles in the community setting**
 - The enablers and barriers in pathways to health services and change**

The HLC Model

- ‘Virtual Healthy’ Living Centre – based on ‘social’ rather than ‘medical’ model
- Nurses and now health trainers based in probation premises who offer personalised and health assessments and consultations to offenders – (appointments often an hour or more in duration)
- Support changes such as smoking cessations
- Refer and signpost to other services
- Workshops on specific issues ie healthy eating

The COR Intervention Opportunity 2003-8

5 years sustained engaged research project

- **Exploring and extending boundaries**
- **Building qualitative 'evidence' from community accounts - critically exploring and creating a model with strong user input**
- **Challenging internal and external models of the activity to provide accounts to help change and ultimately sustain the service**
- **Shaping an improved understanding of the problem of inequality and the solution being explored linked to action**

The Science of Better?... Challenging Inequality?

Engaged Research

- Conflict as well as co-operation – difficulty of ethnography – question of role? Are you inside or outside the organisation? Developing research relationships and analysis with partner organisations
- Onus on ‘voice’ of offender – hidden inequality
‘Half way house between exclusive controlling research on people and fully participating research with people’ (Heron 1996)
- Role of the naïve questioner ... what is the HLC?, what are peoples experiences, how does the model work?

Challenges of the Research Process – Reaching the ‘hard-to-reach’

Expected To Attend	Did Attend	Did Not Attend	Interviewed	Unwilling To Be Interviewed
5	1	4	1	0
3	2	1	1	1
3	0	3	0	0
2	1	1	1	1
5	0	5	0	0
3	1	2	1	0
3	1	2	0	0
3	1	2	0	1
3	1	2	0	1
3	1	2	1	0
36	10	26	5	5

'New' Voices

Added Value of HLC - Time

- **'...The nurse has got time to listen to me...with the GP you spend more time waiting to see him, than the time to actually see him', you are 'in and out in 2 minutes'. Then all they do is say 'yeh, yeh blah blah...give you a prescription and a piece of paper...they don't really sort you out...'**
- **'You don't have to get past the receptionist and then have 5 minutes with the GP to just pick up some medication, with all your issues still to resolve'**
- **'... I couldn't talk to a GP like this- you have only 10 minutes so you can't go into depth about things – there is not enough time to talk about your problems'.**
- **'...If you go into the GPs all you get is a few minutes of time and then they want you out, where is the next patient? I spent 3 and a half hours talking to the nurse and you couldn't do that with a GP'**
- **'It is much better seeing the nurse than the GP as they have much more time .. otherwise it's a case of 'what's wrong with you .. now it's someone else's turn. You know that there is not Mrs Jones in the waiting room and you have to get on'...**

Added Value of HLC – *rapport / openness / trust / personalising the Service*

- **‘I could go and talk to the nurse about anything that was bothering me – even if I had a ‘wart on my willie’. I would have no embarrassment or difficulty about talking to the nurse about it. It really helps to have the time to talk through your problems. In fact when I am talking to the nurse I forget that I am talking to a trained nurse, its just as if I am talking to someone I have known for a very long time, so I can talk about anything I want. There are no barriers as they don’t wear a uniform or anything like that ...**
- **‘I can speak to the nurse all the time and ask questions, which eases you ... ‘this is not something that I would do at a GP’**
- **‘You need counselling and someone to talk to about things, as much as you need medication.’**
- **‘It is a great service because it is able to change how you think about things. You think that you are in control but then understand that you are not. You can talk through feelings and understand them more – that you have to communicate.’**

Added Value – Personalising Health Messages / Motivation for Change

- **‘They provide support without control’.**
- **‘They give you the choices, the advice, the telephone numbers’.**
- **‘They get me on the scales and take my blood pressure and keep nagging me about my smoking without telling me what to do’.**
- **‘They (nurses) don’t bombard you – otherwise you would probably be more defensive and go against them’.**
- **‘I found out things that I wasn’t aware of. I put the leaflets about healthy eating/nutrition in the drawer – but have now got them out later and am reading them and acting on the advice’.**

Added Value: Health and the Criminal Justice System – Role of HLC

Offender Health Survey (2007)

17% considered that being an offender had affected their use of health services, 42% that being an offender had affected their health

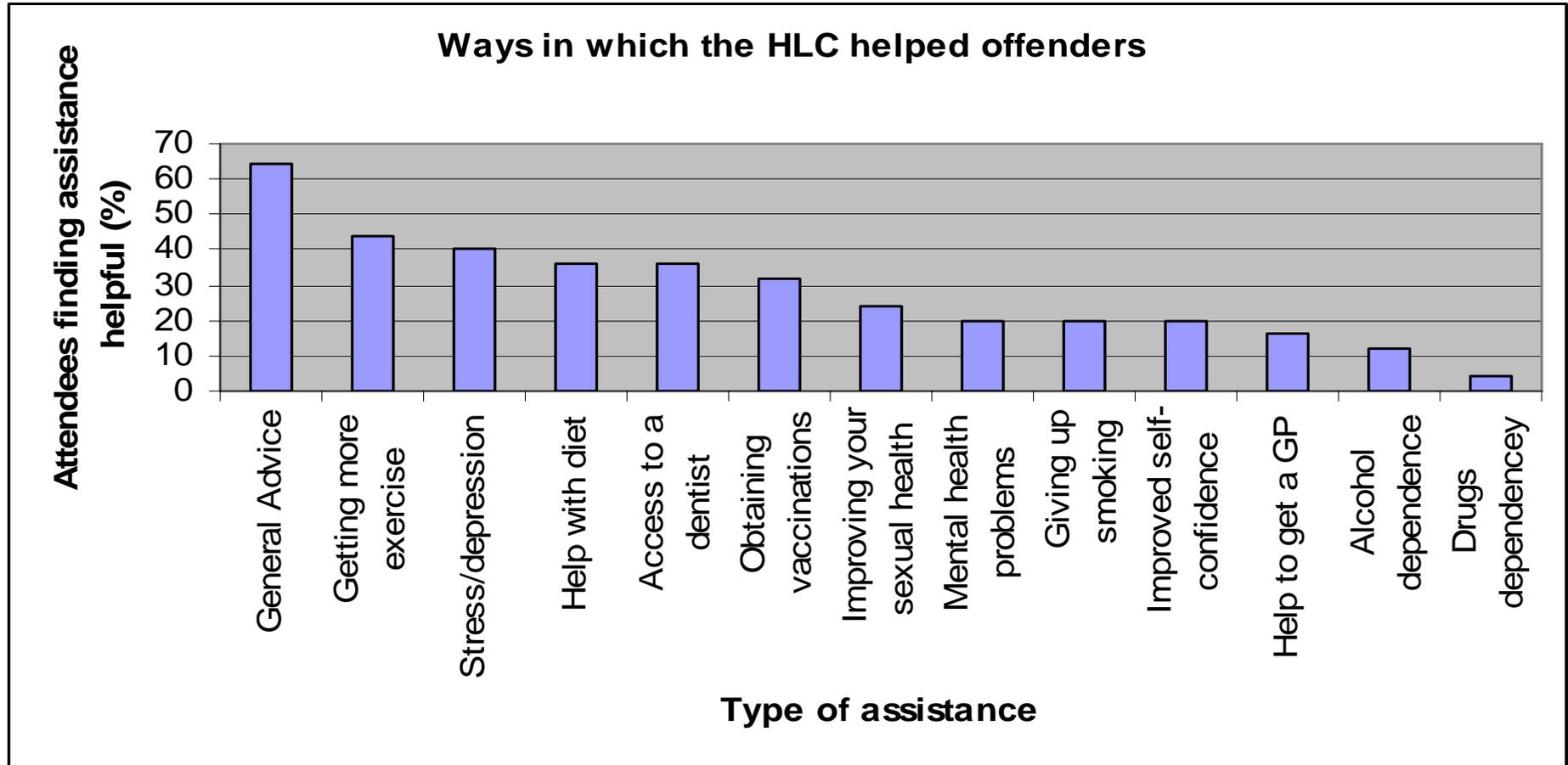
HLC provides:

- Extra dimension of support for those released from prison – Sattar (2001) offenders on release most at 'risk'
- Removal of 'barriers' of perceived stigma/'authority'

Offender Voices:

- 'Had just come out of prison so it was a nice friendly service as I wasn't ready at that point to meet people and go to a doctor's surgery and wait there'.
- 'Drs are very much about authority and after 7 years in prison you become institutionalised and so the nurses approach is very good'.
- 'In prison they isolate issues too much like drugs and alcohol – they put you in boxes – don't look at the problems of addiction as a whole.'

Holistic Approach – Types of support attendees found helpful



More lessons - Behind the Community Images?

- **Often people assumed by health educators to constitute a community (for example intravenous drug users) turns out to be a heterogeneous group, rather than a peer group characterised by a common identity – which would bind information together in the task of renegotiating behavioural norms and practices. Social interaction and solidarity do not automatically flow from the fact of addiction to a common substance, as many programme organisers have so optimistically assumed...Much more work needs to be done in developing understandings and actional models of what constitute the ‘communities’ whose existence is presupposed by so many educational interventions**

Campbell et al (1999)

(self) Perceptions of behaviour – Two 'healthy' people

- RESPONDENT 'A'

- Never smoked
- Not stressed
- No illegal drugs
- Doesn't drink

- RESPONDENT 'B'

- Smokes daily
- Stressed through:
 - ◆ unemployment
 - ◆ Housing
 - ◆ drugs
- Takes: crack cocaine, cannabis, methadone and heroin
- Drinks 9 units daily

Contributing evidence: Pathways to Change

- **‘I need to know that I will be around in 30 years time...for my children and my children’s children. I look at them and want to still be here to see them....’**
- **‘I got to my 38th birthday and thought where’s my life gone? It really upsets me to think how much my life has been screwed up...’**
- **‘Only now that I realise how important health is...I got into soft drugs at 18, then heroin had a really ‘bad effect’ on my life...I got into trouble...At 23 I decided I had to sort my life out...I am now seriously getting off the drugs and getting my life back...’**
- **‘As a lad I couldn’t care less about health...my life was chaotic. I didn’t have a family...my circle of friends were all a bad influence, I lived on a bad council estate and just got into drugs and everything that was bad. I have just started to realise that this is not a life...’**
- **‘Told that I would end up dead if I continued drinking...’**
- **‘I am starting to feel good about something and excited and capable and that is a new feeling. I never used to make plans ... I used to live day by day. I have now structured my life and feel that there is something to live for ...’**

Contributing evidence: Barriers to Change

Routine, control and coping strategies

‘Smoking is my safety pillow’

‘Mostly you take drugs/smoke to deal with the stresses of life’.

‘I want to give up smoking – but it is a habit – something to turn to – you use it as a crutch – it is an addiction. The alcohol is also a crutch’

Contributing evidence: Attitudes to Risk

Health not unitary concept: Blaxter (1990). There are also trade-offs:

- **'If I gave up smoking I would get bored and start taking drugs instead.'**

Other assumptions about health needs and desires may also be challenged:

- **'I don't want to live and don't know why people want to help me'**
- **'I am not really worried about the length of my life...I live for the moment. Something I don't think about is risk'**

Risk, Resistance and Reactance -

Attitudes to risk and low levels of self-esteem:

'It's the risk that you are chasing'

Impact of COR Intervention?

- Robust narrative built – deeper understanding of complex issues/intervention and wicked problems
- Support of individual actors and partner organisations with opportunities for reflection on how to act and navigate the swamp
- Sustaining and helping secure mainstream funding of the project by providing ‘evidence’ turning tacit knowledge into tangible resources and reports

What is learnt?

- Is Vertical Equity the solution?:
- Choosing Health (2004)– ‘choosing health’ is dependent on matching support with individual need

However:

- HLC lessons in terms of service delivery and health promotion should be integral to mainstream health services – reducing need for vertical intervention?
- Does it solve only a temporal problem? Does long term solution to inequality rest in more permeable mainstream health services?
- Equality vies with individual belief systems and actions – the ‘right’ to be unhealthy as well as healthy.

Final Reflections

COR is about developing a process not a fixed recipe

The success of sustained research projects are dependent on research partners and the sharing and developing of practice, using the long partnership to build up a better informed picture of how to analyse and improve a complex situation

Engaging and evaluating messy interventions and hard to reach groups is in itself a messy process – but it is only by being in the swamp that we can navigate it!

COR is constantly challenging and not for those who want simple solutions!

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