

# The Development of a Pilot Electronic Multi-Agency Information Sharing System for Offenders with Mental IllnessQ

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## ***Executive Summary***

Dr Jane Senior,<sup>1</sup> Dr Sharon McDonnell,<sup>2</sup> Dr Charlotte Lennox,<sup>3</sup>  
Dr Li Yao,<sup>4</sup> and Dr Ning Zhang<sup>5</sup>

<sup>1</sup> Department of Community Based Medicine, The University of Manchester

<sup>2</sup> Department of Community Based Medicine, The University of Manchester

<sup>3</sup> Department of Community Based Medicine, The University of Manchester

<sup>4</sup> Department of Computer Science, The University of Manchester

<sup>5</sup> Department of Computer Science, The University of Manchester

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**Address for correspondence:**

Dr Jane Senior  
Offender Health Research Network  
Room 2.315  
Jean McFarlane Building  
University of Manchester  
Oxford Road  
Manchester  
M13 9PL

Email: [jane.senior@manchester.ac.uk](mailto:jane.senior@manchester.ac.uk)

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## **Background**

In recent years media attention has focused disproportionately upon a small number of violent crimes perpetrated by mentally ill people living in the community. Inquiries into such events commonly cite a lack of adequate information sharing, both within and between agencies, as contributing to inadequate risk management.

Offenders often have complex and inter-related needs which challenge the interface between the criminal justice, health and social care sectors. Multi-agency partnerships are required to meet these complex needs. However, multi-agency working brings with it ethical conflicts around information sharing that are not based solely on individual clinician/service user relationships; rather they are more complex, with different disciplines having differing treatment philosophies. A change in attitudes and values, as well as behaviour, is required to address the anti-sharing culture.

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## **Aims**

To establish a Multi-Agency Information Sharing (MAIS) network which would provide a single, accessible mechanism through which risk information about recently released prisoners could be shared promptly, securely and reliably between community mental health and criminal justice agencies.

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## **Methods**

### **Part 1: Develop and pilot MAIS Network**

To establish the MAIS network the research team first had to establish what mental health and risk information criminal justice agencies needed about recently released prisoners, and which agencies could have access to which information. An initial mental health and risk dataset was presented to the study's operational steering committee for ratification. Following a number of rounds of consultation the resulting version was ratified by both the operational steering committee and the NHS Research Ethics Service (NRES).

The MAIS network was specifically developed as a secure, web-based, e-Workbench service, designed to provide browser-based, fine-grain

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controlled accesses to the mental health and risk minimum datasets of mentally ill prisoners upon release from HMP Liverpool.

The MAIS network was designed for participants released from HMP Liverpool. The inclusion criteria were those of working age (21-65), with an identified severe and enduring mental illness (SMI).

#### *Evaluating the MAIS Network*

The scalability, robustness, accessibility, usability and security of the network were tested.

#### *Qualitative evaluation of the MAIS network*

This aspect of the study aimed to examine the views of the frontline health and criminal justice agency professionals on the value and importance of such an initiative. Fifty-four individuals were interviewed. Participants' perceptions of the MAIS network were analysed using transcripts and notes taken during the interviews and field notes taken after each interview.

### **Part 2: Examination of how the lessons learnt from the pilot MAIS network can be incorporated into national health and criminal justice policy concerning the care and management of mentally disordered offenders**

The aim of this part of the study was to examine the feasibility of expanding the MAIS network to include service providers nationally. A purposeful sample of key individuals identified as influential nationally in the field of information sharing within criminal justice and health care agencies was interviewed. Thematic analysis using the constant comparative method was used to analyse the data<sup>57-59</sup>. Data collection ceased when saturation of themes occurred.

### **Part 3: Conduct a process evaluation of the development of the MAIS network, and the issues raised around information sharing and partnership working.**

The aim of this part of the study was to conduct a process evaluation of the MAIS network which investigated the process of delivering the MAIS network, including alternative delivery procedures. Processes used to establish the MAIS network and issues raised around information sharing and partnership working will be explored.

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## Results

### **Part 1: Develop and pilot MAIS Network: Development of Minimum Dataset**

Developed and ratified by a multi-agency group of health and criminal justice professionals, a health and risk minimum dataset was developed.

The health and risk details of 31 service user participants were entered onto the MAIS network. All were male, aged between 21-56 years. Twenty-four (77%) were released from prison during the study period. Twenty-five (81%) had a history of multiple suicide attempts. Twenty-seven (87%) participants had a history of violence to others. Fifteen (48%) were subject to Multi Agency Public Protection Arrangements (MAPPA). Of those released from prison during the study period, one (4%) subsequently committed suicide; six (25%) were further detained in police custody; and four (17%) were admitted to mental health in-patient care.

One hundred and eighty eight individuals working in police and criminal justice health services in Merseyside met the inclusion criteria to register as professional users of the MAIS network. Those registered included ninety-six police officers; seven police custody nurses; three forensic medical examiners; eight members of the Criminal Justice Liaison Team; seven members of the prison mental health in-reach team and one member of the prison-based dual diagnosis team.

Users were given 'read only' access to the MAIS network and it ran as a live system for eight and a half months. Over this time, nine separate searches by registered users were conducted. The lack of activity on the system was attributed to the fact that only 31 participants were in the network and limited awareness of the network by frontline police officers.

The network was designed to be capable of holding a maximum 30,000 individuals in the database and provide timely response for up to 150 concurrent requests. The MAIS network ran reliably throughout its lifetime. The resistance level of the MAIS network was analysed against several types of security attack.

A qualitative evaluation of the MAIS network was undertaken, focussing on users' (staff and client) views of the network in terms of acceptability, utility and lessons learnt for a wider roll-out. Discussions surrounding service users' reasons for participating in the study made it clear that, overall, service users were content to share such information with police officers if it contributed to their safe detention in custody. Professionals should regard service users as active participants in the multi-agency partnerships formed to care for people throughout the offender pathway.

The information held on the MAIS network was regarded as being more informative than that currently available to the police via limited and often inaccurate mental health and suicide risk warning 'flags' on the Police National Computer. Issues surrounding the current mental health model and the possibilities of progress being made in relation to multi-agency information-sharing and partnership working were explored.

**Part 2: Examination of how the lessons learnt from the pilot MAIS network can be incorporated into national health and criminal justice policy concerning the care and management of mentally disordered offenders**

Twelve national leading authorities on information sharing across health and criminal justice agencies were approached to take part in a semi-structured interview and eleven agreed; the twelfth nominated a deputy. Participants' perceptions of the pilot MAIS network and the feasibility of a national roll-out of the system were explored.

Every participant voiced concerns about barriers that impede multi-agency information sharing along the offender pathway and stressed the importance of these issues being addressed if we are to significantly improve collaborative working and the way in which risk information is viewed and shared. Participants stressed that the study was important as it challenged and tested boundaries between criminal justice and health agencies along the offender pathway. Despite the limitations of the research, the majority of participants were supportive of the pilot study.

However, national leads stressed that the MAIS network in its current form could not be implemented nationally; due to current financial constraints, it would not be possible to develop a stand-alone system and thus, its concepts would have to be integrated into another health or criminal justice agency IT system currently in use.

**Part 3: Conduct a process evaluation of the development of the MAIS network, and the issues raised around information sharing and partnership working.**

It has been long recognised that multi-agency information-sharing within the criminal justice system is problematic; however little practical guidance is available on how to motivate and encourage healthcare and criminal justice agencies to work together effectively. This is in spite of multi-agency partnerships being universally viewed as essential for the delivery of 'joined up' care across the offender pathway. To complete this work, we considered all agencies that would have access to the MAIS network effectively as part of a single 'risk network', regardless of whether they were employed by healthcare or criminal justice agencies. We remained mindful of the apparently competing tensions and conflict between health and criminal

investigative processes and concentrated on developing a system fit for purpose for all agencies. To that end, a wide range of informants (service users, police and probation services, primary care workers and general practitioners, community, police and prison-based mental health workers) guided the research team on every aspect of the study, ranging from recruitment; what data should be shared on the MAIS network; and best ways of implementing the system.

Changes to the original research protocol were made during the life of this study. Broadly, these related to lower recruitment than predicted and subsequent low use of the network by criminal justice personnel. These factors hampered our ability to conduct an evaluation of costs and full utility and prevented any examination of impact upon clinical decision making or service user outcomes.

However, we do feel that this report positively adds to the field of knowledge in this area. We demonstrated clearly that a viable IT infrastructure to deliver an Internet based multi-agency information sharing system can be built, thus providing proof of concept. We achieved, by cross-organisation consensus, a health and risk minimum dataset sensitive to operational, legal and cultural needs of both health and criminal justice agencies. We demonstrated that organisational boundaries of information exchange can be delineated, managed and audited. Through the execution of this project we have learnt key lessons to guide us in determining a fruitful forward direction for this work, based on both our own experiences in conducting the work and our interactions with service users and criminal justice system and health professionals.

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## Recommendations

### **Implications for Management**

- Direct access to certain health and risk information by criminal justice staff should be formally accepted as NHS national offender health policy.
- Service managers and national leads should embed local/regional multi-agency partnership developments within an ethos of them forming the bedrock of a single 'team' which exists to meet the needs of those in contact with the criminal justice system using a holistic, joined-up approach.

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- Connecting for Health (CfH) should refer to the findings of this study in relation to their examination of future developments in IT systems supporting offender health delivery with the aim of assisting frontline staff to best ensure safer detention and inform health and criminal decision making processes.
- The CfH minimum dataset, informed by the MAIS template and incorporating the additional CJS risk and offence data, should be embedded into the widest available clinical IT system operational across all criminal justice settings, including police, prison and probation services.
- Criminal justice staff should be allowed to be registered users of any clinical IT system which contains the health and risk MAIS dataset, granted 'read-only' access to role-specific items; items to be agreed by the consensus methods used in this study.
- Criminal justice staff should be granted 'write privileges' to populate the criminal justice risk and offence data items.

### **Implications for Practice**

- The minimum offender health dataset should include data items regarding risk and past offences which will be populated from criminal justice agency information systems.

### **Implications for Service Development**

- Criminal justice and health agencies at national, regional and local levels, should develop a sense of shared responsibility and ownership of their role in addressing the health and social care needs of those in contact with the criminal justice system.
- Service users and carers should be regarded as integral members of multi-agency partnerships, increasing patient choice, autonomy and responsibility.

### **Implications for Research**

- Future research should examine best practice around rolling out the MAIS network in terms of embedding the initiative into frontline daily practice, including a review of cross-organisational training methods and working practices.
- Future research should focus on refining inclusion/exclusion criteria for the clients with mental health problem whose information could be most fruitfully included on the MAIS network.

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- Future research should identify information available from non-health services which should be included within the MAIS dataset, addressing the issue of “write” privileges for criminal justice personnel.
- NHS research ethics, and particularly governance, procedures should be streamlined, with all NHS organisations ‘signing up’ to standardised procedures and reasonable timescales for the processing of applications.
- The utility and reliability of routine NHS mental health data as part of the research process should be investigated.

## **Addendum**

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk).