

REPORT

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



On the Outside

Continuity of care for
people leaving prison

a **better** way



On the Outside

Continuity of care for people leaving prison

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ISBN13: 978 1 870480 77 2

Published by

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Sainsbury Centre for Mental Health works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services. We now focus on criminal justice and employment, with supporting work on broader mental health and public policy. Sainsbury Centre was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding.

Charity registration no. 1091156

A company limited by guarantee registered in England and Wales no. 4373019

Design: www.intertype.com

Printing: Chandlers, UK

Cover photograph: Katherine Hall

Ethical approval

This research received ethical approval through an NHS ethics committee and HM Prison Service ethics procedure. All names have been changed to ensure confidentiality.

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Acknowledgements

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Acknowledgements

The project team would like to thank all the prisoners, prison staff and professionals in the community who took part in our interviews.



Executive summary

Continuity of care is vital in all areas of health care. For released prisoners with mental health problems it is especially important to help them get their lives back on track on the outside.

We interviewed 27 female and 18 male prisoners to find out what support they needed once they were released and to examine what services they received. We also interviewed 25 professionals working in a range of agencies supporting prisoners and ex-prisoners.

We aimed to find out whether continuity of care between prison and the community exists for released prisoners and how better to achieve it.

Accommodation

Half of the male prisoners we interviewed were anticipating being homeless on release and half of the female prisoners were technically homeless but relying on friends and family for accommodation support. Being homeless on release disrupts continuity of care as it is more difficult for prisoners to get health care in the community without a fixed address.

Health care

Many more women prisoners than men disclosed mental health problems to us. Depression was the most commonly mentioned mental health problem.

The biggest complaint about prison health services was long waiting times. Some prisoners said their health needs were not being followed up within prison, let alone on release from prison. Prisoners also reported that problems with depression and anxiety were either not being assessed or further support was not provided following an initial appointment with a GP.

The majority of prisoners were registered with a GP in the community. However, a couple of prisoners needed to register with a new GP on release and said they had not been helped to do this by the prison health care service.

Substance misuse

Three-quarters of the prisoners expressed problems with drugs or alcohol. However, substance misuse problems rarely occur on their own: the majority of prisoners have complex needs and require a range of services tailored to their circumstances.

Early release

The End of Custody Licence scheme enables some prisoners to be released 18 days early to reduce overcrowding. However, prisoners and professionals are not always informed of this decision until the last moment. This has a clear impact on continuity by making it more difficult to plan care without a sentence end date.

Short sentences

Short sentences can disrupt any health care that prisoners may be receiving in the community. At the same time they do not provide enough time for prisoners to have their needs assessed inside prison.

Parents and partners

The emotional impact of imprisonment on family members of prisoners is considerable. It is left to family members in the community to fulfil a number of roles such as looking after children and providing financial support.

Pre-release work

Professionals emphasised the importance of working with prisoners prior to release, both to build a rapport and to plan services they might want to use in the community. This can be difficult in practice and many prisoners do not feel they get enough support to plan what will happen after they are released.

Access to services

Prisoners may struggle to get access to services for a range of reasons. Waiting times and transfers within the prison system can impede access. Prisoners with complex needs may have too many different agencies to work with when they are released.

Individualised care

Care and treatment need to be adapted to individual need. Many professionals said ex-prisoners often lost touch with services because they were not sufficiently tailored to their needs.

Relationships between agencies

Relationships between statutory and non-statutory agencies can be problematic. Information sharing is an important activity that needs to be improved. Some non-statutory agencies duplicate each other's work and compete for clients.



Introduction

Box 1: Laura's story

Laura was sentenced to prison for stealing a bottle of wine. She was homeless prior to coming into prison and the situation was going to be the same on release. She intended to return to the place where she had been sleeping rough for three months. Laura felt that she had not received any help with her housing needs because she was in prison for only a short time. She also had no local connections with the area she wanted to live in, which made it difficult for the local council to house her.

Laura said she was very upset about the health care in prison because she had not been taken back to the hospital for a follow-up appointment after hurting herself in a fall. She had detoxed from alcohol in prison but thought that she would probably start drinking again in the community.

Laura described herself as being very depressed and had been prescribed anti-depressants when she was seen by the GP in prison. She stopped taking these after a week because she felt no better.

She had a lot of praise for the prison officers and felt less intimidated because of the use of first name terms between officers and prisoners.

Laura was told she was eligible for 18-day early release on a Friday afternoon and she was to be released on the Monday. She felt this was 'crazy' because it meant she would not get to see the doctor before she was released. It also meant she would not be able to let her partner know as she communicated with him by letter.

Policy background

Recent reforms to prison health care services have recognised the importance of continuity of care in the prison population.

In 1999, the Prison Service and the NHS Executive stated that prisoners should receive equivalent health care to that which they would receive in the community, which should not be disrupted by coming into prison, being moved between prisons or being released (Joint Prison Service & National Health Service Executive Working Group, 1999). They suggested that the Care Programme Approach (CPA), a system of care planning for people with a diagnosis of severe and enduring mental illness, should be used in prisons.

In 2008, the document *Refocusing the Care Programme Approach* (2008a) suggested a new approach to CPA. The criteria for eligibility for the ‘new’ CPA include a diagnosis of severe mental disorder, risk of self-harm, history of offending, substance misuse and multiple service provision from different agencies, for example housing, employment, criminal justice and voluntary agencies.

The Government also created prison inreach teams to provide prisoners with the same care and treatment for severe mental health problems as they would receive in the community (DH & HMPS, 2001). To achieve this, inreach teams aim to ensure continuity of care between the community and prison by liaising with health services outside prison.

The Prison Service issued an order on continuity of health care for prisoners (HM Prison Service, 2006). The order provides guidance on transfer and discharge of prisoners. Its key points include:

- 1 If a prisoner has a significant mental health problem and does not already have a community-based care coordinator then a referral to a local community mental health team (CMHT) must be made.
- 2 If a prisoner is not registered with a GP in the community then the prison health care service must help the prisoner register with one before release.
- 3 Follow-up appointments for secondary care services should be arranged for the prisoner where appropriate.
- 4 Prisoners should be supplied with an appropriate supply of medication for release and the prison should assist them with completing a prescription exemption form.
- 5 Prisoners should be provided with contact details for local services such as GP surgeries, walk in centres, drug agencies, Samaritans and NHS Direct.

These policies have ensured that continuity of care is on the health care agenda for the prison population. However, research has shown that there are some difficulties in implementing this. A review of London’s prisons (Durcan & Knowles, 2006) reported that inreach teams found it difficult to engage with community mental health teams and organise care when a prisoner was released. Also some care coordinators were reluctant to continue responsibility for their clients when they went into prison. In some instances, this was practically difficult if clients were located in a prison a long distance from their home and where their care coordinator was based (Durcan, 2008).

Mental health care needs

The prison population continues to rise and consequently so will the number of prisoners with mental health problems. Table 1 sets out estimates of the rate of mental health problems in the prison population.

Table 1: Prevalence of mental health problems

	Prevalence among prisoners	Prevalence in general population (adults of working age)
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

(Singleton *et al.*, 1998; Singleton *et al.*, 2001)

Continuity of care is critical for released prisoners with mental health problems. Men recently released from prison are eight times more likely to commit suicide than the general population. One-fifth of these suicides occur within 28 days of release (Pratt *et al.*, 2006). Released prisoners are also at risk of death from a reduced tolerance to substances because they have detoxed while in prison. One study reported that one in 200 adult males who inject substances are likely to die within a fortnight of being released (UK Drug Policy Commission, 2008).

Despite a wide awareness of the risks, continuity of care between the community and prison is lacking. Birmingham (2004) reported that prisoners with mental health problems often do not receive treatment or care in the community because their needs are not properly identified in prison.

Melzer *et al.* (2002) identified 140 prisoners who had experienced psychosis during their initial prison sentence. When they followed this group up, only 53% had received help for mental health, substance abuse or emotional problems since their initial interview, even though some of these were still in prison. Of those who had been released only 23% had an appointment with a mental health professional.

Accommodation is one of the main problems for those released from prison. If this basic need is not met upon release from prison, it is likely to have an impact on continuity of mental health care. Williamson (2006) reported that 42% of released prisoners had no fixed abode and Niven and Stewart (2003) found that only 19% of prisoners had received help with accommodation while in prison. Without an address, prisoners may find it more difficult to register with a GP. Continuity of care is likely to be disrupted if a prisoner does not have a GP through whom to gain access to primary and secondary care.

Most prisoners who are sentenced to over 12 months will be released on licence half way through their sentence and will have to engage with the Probation Service and abide by licence conditions. These requirements include attending regular appointments with a probation officer and informing them of any change of address.

Prisoners who are sentenced to less than 12 months do not have any involvement with probation services and can be released without any requirement to liaise with statutory agencies. Those with very short sentences may not be in prison long enough to have their needs assessed or to get access to services that could help. This means that many prisoners, including those whose mental health

problems are not severe enough to meet the criteria for CPA, will be released from prison without any statutory aftercare being arranged.

This report

This report sets out the evidence from a research study conducted by Sainsbury Centre into the continuity of care experienced by prisoners before and after release. Chapters 2 and 3 describe the research project and the people we interviewed. Chapter 4 examines what continuity of care means for released prisoners. Chapters 5 to 7 investigate the key areas of care for which continuity is vital: housing, health care and substance misuse. Chapters 8 and 9 look at the impact on continuity of care of early release and short sentences. Chapter 10 focuses on the experiences of prisoners' families. Chapters 11 to 14 look at how services are organised and some of the keys to improving continuity, such as communication between agencies and giving prisoners more information about services. Chapter 15 sets out our recommendations for improving continuity of care between prison and the community.



What we did

Although continuity of care has been researched in a variety of health care settings, there has been little research into what continuity of care means for prisoners. This report aims to:

- 1 Identify the key elements of continuity and what they mean for people leaving prison.
- 2 Identify the resettlement needs of prisoners due for release and how these are met or not met (either through formal services or informal networks such as family and friends).
- 3 Identify care pathways and approaches to engaging with released prisoners, and find out whether services are flexible in meeting their needs.
- 4 Identify effective ways of tracking prisoners from prison into the community.
- 5 Explore the views of professionals concerning continuity of care and resettlement for released prisoners.

We aimed to track prisoners over three points in time to explore their journey from prison to the community. We aimed to include males and females, those from Black and ethnic minority groups (BME) and those with and without a diagnosed mental health problem.

Prisoners were recruited from one male and one female local prison in the South of England. The local inmate database system (LIDS) was used to identify prisoners who were due for release within a month. These prisoners were then approached to take part in a semi-structured interview. The interview consisted of questions regarding:

- Mental health problems prior to or during their sentence;
- Mental health care they had received in prison;
- Plans for release, for example employment and accommodation;
- Agencies or professionals they had worked with;
- Opinions about the help they had received.

We interviewed 27 female and 18 male prisoners. To facilitate tracking on release, prisoners were asked to provide contact details for themselves, family and agencies they might engage with in the community.

Approximately two weeks after release we attempted to contact prisoners to interview them for a second time to explore their experiences of resettlement, and find out about their mental health concerns and what agencies they had engaged with since release.

Initially we planned to interview people a third time, but due to problems in contacting prisoners on release, interviews were conducted when possible regardless of the time since release.

The typical male prisoner interviewed was white British, single, aged between 31 and 40 years' old, a father to at least three children and serving a sentence of between one and three months (Table 2). The typical female prisoner was younger, aged between 22 and 30, and less likely to be serving a sentence of less than three months.

Table 2: Demographics of prisoners interviewed

		Females (27)	Males (18)
Age	17	1	0
	18-21	1	0
	22-30	11	5
	31-40	5	7
	41-50	8	5
	51+	1	1
Ethnicity	White British	21	11
	White Irish	1	2
	Other White	1	0
	White / Black Caribbean	0	2
	White / Black African	2	0
	White / Asian	1	0
	Caribbean	0	1
	Asian	1	0
	Black African	0	1
	Spanish	0	1
Marital status	Single	16	13
	Married	1	1
	Divorced	1	2
	Co-habiting	6	2
Number of children	None	10	2
	1	6	3
	2	6	4
	3+	5	9
Sentence length	On remand	3	0
	Less than a month	0	1
	1-3 months	9	7
	4-6 months	4	2
	7-9 months	1	1
	10-12 months	0	0
	1 year and over	1	0
	2 years and over	1	3
3 years and over	1	2	
Educational level	Left school before 16	9	7
	Between 16 and 18	15	9
	Attended further education	4	1

Professionals in prisons and community services were also invited to take part in an interview or focus group. These explored the roles they fulfil in the resettlement of prisoners, their views on continuity of care and what barriers exist to engaging with released prisoners. Of the 25 professionals who participated, four were based in prison and 21 worked predominately in the community. Professionals from statutory agencies included psychiatric nurses, GPs and substance misuse workers. Those from non-statutory agencies provided a range of services, such as generic resettlement assistance, employment advice and assistance with housing needs.

We explored the role of informal support provided by family and friends of prisoners through two focus groups. These were arranged through an organisation that runs a regular support group for friends and families of prisoners.

Each interview (when tape recorded) was transcribed in full by the researchers, and where interviews could not be tape-recorded detailed notes were made. These were analysed by the research team and four sets of themes were developed which represented the experiences of males, females, professionals and families of continuity of care and resettlement. These were incorporated to produce broader themes, which highlighted the key areas of continuity and resettlement for prisoners and professionals.



Tracking people on release

We asked prisoners to provide us with contact details (see Table 3) to enable us to track them in the community. Female prisoners were more willing to give us contact details either for themselves or for family members with whom they were in contact. The female prisoners were slightly younger than the men. This may explain why they were more likely to give family contact details as they were anticipating going to their family on release.

Men were much more reluctant to provide contact details. Eight were anticipating being homeless on release and therefore had no forwarding information to give and did not want to give us other details. They were also reluctant to provide information about agencies with which they might engage.

A number of prisoners said they would contact the researcher on release rather than provide their own contact details. They may have been suspicious of the research or how their details could be used. Howerton *et al.* (2007) found that ‘help seeking behaviour’ in male offenders was affected by a general mistrust towards the system and health care professionals.

People with severe mental health problems can see as many as 23 different professionals from seven different agencies between arrest and return to the community (NACRO, 2007). An evaluation of a link worker scheme found that half of clients needed help from between six and ten agencies in just three months (O’Shea, Moran & Bergin, 2003). This again may suggest why prisoners were reluctant to provide contact details, as they may be frustrated by having to speak to many different agencies in order to get their needs met.

Table 3: Contact information

Information provided	Females (27)	Males (18)
Contact address given:		
Own home	9	2
Family member	10	3
Hostel	5	0
Contact phone number given:		
Their own	15	4
Someone in their family	9	3
Contact details for agencies	7	3
No contact details given	0	8

We sent a letter to those prisoners who had given us an address in the community. We reminded them that they had taken part in a research interview prior to release and invited them to contact us if they wished to arrange a second interview. Three prisoners responded. We also tried to contact people by phone and text message, which proved more successful. As a result, eight follow-up interviews were conducted with female prisoners, but we were unable to interview any of the male prisoners.

We were able to find out information about seven former prisoners by contacting the agencies that the prisoners had said they might use in the community. Most of these were non-statutory agencies, but we did make contact with one probation service. The probation officer of a female prisoner informed us when she was sent back to prison after breaching her licence conditions and we were unable to interview her.

Keyworkers and support workers who were in contact with prisoners on release helped us to get in touch with some people in the community. One support worker based in a homeless day centre gave us information about a former prisoner and facilitated a meeting with her after release. This support worker also informed us of the former prisoner's progress in trying to get a placement in a therapeutic community. A drug and alcohol worker whom we contacted via phone and email told one former prisoner we wished to contact her. The prisoner sent us a text message with a contact phone number and we conducted her second interview by phone.

Even if we were unable to speak to prisoners, other services were willing to pass on messages. For example, one woman told us she would be staying in a homeless day shelter on release. She was able to receive post at this address and staff agreed to pass messages on to her. They also informed us when she moved to a more permanent shelter. Unfortunately we were unable to speak to her directly.

Where attempts at contacting the prisoners through their own details failed, we attempted to find out information about them from their family. Five family members were able to provide information about a released prisoner. One prisoner was homeless but had provided us with phone numbers for other family members. We were able to contact her father who told us about her past. He said that he had had many mobile numbers for her over the past few years but they had often been cut off. Other family members did not provide so much information about their relative, but were willing to pass on messages or tell us that they had not seen them since they were released from prison.

One of the problems we encountered when attempting to conduct interviews with the ex-prisoners was that often they did not arrive for their appointments. This happened on more than one occasion with some prisoners. We were able to interview some of these at a later date but for others this was not possible. We spoke to one woman briefly on a number of occasions and obtained some information through phone calls with her and her family. Other prisoners who missed their interview times were clearly experiencing chaotic lives since release. One prisoner missed an interview with us because she had been re-arrested and had been in court.

Our experiences in trying to contact prisoners for this study highlights the need for services to be proactive and flexible in engaging with released prisoners due to the difficulties in arranging meetings and appointments. This was confirmed by one of the professionals we interviewed.

“ Their attendance depends on a huge amount: on whether they're managing to stay sober; whether they're managing to stay off drugs; whether they're managing to sleep; and whether there are mental health issues. ”

(Employment agency)

We were not able to contact any of the male prisoners on release. Eight of the 18 we interviewed in prison expected to be homeless on release and the majority of these did not provide us with any contact details in the community. The brief contact details they provided about agencies were either incomplete or the services had not heard of the prisoner in question.



What is continuity of care?

Definitions

Continuity of care is a term frequently used in health services but which has been given many definitions. The principal idea is that people experience a coordinated and smooth progression of care through the health care system (Freeman *et al.*, 2002).

Three main types of continuity have been identified (Freeman *et al.*, 2007):

- 1 **Management continuity** between different professionals and services to create integrated services that are appropriate to people's needs (England & Lester, 2005).
- 2 **Informational continuity** between professionals who provide care. Professionals should have access to information about a person's previous health care (Saultz, 2003). This prevents people from being frustrated by frequent changes in health care staff when they often have to repeat their medical history (Kai & Crossland, 2001).
- 3 **Relationship continuity** in therapeutic relationships (e.g. between professional and client). Haggerty *et al.* (2003) describe it as a bridge between past, present and future care which provides people with a sense of coherence.

The importance of tackling paternalistic attitudes that discourage patients from taking a more active role in their care was highlighted by Freeman *et al.* (2007). While acknowledging that continuity is good for many NHS patients, they emphasise that in terms of resources, priority must be given to the most vulnerable groups (Freeman *et al.*, 2007). The National Coordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) in conjunction with Sainsbury Centre and the Peninsula Medical School has subsequently funded a three-year project, Care of Offenders: Continuity of Access, which will complete in 2010.

Professionals' views

Some of the professionals we interviewed discussed what continuity of care means to former prisoners. A substance misuse treatment manager provided one definition which highlights two important aspects of continuity of care. First, it points to the importance of providing a service that encourages the service user to take responsibility for managing their own care. Second, it stresses the importance of services being flexible in the amount of time they work with clients and the services they provide.

“ I understand continuity of care as holding and supporting the person until such time as they begin to become able. ”

(Substance misuse worker)

A second definition of continuity of care was given by a forensic community psychiatric nurse (CPN). This definition stresses the importance of continuity between professionals, where they exchange information to ensure that the client experiences a smooth transition in care.

“Continuity would mean if I’m moving service or whatever, I transfer the care to somebody but I inform them of the situation and they can continue from where I’ve left [off].”

(Forensic CPN)

These definitions illustrate what professionals believe is the ideal in continuity of care. But, particularly for staff in non-statutory agencies, the reality was different. A prisoner may leave a prison which has provided some level of assistance, but receive no support in the community.

“If you’re lucky you’ll be in a decent prison with a decent support network. What happens is, of course, once you come out of those gates you’re given the basic £40 and you’re left to your own devices.”

(Resettlement agency)

This demonstrates the transition from the relatively supportive prison environment back to a community setting with inadequate care. This pattern seemed especially pertinent for prisoners with a substance misuse problem.

“They get cleaned up in prison but you bring them outside the gate ... to the same area where their drug dealer is. They’re waiting six weeks to see a drug counsellor or drug support worker because the Government doesn’t fund the agencies properly.”

(Resettlement agency)

It was suggested by several professionals that this lack of support resulted in reoffending, as prisoners returned to the same situation they were in before custody.

“You know there is no continuity of care and people wonder why the reoffending rate is so high. It’s a very, very simple equation. We don’t know what these people need because we’re not investing the time in figuring out what they need, and we’re not properly coordinating services for them.”

(Employment agency)

This professional suggested that time needs to be invested in assessing needs and coordinating services. This would help to ensure that the correct services are in place for prisoners when they are released and provide continuity of appropriate support.



Accommodation

The issue of accommodation for people released from prison is well documented and it was clearly an issue for the prisoners we spoke to. Half of the males expected to be homeless on release. Although fewer females expected to be homeless, over half were intending to stay with family on release (Table 4).

Table 4: Prisoners' expectations for housing

	Females	Males
Homeless before prison	4	5
Expected to be homeless on release	3	8
Staying at friends / family on release	12	3
Going to own home on release	6	4
Staying at hostel	2	1

Eleven of the prisoners we interviewed expected to be homeless on release and of these two women told us that they would be sleeping rough. One prisoner was intending to return to the park where she had been sleeping in a tent prior to imprisonment. The other had lost her accommodation because her housing benefit had been stopped. We spoke to her after release and she had spent seven out of fourteen nights sleeping on the beach. She occasionally stayed at her partner's place of residence but was not allowed to do this. She had been told there was a six month waiting list for housing.

When we spoke to her four months later, she was still homeless but was now staying at her partner's full-time because she had been robbed twice at a homeless shelter. She reported feeling low and had been drinking again, often out of boredom. She had suffered a number of physical health problems, which had meant she had been housebound for some time.

These experiences were echoed by the male prisoners, as demonstrated by David's story (Box 2).

Box 2: David's story

David had been told the day before our interview that he was due for early release the next day. He had not been expecting this but did not think it had affected his plans for release. He had been homeless for approximately seven months prior to being in prison and said that his flat had been taken away from him last time he had been in prison. He told us that he had put in lots of applications to try to organise housing, but he had heard 'nothing' from these. We asked whether he knew of any hostels that he could go to and he said he had tried to 'find information about these' but no one had been to see him. He said it was 'scary' to leave prison without anywhere to go, but that he would take things as they came. He had been homeless before and knew what to expect. He said if he could not find anywhere to stay, then he would go back to the cemetery that he had been sleeping in before he came to prison.

The impact of homelessness

The relationship between housing and reoffending was recognised by prisoners and professionals, and echoes previous research that suggests having stable accommodation can reduce reoffending by 20% (Social Exclusion Unit, 2002). One female prisoner, who was planning to stay with her friend's son on release from prison, felt that her continuous reoffending was due to the fact that she did not have a place to live, which in turn made getting a job more challenging.

“ I will be back [in prison]. It might not be for six months, it might not be for a year, but I will be back until I've got somewhere to live of my own and a job and I can get on with [things] and [earn] a bit of decent money to live on. I'll be back until these people get it through their heads that jail doesn't change things. Changes have to come from out there. I can't do it by myself.”

One male prisoner commented:

“ Housing gives you a building block to organise everything else on and without it things fall on top of you.”

Professionals agreed. They felt that people who have to sleep rough would be more likely to reoffend. It is likely to be harder to maintain a social network, find and maintain a job, receive benefits and obtain health care if you are homeless.

The disruption of health care for those who were homeless was illustrated by two female prisoners who were sleeping rough on release. Both had previously misused alcohol and had detoxed in prison, but one felt that she would start drinking again when back in the community. The importance of housing is two-fold. Firstly, prisoners are more likely to drink or use substances if they do not have somewhere to live, perhaps as a coping mechanism. This was demonstrated by a male prisoner who said that if he had to sleep rough on release then he would probably go back to drinking as he felt it was easier to sleep on the streets if he drank. Secondly, without a permanent address it will be more difficult for prisoners to get access to the services they need and this will disrupt any continuity in care they may have received in prison.

While housing was the most frequently reported need by nine of the professionals we interviewed, one drug intervention programme (DIP) worker stressed that other needs must also be met. They

suggested that although housing is a priority it must go alongside addressing substance misuse issues, as clients who continue chaotic drug use will not be able to maintain housing tenancies. This would also apply to mental health needs, as it may be difficult for someone to maintain a housing tenancy if they are not receiving support for a mental health problem. This is demonstrated by Lucy's experiences (described in Box 3). Although she had been found housing by the prison it was clear that this was only one of a number of needs.

Box 3: Lucy's story

Lucy was serving a prison sentence for Actual Bodily Harm (ABH) against her husband and had been a victim of domestic violence. She had detoxed from alcohol in prison and participated in a programme about domestic violence which she told us she had found very useful. She was unable to return to her home on release and was found a place in a hostel. When we met her a few weeks after release, she was very distressed and had been drinking. She felt unsafe in the hostel and did not feel she could speak to the keyworker assigned to her at the hostel. She said she was feeling depressed and that someone had told her to smash a window so she would get sent back to prison. She had thought of doing this because she had felt safer in prison.

Housing support

Many prisoners reported receiving no help with housing while in prison. Since April 2005, all local prisons have been required to carry out a housing needs assessment for every new prisoner, including those on short sentences (Department for Communities & Local Government, 2006). A housing and benefits officer in the female prison described how this happened in practice.

“When they're down in reception they have a housing needs form filled out, which is then brought up to me the next morning, and then we see them within 24, well 48 hours... We do see pretty much everyone who comes in... if it's needed. If it's something quite urgent then they write on the form: needs to see housing urgently.”

(Housing and Benefits Officer)

Perhaps those prisoners who reported a lack of housing support did not make it clear at this initial assessment that they needed support. This could be because reception into prison can be chaotic. It may not be the best time to assess the prisoners' needs, as they may have spent a long time travelling to the prison and may be suffering from the withdrawal effects from drugs and alcohol (Durcan, 2008).

Housing advice beyond reception was available in both the prisons we visited, but prisoners reported problems with this. One prisoner joked that a housing agency to which he had applied would probably come and see him after he had been released. One female prisoner told us she had been seen by a fellow prisoner employed within the housing service. Although the role of peer support can be important in prison, this woman was unhappy with it.

“ I’ve put enough ap’s [applications] in to see the housing and I ended up seeing an inmate which peed me off a little bit, because she pointed at the board with hostels and that, and I said no I want to get a flat. She said I’ll call you back in two weeks’ time and she never did.”

Not all prisoners reported negative experiences of housing support in prison. A couple of male prisoners had been found accommodation in a bed and breakfast, but this was only for two nights. One prisoner said he would have to arrange further housing by attending the council’s homeless person unit, which is what most prisoners in need of housing do on the day of release. While two nights’ accommodation does provide a brief amount of continuity from prison to the community, it means prisoners could be left with no support to arrange further housing once they are in the community.

Interestingly, one prisoner did not want the help with accommodation that he was being offered. He told us that his DIP worker was going to meet him at the gate of the prison on the day of his release and they would take him to the council to organise housing. In the past, he had been in a similar situation and he described how ‘it could take all day to complete forms and be found housing’. He thought that he would rather be left to his ‘own devices’ and ‘get drunk’.

Another prisoner had been told he had to collect a letter from the probation service on the day of release and then take this to the council to arrange his housing. He felt this was too much to do on the day of release, especially when he did not know what time he would be released.

Problems with arranging housing

Professionals explained some of the difficulties in housing prisoners. One professional emphasised that to be able to get housing, released prisoners must have priority needs, for example have children, be pregnant or have a mental health diagnosis.

“ Because there isn’t the housing there, and in order to be eligible for... statutory social housing, you have to be in a priority needs group.”

(Accommodation agency)

Yet it was also reported that there could be difficulties housing prisoners with priority needs. A forensic CPN suggested that housing providers are often reluctant to accommodate clients with a forensic mental health history, as they are wary of the amount of support they may demand.

“ Because once they hear someone’s in a forensic team or got a forensic history... they think ‘oh we’ve got to put them in supported accommodation’ or ‘will we be able to manage these people?’ They just start asking loads of questions, just because of the forensic need. We tell them the risk is not high, we’re working with them, we’re managing the risk, and they’re taking their medication and whatever, but I find the housing very difficult.”

(Forensic CPN)

One forensic CPN reported difficulties with housing illegal immigrants as services for released prisoners are often funded by address. Therefore local authorities do not like to take responsibility for illegal immigrants who do not have an address.

“ Sometimes we have problems with illegal immigrants because nobody’s going to pay for them, because you’re funded according to your address or GP or whatever, and some of these people don’t have any of that and so there’s a battle over who’s responsible for them. ”

(Forensic CPN)

Finally, one substance misuse worker illustrated the importance of ongoing support with housing needs. He explained how some people, who have been in temporary accommodation for many months, find it a daunting experience when they are finally given permanent accommodation and need further support.



Health care

There were marked differences in the way in which male and female prisoners talked about mental health problems and therefore their experiences are discussed separately. Table 5 shows how many of the prisoners we interviewed discussed mental health issues.

Table 5: Mental health problems discussed at interview

	Female (27)	Male (18)
Depression	12	3
Anxiety	4	1
Schizophrenia	1	0
Personality disorder	1	0
Deliberate self-harm	4	1
Bi-polar disorder	2	0
Substance misuse: drugs	14	12
Substance misuse: alcohol	5	3

Women prisoners

Many of the women we spoke to talked about current mental health problems. Most frequently this was depression and anxiety. There were a number of issues with regards to prisoners' mental health and the continuity of care they received in prison and between prison and the community.

Some prisoners told us they had been prescribed anti-depressants by a GP when they came into prison but had not seen any health care professionals since.

“ I could be in there cutting up or something and they wouldn't even know. I'm not really sure they do anything, y'know. I know they do checks now and again but during the day they don't seem to do that. ”

Another woman had stopped taking her anti-depressants after only a couple of weeks because she felt they were not having an effect and no one had followed this up with her. She said she had tried to see the prison health care service about this but had not been able to get an appointment.

“No, they won’t even speak to me about it. I put in an application to see the doctor... I’ve even stopped taking it now... they weren’t doing anything.”

This woman did not have a GP in the community and did not know how she would get health care when she was released. We asked her whether she thought she would need to take anti-depressants in the community and she said she would.

Other prisoners told us they had not had their mental health needs assessed at all. One prisoner had seen the GP on a number of occasions but, as appointments are only ten minutes long, by the time she had talked about her physical health problems she had no time to talk about her depression. She told us she had been put on suicide watch but no one had come to talk to her. She had spoken to the Listeners (peer support provided by fellow prisoners who are trained by the Samaritans) but felt they were not qualified to deal with ‘real’ psychological matters. It was clear to the researchers that this prisoner had a number of mental health problems, and had a previous diagnosis of personality disorder. Yet in her opinion, her needs were not being met.

One prisoner described serious problems with anxiety which had a physical and emotional impact on her, particularly when she was locked in her cell. When asked what help she wanted she said:

“Well I think if there had been a psychologist who was really good at their job and really really does understand prison, I would have liked to go to a psychiatrist... I’ve not asked because I didn’t really think that was open to me.”

This prisoner had a severe anxiety problem but appeared to get most support from the prison officers.

“And the officers, I can’t fault them, they’ve been very kind.”

She told us she had not received any support from the health care service in the prison, despite being diagnosed with mental health problems in the past.

Prisoners will have most of their interactions with prison officers. It is imperative that prison officers have mental health awareness training, so they can recognise when a prisoner might need additional support over and above what they can, and have time to, provide. Continuity of emotional support from prison officers is likely to be disrupted by prisoner movement within and out of the prison, and also the movement of staff to different locations. It is thus unlikely that prisoners will have the opportunity to develop any relationship continuity with prison officers.

Some prisoners were receiving mental health care before coming into prison, as Amy’s story demonstrates (see Box 4).

Amy’s situation shows a lack of continuity from the community into prison, as she said that her keyworker had not been in contact with her since she had been in prison (although we were unable to confirm this). Continuity of care from prison to the community was not in place. Amy told us she had to organise a psychiatric appointment on release and she was also trying to organise housing with the help of the housing officer who had given her a list of hostels. We do not know if Amy was in touch with the inreach team, but clearly she had a mental health problem and had also detoxed from alcohol while in prison. Continuity of care in this case is imperative to ensure Amy receives ongoing care for her schizophrenia: for example, to ensure prison health care staff inform her care team in the community about her treatment.

Box 4: Amy's story

Amy told us she had schizophrenia and had mild outbursts when she felt stressed. She said a recent increase in her medication had been 'brilliant' and had helped her to sleep 'much better'. But she appeared confused and distracted in her interview and frequently jumped from topic to topic. She told us she had a psychiatrist and a keyworker in the community. She had worked with her keyworker for four years and had seen her twice a week, but had not seen her since being in prison. She told us she needed to see her psychiatrist on release and would need to make an appointment with him. But she also said that she might be moving when she left prison and would therefore need to find a new psychiatrist. She said she had seen a doctor in prison who had asked her questions that she could not answer.

Very few of the women we interviewed had a clear idea of the medication they were on, the dosage or indeed what it was for. The only words one woman could use to identify the medication she was taking were "*they're green and yellow*".

If the prisoners had more knowledge about their care or were more involved with the care they received, then they might be better placed to ensure the continuity of their own care upon release. They would be able to tell a GP, for instance, what medication they had been on, the dosage, and why it had been prescribed. This would be particularly helpful, as GPs cannot get access to prisoner notes electronically and must request for information to be faxed from the prison. This, of course, relies on staff at the prison having the time to do this and can cause delays.

Male prisoners

Male prisoners were quite reluctant to talk about any mental health problems. They did not appear to identify any problems of anxiety or periods of feeling low or any other problems, which might have been indicative of an underlying mental health problem. Durcan (2008) reported that prisoners did not want to reveal any vulnerability and did not trust prison staff. They felt they had to conceal their mental health issues because of concerns that other prisoners would not understand their problems. This was also reported by Howerton *et al.* (2007) who found that male offenders did not feel comfortable talking about personal problems with someone with whom they did not have a pre-existing relationship.

One prisoner was quite shocked to see 'mental health' on the consent form and quickly said he did not have any mental health problems. Another prisoner had not discussed any mental health problems throughout his interview, but at the end said he had been receiving incapacity benefit because of depression. He went on to explain his history of depression and how his mood had been "*up and down*" in prison, particularly in relation to waiting to hear whether he would be released with an 'electronic tag' or released 18 days early under End of Custody Licence (ECL).

If prisoners are wary of disclosing mental health problems, they may not receive the care or treatment they require, or treatment they had received in the community could be stopped if they do not disclose their problems when they come into prison.

Few male prisoners talked about mental health problems explicitly, but some talked about problems with fellow prisoners that had caused them distress. The language they used suggested that these experiences might have had some impact on their mental health.

One prisoner had initially chosen to share his cell with his friend but said they were not getting on because *“the little things get annoying and he is driving me mad”*. This issue was also highlighted by a prisoner who had nearly had a fight with his cell mate and another who said that:

“It can proper piss you off; send you off the rails if you share with someone who is detoxing.”

One prisoner did not have problems with his cell mate but with other prisoners and said that *“it drives you crazy”* when you have to spend time out of your cell with the same prisoners who are always talking about the same things.

Although these prisoners were talking about specific problems, it appears that these experiences could lead to feelings of anger and annoyance. These feelings might exacerbate any existing mental health problem. This shows how a prisoner’s needs might change during a prison sentence. It highlights the importance of management continuity and shows that services should be flexible and adapt care according to individual need.

Only a couple of prisoners explicitly discussed their mental health problems and these tended to be longstanding problems rather than something triggered by their current prison sentence as demonstrated in Darren’s story (Box 5).

Box 5: Darren’s story

Darren had one week left to serve in prison before being released on licence for a year. His main concern was that a voluntary agency in the community had initially agreed to work with him on release, but had reviewed his case and decided he was not appropriate for their caseload because he did not meet their criteria for mental illness or drug problems. Darren was angry with this as he described himself as being a ‘Jekyll and Hyde’ character because he ‘had a very changeable mood’. He said he had been taking anti-depressants for years and drinking alcohol had not helped his depression. He had detoxed when he went into prison, which he had found difficult as he had been drinking for 20 years. He said he drank when he was bored and would try to drink in moderation on release.

Darren’s main concern was that the agency would not work with him because he did not meet their criteria for mental illness. He was clearly angry and upset about this and wanted to show us the letter they had sent him. He had seen one of their workers earlier in his sentence and had been anticipating their support on his release.

One prisoner, Paul, talked about mental health problems when he first came into prison. His story shows that he had a range of needs including mental health problems (see Box 6).

Box 6: Paul's story

Paul was detoxing from methadone when we interviewed him and said he was finding this difficult. He looked physically unwell. He had been using crack and heroin for 20 years but planned to carry on with his detox on release. He was due for release in two weeks' time and did not know whether he would have to work with a drug worker when he left prison. He had been in prison for a total of 26 months, although this had been spread across three years as he had been released and then recalled on two separate occasions.

Paul told us he would not have any contact with probation services after release because he had now completed his entire sentence. He explained that when he first came into prison he tried to commit suicide as *"I sickened myself by [my] violence"*. He had spent time on the health care wing but did not like the anti-depressant he had been given. He said he had seen a doctor and been *"given reassurance and told to stop being stupid"*.

Paul was going to be homeless on release and his applications to receive housing assistance had not been answered. He did not have a GP in the community but thought he would need one in order to get access to drug treatment.

Prison health care

The main complaint about prison health care from both male and female prisoners was about waiting times. Prisoners, particularly those on short sentences, could leave prison without having their health care needs addressed.

If prisoners do manage to get seen by a GP more than once, it is unlikely that they will see the same doctor. One female prisoner said that the GPs were always changing, and the prison GP confirmed that nine doctors covered the rota at the female prison.

HM Inspectorate of Prisons (2007) interviewed nine GPs about mental health care in prisons. None of them had specialist training in caring for prisoners with complex mental health needs and they had little input into multi-disciplinary meetings or contact with psychiatrists.

Prisoners' partners had particular complaints about the health care in prison, and felt the care that their family members received was inadequate. This suggests that problems with health care are a concern to prisoners as they are talking about them with their family members.

Professionals based in the community also expressed some concerns about health care within prison. Poor transfer of information from prison to the community was a major complaint.

“ I've found at the health care unit at [name of prison] that if a person's going to be released they don't pass on the medical information to the GP; they're not allowed to pass it on to their GP or any other local mental health team. ”

(Resettlement agency)

The same person felt that continuity from prison to the community was unlikely to be achieved when the prison struggles to transfer information within the same prison.

“Neither do they pass on information within the prison, so if someone’s going from the mental health wing to the general wing they don’t pass information over... and the prisoner’s going to be saying ‘hang on I need to be taking my medication’... If they don’t pass it on within the same prison you can guarantee they won’t pass it on between different prisons.”

(Resettlement agency)

Another professional told us:

“They were coming out of prison with no support in place, very last minute. We had to meet them, take them to the homeless persons unit. They were given something like one day’s medication at reception as they were leaving. They were diagnosed with schizophrenia and were coming out with absolutely nothing.”

(Resettlement agency)

Continuity seemed to be lacking for prisoners with mental health problems in both prisons. This may have been because we did not interview any prisoners who were in contact with the inreach team and subject to the CPA, which is one way of ensuring continuity for prisoners who are already engaged with a community mental health team.

“It helps in continuity of care, somebody looking at the care package, because if you don’t identify anybody then things would fall apart, but if there is somebody who’s the care manager... who’s identified in a CPA, the care manager will make sure they’re liaising with everybody, and everybody is doing everything.”

(Forensic CPN)

Most of the prisoners we interviewed, however, described problems with anxiety and depression which would not be covered by the CPA. It is possible that those prisoners with less severe mental health problems are experiencing less continuity of care from prison as no formal arrangements apply.

GP registration

The majority of prisoners we interviewed told us they were registered with a GP in the community. This number was much higher than expected. Williamson (2006) found that 50% of released prisoners were without a GP. This may reflect the characteristics of this group of prisoners who were serving short sentences and therefore were returning to the area they came from. Both prisons were local prisons which mainly held prisoners from nearby. This may mean there is less need for them to register with a new GP, compared to those on longer sentences who might have moved out of their area and who decide to relocate on release.

A GP in the community explained that prisoners would become a temporary resident of a GP practice while in prison and then return to their local practice on release. This arrangement should provide effective continuity of care as prisoners can continue to receive primary care when they are released from prison. This may also improve informational continuity: where necessary, a prison can liaise with the same GP practice prior to and after release to share information about a prisoner’s health needs.

For those prisoners not registered with a GP in the community, continuity may be more difficult to achieve. One prisoner, who was receiving care for a bad shoulder in prison, was not registered with a GP in the community but felt he would have to do this to continue with his current care. He said he had

not been helped to register with a GP by the prison. This should have been done as part of the Prison Service Order on continuity of health care (HM Prison Service, 2006).

One of the female prisoners told us she was unable to register with a GP because she was homeless. This was having an impact on her ability to get mental health care, which reflects the important role that GPs play in providing access to secondary care services, but she was still able to get substance misuse care.

“ *Can't, can't. Catch 22. I can get my methadone script NFA [no fixed abode], I can get my Valium prescription NFA, Diazepam ... but I can't get mental health treatment.* ”

Although this prisoner had struggled to register with a doctor, a GP we spoke to said homeless prisoners could register using the address of temporary accommodation they might be staying in, such as a hostel or Bed and Breakfast. However, if someone was sleeping rough and had no form of identification this would make it more difficult to register.



Substance misuse

Three-quarters of the prisoners we interviewed reported either a drug or alcohol problem. Some of the prisoners' experiences of substance misuse care on release from prison showed the need for care to be flexible (see Box 7).

Box 7: Hannah's story

We interviewed Hannah while she was on remand in prison and then spoke to her three weeks after her release. She had been given a suspended sentence with a Drug Rehabilitation Requirement (DRR). This meant she had to attend a substance misuse group four times a week. She did not like attending the groups, particularly as she said other members of the group were still using drugs. When we saw her in the community she had missed three sessions. She said she intended to get a sick note from her GP as she had been suffering with a cold. She appeared confident that missing these sessions would not be a problem, although she told us that if she did breach the conditions of her DRR then she would have to return to prison.

Although Hannah told us she had missed these sessions through illness, she also told us she had moved out of the area where the groups were held because she had moved in with her boyfriend. He appeared to be a source of support for her as he did not use drugs. She was keen to find work, because she was saving money for a deposit to rent a flat, but was finding it difficult to find a job which fitted around the requirements of the substance misuse groups.

Although Hannah's experiences were unusual because she had been released from prison and given a Drug Rehabilitation Requirement (DRR), they do reflect the importance of adapting treatment and services to meet a prisoner's needs. Her experiences suggest that by not attending the groups she was not fully engaging in her treatment and was disrupting the continuity of the substance misuse care she had received in prison.

Another female prisoner (see Samantha's story, Box 8) demonstrated a further need for individualised substance misuse care.

Box 8: Samantha's story

Samantha was in contact with the CARAT (specialist substance misuse) team in prison. In her initial interview with us, she said that she would get in touch with her local drug intervention programme (DIP) team on release as she had received a letter from them. This showed good continuity between prison and the community as arrangements had been made for Samantha to continue her substance misuse care.

However, she commented:

“It's all really pointless because I'll be back on the puff when I get out anyway.”

Samantha returned to the community to live with her partner (who was also a drug user), against whom she had committed Grievous Bodily Harm (GBH) and who had been found guilty of two charges of assault on her. She had not received any benefits since being released and had taken out a number of crisis loans. This lack of money was putting a strain on her relationship with her partner and during the interview she mentioned that her “mental health had been a bit up and down”. She had felt depressed at times and was having trouble sleeping. She had not seen her GP since release but had received a repeat prescription for her anti-depressant medication.

Two months after release, Samantha told us she was still using cannabis but this had reduced because she did not have any money. She had not seen her DIP worker, although an appointment had been arranged for her. She had tried to contact her CARAT worker in the prison on a number of occasions because she needed some paperwork from her.

Samantha's story shows how difficult it can be to provide continuity of care for prisoners. Even though Samantha had engaged with a CARAT worker in prison and had an appointment arranged with the DIP team in the community, she failed to engage with these services. It should have been made clear to Samantha that the DIP team would be responsible for her substance misuse care in the community, and not her prison-based CARAT worker. However, Samantha did not just require support for a substance misuse problem and it is unlikely that her own priority was to address this, as she felt cannabis helped her to sleep. Perhaps, if all her needs had been assessed in prison, she could have been referred to the most appropriate services. Instead she was given information about a DIP service that she was unlikely to use, when she had more pressing needs such as organising accommodation and finances.

This example shows the importance of motivation in prisoners who want to address substance misuse issues. At least three of the female prisoners suggested this.

“You've got to want to help yourself, at the end of the day. If you're not willing to help yourself, there's no hope really.”

“But it's got to be me who wants to stop, I can stop for you but it's not the right reason, if I stop it's got to be for me and when I'm ready I will.”

Although male prisoners did not specifically talk about motivation, their experiences also highlighted the importance of adapting services to meet their needs. This was achieved for some prisoners and

demonstrated both management and informational continuity between prison and community-based services.

One prisoner had decided not to work with a CARAT worker in prison because he was already working with a substance misuse team in the community. He had been taking methadone for 16 years and the prison maintained this treatment. When we spoke to him in prison, he said that the prison GP had faxed his methadone prescription to the community team the previous week. This meant that the team would be ready for his release and would not have to waste time finding out what dose of methadone he had been taking in prison. This showed flexibility towards this prisoner's needs, as he did not want to engage with a CARAT worker but wished to continue working with the community team.

Unfortunately continuity such as this does not always happen, as a resettlement agency professional told us:

“We've seen it with those who've got drug issues, suddenly now their 'script information hasn't followed them out to the community and the next worker who's less likely to provide them with the right sort of drugs.”

(Resettlement agency)

Another prisoner had seen a drug counsellor once a week in the community but did not think that his counsellor knew he was in prison. Relationship continuity in this instance was disrupted as the prisoner was not receiving any treatment for his substance misuse problem in prison. However, he did not seem concerned about this and reported that he would re-engage with his counsellor on release.

The importance of continuity between sentences was described by one prisoner who had wanted to work with the same CARAT worker when she returned to prison after breaching her licence.

“She was my last CARAT worker when I was in here, so she knows a lot about me and as soon as I got in here I asked for [her] straightaway. I don't want no other CARAT worker... It helps when I'm in prison to see people I already know.”

One problem specific to the female prisoners was the levels of methadone they were prescribed when they came into prison. A few prisoners complained about having their dose of methadone significantly dropped to 25ml when they came into prison.

“That's one of my biggest [complaints] being reduced from 70mls straight down to 25 and that is dangerous. I think they should give people more methadone if you're on a 'script out in the community, that's my biggest thing that I wanted to say.”

Prisoners talked about the physical and mental side effects of this. One prisoner had been detoxed from heroin onto methadone in the community, but her dosage was dropped by 60mls within two days of being in prison and she told us she had ended up self-harming, having never done this before. These drops in methadone levels have even more of an impact on those prisoners serving short sentences. Their methadone levels are reduced for a short time in prison and then increased again in the community.

“I've done a telephone assessment, they said 'how much methadone are you on' I said '25' and she said 'are you still ill' and I said 'yeah, in the morning' and she said 'why don't they put it up' and I said 'well it's prison you know what I mean'. They [community drug workers] don't realise how it is in here.”

The final concern raised, again predominantly by female prisoners, was the impact that detoxing can have on mental health.

“ I think [about the detox doctor] you don't know nothing, you're detoxing me and I'm getting all these emotions and coming back to reality sort of thing. It's all flooding back. It's why I don't want to be detoxed now. ”

It is unlikely that substance misuse problems will occur in isolation. Prisoners will have multiple needs that require support and treatment. The actual process of detox may also have an impact on the feelings they experience and this may affect their mental health, particularly if the reason for taking substances was to cope with emotional difficulties.

“ She said I've got all these emotions in my head that I haven't felt for years, she said I can't cope with them and how to deal with them ... she said I can't cope, I don't want to feel what I'm feeling, which is why she took the drugs in the first place, she doesn't want to feel what she's feeling. ”

This highlights not only the importance of continuity of care for substance misuse problems, but that these prisoners have multiple needs and the importance of the prison and relevant agencies working together to provide appropriate care. This is likely to be difficult to achieve.

“ Our [CARAT workers] intervention is psychosocial, and the detox team are obviously the prescribers. We have an alright relationship with them. There's definite room for improvement ... The prison are recruiting new staff to help with that link, because I think they're very very under-resourced and they're very busy and there's a limit to what they can actually do in relation to working with CARATs and joint care planning. ”

(Substance misuse worker)

A recent report on West Midlands prisons found that although substance misuse professionals knew prisoners on their caseload had mental health problems, they did not know what treatment they were receiving (Durcan, 2008).



Early release

The End of Custody Licence (ECL) was introduced in June 2007 to reduce overcrowding. It allowed eligible prisoners to be released up to 18 days earlier than their sentence end date. Even though our interviews were being completed in late 2007 and early 2008, there was still confusion surrounding ECL.

The main concern expressed by prisoners was the lack of information about their new release date. This was not only frustrating for prisoners but could have an impact on continuity and resettlement needs.

“ *I just don't know where I am with my family, I don't just want to be rushed out and not told or nothing. I've got to pack and everything, they just don't realise.* ”

One male prisoner felt not knowing his release date had affected his mental health.

“ *It done my head in a bit, wanting to hear about it and would be better if they said you ain't got it, rather than the unknown.* ”

Lack of information about prisoners' release dates was also having an impact on continuity of care between prisons and the community. At the female prison, prisoners were supposed to have a meeting with a nurse prior to release. The purpose of this was to discuss any health needs, to check whether the prisoner had a GP, and to write a letter for the prisoner's GP detailing the medication they were on and the reasons for it. While there is no guarantee that prisoners will give the letter to their GP, for those that do, it provides a quick and accurate way of passing information on. This is crucial for continuity of care, but some prisoners were being released early before they could be seen in the pre-release clinic.

“ *That's crazy because if you get 18-day early release, you see the doctor two weeks before you go ... so if you get your 18-day early, you're out before you've seen the flipping [doctor].* ”

The inreach team told us that prisoners could be refused early release if they think a prisoner needs input from a community mental health team. However, they often do not know prisoners' release dates, whether these are through early release or not. The team leader told us this situation had now improved as administration staff had access to the local inmate database (LIDS) and could check release dates. If an inreach team is unaware of when prisoners are being released, this will have a huge impact on their ability to organise continuity of care for a group of prisoners that has severe and enduring mental health problems.

To be eligible for early release prisoners must provide an address, which has led some prisoners to lie about their housing status so they can be released early.

“It’s the amount of women you know that are homeless that all of a sudden have an address... I’ve been outside, coming into work in the morning, when people have been released on ECL and one of them even had the nerve to turn around to me and say ‘I’ve got nowhere to go’... [But] have you not just signed paperwork saying you’ve got somewhere to go?”

(Housing and Benefit Officer)

This was confirmed by the female prisoners who told us they anticipated being homeless on release but were released 18 days early. If a prisoner lies about their housing status and is then released early with inadequate housing arrangements, service providers are losing the opportunity to assist this person. Once in the community, released prisoners may ‘fall through the net’ and not be linked with appropriate help. Even for those prisoners who do engage with housing support in prison, it will be more difficult to arrange housing if they do not know their release date.

Unfortunately it is not only prisoners who do not know their early release date. One worker from a community agency commented on the problems early release caused for them. The organisation links prisoners to community services such as housing and substance misuse agencies. It aims to make contact with clients prior to release and then meet them on the day of their release. If the prisoner is told at the last minute that they have a new release date, they may not have the opportunity to inform the agency.

“They only get told the 18-day release at the very last second, so even if we had something working in the prison they can’t get that information to us. We have guys go out to some prisons, stand outside in the freezing cold all day and then [get told] ‘oh they were released two weeks ago’.”

(Resettlement agency)

If the service has not met the prisoner at the gate as planned then it can be hard or impossible to contact the prisoner once they are back in the community. This may prevent the service working with the client and can disrupt the continuity of the service in those crucial first few weeks after release.

“Major problems for us, we’ve got a release date of 12th December and we find out they’ve been released on the 28th November and you’re like hang on a minute. Then you’ve got to track him down, find him and a lot of time he’s disappeared.”

(Resettlement agency)

A prison-based CARAT worker also described similar difficulties. They often do not find out release dates until two days before release. Subsequently they have adapted their policy for arranging follow-up appointments.

“The person who obviously thought of this policy had never worked in a prison. What we do as a team is anyone sentenced who fits the criteria... we take off the 18 days and just work to that date anyway. The DIPs now know the situation within the prison, so will make a kind of impromptu appointment for a lady if she’s just come out.”

(CARAT worker)

The potential to be released 18 days early will have an impact on resettlement plans, particularly in organising accommodation and planning appointments on release. It is important that all agencies are aware, where possible, if a prisoner is to be released early. This again highlights the importance of informational continuity between agencies, particularly between the Prison Service and community agencies.



Short sentences

Prisoners serving short sentences appear to experience not only a lack of continuity but also less support from services in prison and the community. Half of the female prisoners for whom we had information received a sentence of 12 weeks or less. This would be automatically halved and with the possibility of release 18 days early, would mean serving approximately three weeks in prison. One female prisoner we spoke to was only in prison for ten days. Professionals defined a short sentence as one that lasted less than six months and felt that prisoners with a short sentence may be excluded from some services.

“ *If somebody has got less than six months it’s unlikely that they’ll be able to get on. So a short sentence prisoner is not going to be able to do the programme.* ”

(Substance misuse agency)

“ *Everything is set up for prisoners who are going to be in for a minimum of six months.* ”

(Employment agency)

Lack of services was considered a serious problem and was mentioned by eight of the professionals we interviewed. One professional felt it was such a pertinent problem because short sentenced prisoners are the ‘revolving doors’ population, the people who get caught up in the cycle of crime and prison.

“ *Take the short term prisoner which is the most dangerous prisoner because ... they’re out the door, they’re back in, they’re out the door and there’s no programmes for them, there’s no support packages in place because they haven’t got time to assess them or work with them at all.* ”

(Resettlement agency)

One woman prisoner had only been able to complete one week of a cleaning course before release because she had spent time on the waiting list.

“ *Yeah, well I’ve been waiting for the [course] but it only started Monday, and I really wanted that ‘cos I do cleaning on the out, so that would have been really helpful, but because I’ve done the first week I’ll get [a] certificate for that.* ”

Another prisoner, who had wanted to work in prison and had put in lots of applications, had not been given a job and had only been able to attend education classes a few days before release. Although she did not attribute this to being in prison for a short time, it is likely that a job would have been found for her if she had had a longer sentence. We asked her if she thought she would get a job at this stage of her sentence.

“ *It’s too late ... at this stage of the game I’d tell them to stick it up their arses, I really would.* ”

Interestingly, one prisoner found shorter sentences harder to do than longer sentences as she found she was always thinking about home, whereas with a longer sentence she knew she had to get on with life in prison.

“*Actually this has done my head in more, you probably think that’s strange but it’s the little sentences ... my head’s at the gate, my head’s home, whereas with my three and a half [years’ sentence] I had to get myself set for being in jail nearly two years.*”

This view is important to consider when professionals suggest that services are inadequate for short sentenced prisoners. Some prisoners may not want to engage in services or be proactive in their care if they are only in prison for a short time. One prisoner told us she was depressed and had been prescribed anti-depressants when she came into prison. She knew of services such as the Listeners in prison but did not want to use them.

“*Not because I’ve not wanted to, but if I was in here any length of time I would. I’ve got it in my head that I’ve only got a few weeks. If I was in here a couple of years I would use the services.*”

Coming into prison even for a short time can be disruptive for prisoners. They might be removed from their existing sources of support and services in the community and then not have these needs addressed while in prison. A professional working for an employment agency told us:

“*In that time no one’s had the chance to talk to her: what her housing needs are, what her educational status is, where her children are, no one’s had the time to do any work with her at all. All that has happened is that she’s gone into prison long enough to lose her children, to lose her home and to lose any work she might have had.*”

(Employment agency)

This disruption was further highlighted by Jessica’s story (Box 9) which describes her experiences of coming into prison for only ten days and perhaps suggests that a community sentence would be more appropriate in this instance. Community sentences are proving to be successful in reducing reoffending, with latest figures suggesting that frequency of reoffending for community sentences has fallen by 13% (Ministry of Justice & National Probation Service, 2008).

Box 9: Jessica’s story

Jessica only served ten days in prison. She told us she had received anti-depressants in the community but did not think these had helped. She had been prescribed different anti-depressants by the prison GP. When we spoke to her on release from prison, she said that she wanted another change in anti-depressants as her current medication was making her feel groggy.

Jessica had reoffended on release from prison and been given a 12-month suspended sentence with the condition that she attended a group three times a week, which she described as ‘looking at relapse prevention and crime prevention’.

When we spoke to her a few weeks after her release, and after she had been given a suspended sentence, she appeared much more settled. She was engaging with her substance misuse worker, was in the process of getting her anti-depressant medication changed and wanted to get a job.

A female prisoner who had served one of the longest sentences also reported the most positive experience of prison. She had received counselling throughout her sentence and this had helped to address her self-harming behaviour. She was able to complete a number of college courses and had put in applications for housing on release in two localities. Although she appeared very motivated to change, the length of time she served in prison had allowed time for her needs to be addressed.

While the male prisoners we interviewed served longer sentences than the female prisoners, those who did serve short sentences reported different experiences.

Most male prisoners had a history of serving prison sentences and in some ways viewed going into prison as an 'occupational hazard'.

“Life is full of ups and downs and prison is just part of this.”

“Once you are through the door and see someone you know then it is okay, and though I wouldn't say I enjoy it, I just get on with it.”

One professional suggested that the lack of services for those with short sentences does have an impact on reoffending and that the way to reduce reoffending is to offer adequate support services to prisoners with short sentences.

“Actually the easiest way to prevent reoffending is to put in, with the low risk prisoners who are the biggest number, the amount of support they need.”

(Employment agency)



Parents and partners

The majority of views expressed in this chapter are taken from the two focus groups we conducted with partners and mothers with experience of family members being in prison.

Emotional impact

The emotional impact of having a child or partner in prison was clear throughout the focus groups. The impact starts as soon as they discover that their child or partner has committed a crime. One mother described the confusion surrounding her daughter's arrest and how difficult it was to understand this.

“ I didn't believe my eyes or ears. It was like I was dreaming ... So immediately I went there to see if it was true ... yes a big shock. ”

(Mother)

Mothers in particular talked about the range of emotions they experienced while their child was in prison. Many of them described general feelings of anxiety and stress. One mother talked about how her daughter's imprisonment had affected her physical health. Her GP had suggested that she attend the family support group to help her to cope with her feelings.

“ For one month my BP [blood pressure] was very high. I can't do any other thing than just concentrate on this. My mind would not come off there. ”

(Mother)

Another mother had experienced a more extreme reaction to her son's sentence as she felt his imprisonment was like a death. Other mothers agreed with this sentiment and recognised that they were in a way grieving. One mother felt that her son's experiences of paranoia and depression were having a detrimental effect on her mental health.

“ I didn't go into my son's room for six months. I didn't wash his clothes or anything. I couldn't bear it. I couldn't even bear his name being ... you know. And I thought to myself, do you know what my son is not dead. ”

(Mother)

The impression from the focus groups was that mothers experienced more general feelings of anxiety and depression, whereas partners seemed to attribute their feelings to the specific situations in which they found themselves. One woman was particularly stressed because she was the only family member in the UK supporting her partner.

“ *Very stressful... especially with my one. He’s [one of the], what do you call them, foreign nationals. It is a lot on me because obviously they [his family] have to communicate through me by phoning me.* ”

(Partner)

As these examples demonstrate, mental health problems are experienced both by prisoners and their families. The impact of imprisonment is twofold, with both prisoners and family being emotionally affected by a prison sentence. This impact continues to spread beyond the immediate family, as mothers were also concerned about the emotional impact on other family members. One mother was particularly shocked by the impact that her son’s imprisonment had had on her other children.

“ *They knew he was in trouble but they didn’t know this was going to happen to him ... They just cried and cried and cried and I didn’t expect that. I don’t know what I expected really.* ”

(Mother)

In addition to dealing with their own emotions regarding their child’s imprisonment and seeing the impact it had on other family members, mothers also had to carry on with the practical tasks of being a mother which at times was difficult.

“ *I couldn’t eat, I couldn’t cook, I couldn’t... When you’ve got other children that depend on you it’s just terrible.* ”

(Mother)

The extent of the emotional impact on family members is obvious and the mothers particularly appear to have struggled with this at times. The support group in which we met them was important to the women. It was clear from our experience in the focus groups that the family members received a lot of support from each other.

“ *It was when I came here, I saw people of my own ... at that time I thought I was just the only one it had happened to, so I could not even discuss it among friends.* ”

(Mother)

Prisoners did not discuss the emotional impact that their imprisonment might have had on their family. Only a handful of prisoners mentioned receiving visits from their family, and for a couple of prisoners this was because they did not want their children to visit them in prison. For example, one prisoner did not want his daughter to experience the trauma of being searched and another did not want his daughter to have any memories of him being in jail. This prisoner wanted to stop reoffending because he did not want his daughter to start school and have to explain that her father was in prison.

This illustrates prisoners’ concerns about the emotional impact of imprisonment on their children, but it also shows how the ‘continuity of support’ they could have received from family members might be disrupted if they do not have regular visits.

Roles of family members

It was clear from the focus groups that mothers and partners had to fulfil a number of roles for their children and partners while they were in prison, which were succinctly described by one mother.

“ They expect me to be a solicitor, a barrister, a mother and a banker all at once. Do you know what I mean? And the stress is just unbelievable. ”

(Mother)

These roles, particularly for one mother, started as soon as her child was remanded into custody as she had to start looking for a solicitor. This was made more difficult as the mother lived in London and her daughter was in prison in Manchester. She said that making decisions on behalf of her daughter had been quite difficult as her daughter was unhappy with the solicitor that she had found.

“ Now she started complaining that she’s not seeing them regularly. But me, I cannot afford a paid lawyer so it’s the legal aid. ”

(Mother)

Both partners and mothers talked about helping prisoners with accommodation after their release, although they had different experiences of this. One partner described how her partner had lived in her home last time he had been released from prison. She had not known when he was going to be released and he just turned up there. A male prisoner expressed a similar experience. He did not intend to tell his mother when he would be released but planned to turn up and see if he could “blag it” for a few weeks. Mothers had a more realistic view about whether it would be appropriate for their children to live with them on release from prison. One mother recognised that, although she might want to look after her daughter, it would not be appropriate for her to do so.

“ My daughter, she’s a big girl. She’s not a baby any more. You can’t just put a mattress in your bedroom for her to sleep on. She needs her own privacy. ”

(Mother)

Another mother agreed with this sentiment and said that while it would be nice for her son to come and live with her, she would worry about him all the time and hoped that he would get some housing support on release.

“ I just don’t think there’s the support out there when they are released. I don’t know. I’ve not looked into that. ”

(Mother)

The need to provide financial support for prisoners was something that affected the mothers and partners in different ways. Mothers did not explicitly discuss the financial impact of their child being in prison, but the roles they play, for example arranging solicitors, caring for their grandchildren and providing support with accommodation, would be likely to have some financial effect.

Partners described the financial cost of imprisonment. One woman had to make a ten-hour round trip to visit her partner and, although she received financial assistance, she sometimes had to wait to be reimbursed.

“ Yeah as long as it’s within a reasonable amount, they’ll help you with it, but sometimes you have to wait a bit longer to get it back so you’re short... You have to wait so long to get your name put in the system and then you have to wait and wait for the money to come through. ”

(Mother)

Receiving visits is not the only way to keep in contact with family and friends, but as one prisoner described, the prison regime can make it difficult to maintain contact by other means. One male prisoner said he only had the opportunity to speak with his partner when he was out of his cell in the morning and she was at work. Therefore he was never able to speak to her and this made visits even more important.

Another partner told us about the cost of supporting her partner when he was released. He left prison with a £42.50 discharge grant but then had to wait eight weeks until his benefit claim came through, leaving his partner to buy food and pay utility bills. Her partner felt that without money or a job he would reoffend. This is likely to put added pressure on her to support him.

“ [We] went to the Jobcentre to sort out some money. I used to go over there with him and he'd say I need some money otherwise I'll end up going back in prison doing the same thing. ”

(Partner)

This woman was also supporting her partner financially on his current prison sentence by sending him money so that he could buy food from the canteen (the system by which prisoners can buy items such as toiletries, cigarettes and food). This was confirmed by the male prisoners in particular, who told us that their family sent in money for them. Conversely, one female prisoner who had been unable to get a job in prison felt the impact of not having anyone to send her money.

“ It's only been the day before that they've put me into education ... so I've had nothing ... I've got no money coming in ... I've pressed and pressed and pressed to get to education, it's a tenner a week ... It's okay for a lot of women as they get money sent in and clothes and stuff. All I've got is what I stand up in. ”

The final role that fell to mothers and partners was caring for a prisoner's children while they were in prison. This had more of an impact on the mothers we spoke to as they were looking after their grandchildren and supporting their child in prison. One mother said she was looking after her granddaughter because her daughter-in-law, the child's mother, was only 19 years' old and she tried to help when she could.

Half of the male prisoners we interviewed had three or more children and nearly three-quarters of the females had one child or more. A large number of female prisoners were not caring for their children prior to this prison sentence, as they were already being cared for by family or social services due to previous substance misuse problems or previous prison sentences. However, it is important to consider the impact prison has on the children who do have regular contact with their parents and the discontinuity created by a prison sentence.

Views about the prison service

Clearly mothers and partners play an important role in their family member's time in prison and subsequent release. It appears that the mothers seemed to fulfil more roles and felt more pressure on them to support not only their child in prison but also their extended family. Most of the family members we met had a negative view about the prison service, suggesting that the importance of relatives in resettlement is not recognised or valued.

Lack of information from the prison was highlighted. One woman said she only found out that her partner had moved prison when she tried to visit him.

“No one tells us anything, when he got moved, no one told me. I went there [to the prison] and he wasn't there, then I found he'd been moved. He wasn't able to [contact me] he didn't have any [phone] credit left.”

(Partner)

Another woman told us that her nephew had been hurt in prison but that his mother had not been told about this for three days.

“Someone threw oil that wasn't meant for him ... They did not contact my sister for three days, to tell her what had happened to her son. They said they didn't have her address ... There's just no excuse. They just don't really care, they don't care.”

(Partner)

The women were most upset when they felt they were treated as though they had done something wrong.

“From my personal point of view when I walk in there I'm treated like a piece of shit. My son's treated like a piece of shit. They don't differentiate between their crime and me. We are the same. They treat you like you're a piece of shit. And I'm sorry for saying that, but it's true.”

(Mother)

This experience was echoed by a partner who had a negative experience when being searched on entry to the prison and felt that a prison officer had been rude to her. She had complained about this and received a letter of apology from the prison service, but still felt that negative remarks were made when she visited. The women were obviously upset about the way they were treated when visiting the prison.

One partner described the journey to visit her partner in prison.

“You have to get off the train, you have to wait for a bus, you don't know how long you'll have to wait for a bus ... it's on top of this high high hill, it's not a nice place. I don't like it. I wouldn't really go up there by myself...it's not nice.”

In 2007, the average distance that a male prisoner was held from their home was 49 miles. This rose to 55 miles for females. However, 10,100 male prisoners and 800 females were held over 100 miles away from their home (House of Commons, 2008a). Yet support from friends and families is critical in providing accommodation, practical advice and financial support, and in finding employment (Hartfree, Dearden & Pound, 2008).



Pre-release work

Seven of the nine community agencies reported meeting their clients in prison prior to release. This practice was considered essential in providing continuity and served several functions.

“ We go and assess the prisoner before they come out and see what we can do for them in the community.”

(Forensic CPN)

Pre-release needs assessment is essential to maintaining continuity of care. If needs are not assessed while the prisoner is still in custody, then the appropriate services cannot be expected to be available when they are released. This will either result in a delay in service provision or could mean services are never provided. Thorough needs assessments carried out in prison will help to ensure the appropriate service is in place when the prisoner is released.

The practice of meeting prisoners before release was also said to be essential to developing a good rapport. One professional reported that contacting the prisoner before release affected the way they engaged with the service later.

“ I think the through the gate stuff works so much better. Clients that we see prior to release tend to engage much better ... If we meet them at the gate and we've never seen them before, there's less chance.”

(Resettlement agency)

A prison housing and benefits officer suggested another reason for seeing clients prior to release:

“ If people are doing community work then they need to get in here and see their clients while they're in here because, if nothing else, you get to see your clients while they're not using drugs, so you can have relatively good sessions with them.”

(Prison housing and benefits officer)

Pre-release work also affords the opportunity to develop an action plan of future objectives for the prisoner, for example organising educational courses or housing referrals.

One professional said it could be very difficult to track and contact prisoners in the community.

“ If you don't catch them as they come through, then you're likely to never catch them.”

(Employment agency)

A forensic CPN suggested that to improve continuity of care, community teams should be involved well before the prisoner is released.

“ Well before they [prisoners] come out, I think the prison service should negotiate or liaise with the community teams. Then we can start going into prison, showing our faces, seeing these people before they even come out, so we can get them accommodation or a package of care. It’s not like we’re alien or whatever: they know us, they’ve seen us in prison.”

(Forensic CPN)

While pre-release work may be crucial, it is also often difficult. Prisoners may be moved between prisons at short notice or be in prisons outside their local area, which makes pre-release work harder. Prisoners’ priorities may also change once they leave prison. They may agree to engage with a service while in prison but change their minds once they are in the community.



Access to services and information

The ease with which a prisoner learns about and gains access to a service is critical. This chapter is based on interviews with professionals and examines how prisoners are referred to services, what information they get and what barriers they face to using services.

Referral routes

The interviews revealed a number of the current methods for informing prisoners of the available services. These included posters, adverts in prison newspapers and leaflets.

All but one of the non-statutory organisations reported that their referral process with prisons and probation was adequate. One agency said that they got very few referrals from statutory agencies, despite having had a good relationship in the past. Other agencies reported that the decrease in referrals was due to the increased regulations that statutory agencies must abide by.

“ We used to have, years ago, quite a good relationship with probation, but ... probation felt they could no longer refer to us unless we were part of the monitoring. So women would only come to us as part of probation and we weren't willing to do that because we thought it was best to maintain our integrity with our clients ... It has to remain voluntary. ”

(Employment agency)

According to one professional, the probation service does not refer prisoners to organisations unless they have a formal relationship with them. No other professionals made similar comments, so it is unclear how widespread this practice may be. However, if the probation service only refers clients to organisations with whom it has a formal relationship, this may limit their support options.

One professional said it was important that prisoners self-refer. This gives the prisoner the choice of whether to engage with the service.

“ They make the referral themselves because part of it is empowering the client to make the choice themselves. ”

(Resettlement agency)

Other professionals from the same agency told us that for prisoners to turn their lives around the change has to come from within. In the case of someone with a substance misuse problem, they need to be motivated to change. One male prisoner had received a letter about working with a DIP worker on release. He said he would only want to engage with the service if drugs were offered to him and therefore he was unlikely to engage with a DIP worker on release. Although efficient, formal methods of informing prisoners about what services are available may not work if, ultimately, the prisoner decides not to engage with the service.

By contrast, several agencies told us that prisoners were commonly informed about services through word-of-mouth from fellow prisoners. Prisoners seem to tell their peers about services they have heard about or have previously used.

“*Word of mouth in prison, it's better than BT. Once you've worked with one of them, he gets moved to another prison and he tells them about it.*”

(Resettlement agency)

Learning about services in this manner could be a reflection of how prisons function. But services cannot rely on prisoners spreading information by word-of-mouth as information passed on in this way may not be distributed thoroughly or completely.

One female prisoner described a situation where word-of-mouth was not an effective way of learning about services.

“*I tell you what, this is what I've only heard in the last few days when I'm due to get out, but if I'd heard about these and they'd been more available I would have wrote to them ... But nobody told me about them, I got to hear about it from someone else ... Women should be told about these things ... lots of them are frightened to bits, too scared to talk to other inmates.*”

Difficulties in getting access

Although professionals thought referral processes were adequate, prisoners could still have difficulties in gaining access to a service. This seemed partly to be due to a shortage of services. One non-statutory substance misuse agency's specialised service was not provided in all prisons and a transfer to a prison where it was available was often difficult.

With the current overcrowding in prisons, prisoners are more likely to be transferred. This is evidenced by an increase in prison transfers from 5,302 in April 2007 to 6,256 in February 2008 (House of Commons, 2008b). This has an impact on prisoners who may have used a service in one prison but be unable to do so in a different prison. This may have an impact on any resettlement plans they have tried to arrange.

Our interviews indicated that the greatest barrier for former prisoners trying to gain access to services was caused by their difficulty in keeping appointments. This appeared to be a result of both the chaotic lives of released prisoners and of fragmented services.

Prisoners with complex needs might have a large number of appointments to keep and this can cause a logistical problem for the released prisoner.

“*There's housing appointments, there's going to the doctor, there's having to attend your probation officer ... there's having to pick up your methadone script ... Just any small crisis, like your taps aren't working, it all becomes a lot more difficult for someone who's living a chaotic lifestyle and who is vulnerable. It's a lot more difficult for them to sort out.*”

(Employment agency)

Difficulty in keeping multiple appointments is often made worse by services being 'fragmented'.

“*They're on probation orders or court orders and they would turn up at a probation place and they will turn up at the employment centre and they won't go to their housing office or they won't go to their behavioural specialist because they're all too fragmented.*”

(Resettlement agency)

As well as services being fragmented by location, professionals also implied that services do not communicate efficiently with each other. Released prisoners may have appointments to see service providers in several different locations at times which are perhaps not well coordinated. This will force people to choose which appointments to attend and therefore which needs are met.

One prison housing officer implied that prisoners who did not fit into particular boxes experienced the greatest difficulties in obtaining housing.

“If you’re just an ordinary prisoner and you’ve got no drugs, no alcohol [problems], you’ve just served a sentence, it’s sometimes difficult ... because a lot of the hostels will only take dual diagnosis.”

(Housing and Benefits Officer)

Released prisoners with no fixed abode were also said to experience particular difficulties in getting access to services. One organisation explained that local authorities will not take responsibility for homeless prisoners and therefore will not provide funding for the service required.

“Prisoners that are of no fixed address, NFA, homeless, find it the most difficult to access services because there is no local authority that will take responsibility for them.”

(Substance misuse worker)

As prisoners can be often located in prisons a long way from their homes, prison resettlement teams do not necessarily know about services outside their own locality.

“If you are in a prison away from your home, when you’re released you’re not going to be linked in with the services you need in your home area.”

(Employment agency)

Due to overcrowding local prisons are taking prisoners from other areas and this is having an impact on resettlement arrangements. Hartfree, Dearden and Pound (2008) explored employment outcomes for released prisoners. They found that employment and benefit surgery advisers were finding it difficult to conduct job searches and provide prisoners with information about community services because they were not familiar with the area to which the prisoner was being released.

One agency reported that prisoners might want to relocate to a different area when they were released from prison. Relocation would perhaps offer the released prisoner the opportunity to move away from factors in their old community that prompt them to offend. But relocation might be difficult unless the prisoner has established links, for example family, in an area. Local authorities may be unwilling to help to relocate ex-prisoners with multiple needs who will require funding.

“A lot of the women will, especially if they’ve had a chance to detox or stabilise, want to start afresh and that’s a very difficult thing to do unless you’ve got links in a different borough and that borough is willing to take you. If you’re a drug user you’re going to be quite resource intensive, so boroughs don’t really want you.”

(Substance misuse worker)

Two female prisoners explained their reasons for moving:

“I came to [name of town] to get away from all my associates. I didn’t know anybody.”

“I’m going to my mum’s ... It’s good because I can go to my mum’s and know I won’t be bumping into people every 20 metres, like a little safety net I suppose.”

Access for people with mental health problems

Several agencies discussed access to services for people with mental health problems. They reported that having a mental health problem did not impede access. Five organisations suggested that a diagnosis might facilitate access.

“ *When mental health issues [are] normally diagnosed ... we could get far quicker treatment.* ”

(Resettlement agency)

A substance misuse agency reported that having a mental health problem would not affect access but might shape the service in terms of providing extra support.

“ *[A mental health diagnosis] could possibly alter the way they interact with the service or whatever, but only from the point of view that the counselling team needs to be aware that the person has got other issues.* ”

(Substance misuse agency)

It was suggested that although disclosing a mental health diagnosis might facilitate access to services, prisoners may be reluctant to disclose mental health problems.

One organisation reported that a diagnosis of personality disorder might not help an ex-prisoner who was trying to get access to services.

“ *In terms of the homeless person's unit, if you've got a personality disorder ... it's not really classed as a mental health issue ... It won't get you into accommodation or anything, you'll be with everyone else, it's catch 22.* ”

(Resettlement agency)

Another organisation noted that prisoners with common mental health problems are not being identified on entry into the prison system.

“ *All the people going into prison with lower-level mental health problems, they're not being picked up.* ”

(Resettlement agency)

This agency suggested that the mental health screening tools used by the Prison Service only pick up the most severe mental health problems.

“ *There's one screening tool, which I think is called TAG, which is like ten questions and the only thing you can actually gain from that is you can tell if someone is completely psychotic.* ”

(Resettlement agency)

The importance of frequent assessment of mental health problems was highlighted by female prisoners who had continuing problems with depression and by male prisoners who appeared to be affected emotionally by situations they found themselves in during their prison sentence, for example uncertainty about release dates or problems with cell mates.



Individualised care

Many organisations emphasised that the journey from prison back into the community was different for each prisoner.

Flexibility

Five of the eight non-statutory organisations said that providing a flexible service was an integral part of what they offer.

“Some of the women we work with have been coming here for a really long time. We decided we don’t have a specific set end date because everyone’s journey takes a different amount of time.”

(Employment agency)

“Twelve weeks is usually the standard sort of thing ... but it depends on the individual as well. Sometimes that individual might need longer.”

(Substance misuse agency)

By contrast three of the voluntary organisations reported that statutory services did not individualise their service. This was put down to a lack of facilities and their high volume of clients.

“Every statutory agency is so overwhelmed that they don’t have the facilities or the ability to really get involved with their client and so what they want is for people to turn up to appointments, so that they can ‘tick off’ and say that they’ve done this, this and this.”

(Employment agency)

One non-statutory organisation implied that statutory services do not make an impact on reoffending rates because they do not individualise their service.

“They [statutory services] don’t seem to be investigating what’s really happening in the lives of these people and consequently you’re going to have very high reoffending rates because the support isn’t there.”

(Employment agency)

The need for employment support differs from prisoner to prisoner depending on the stability of other factors in their life.

“[Employment] that’s more of a longer term goal really, but you do get some people that are more job ready and their lives are little bit more sorted outside.”

(Resettlement agency)

One agency suggested that employment was less of a priority for women than it was for men. They suggested that women may have been out of employment longer, may have never worked and may have childcare commitments. The same organisation suggested that, compared with men, when women go into prison their children are more likely to go into care. Therefore, when women leave prison, their priority is to get their children back and care for them rather than to find employment.

This difference prompted one service provider to comment on prison education services.

“A lot of prison education is designed around men. Rehabilitation is designed around male needs, and the men’s needs are generally for getting work. For women the issues are different.”

(Employment agency)

The overarching theme seemed to be the importance of individualising services to fit prisoner needs.

“There needs to be more of a genuine attempt to understand what the individual circumstances are for each person. That’s the problem because you can put them into categories of male offenders and female offenders and people with a history of drinking or drugs, or you know. But they’re actually all individuals and they’ve all got a mixture of reasons and they all need that dealt with.”

(Employment agency)

Retention

Once a released prisoner has begun to use a service, continued engagement is vital. Professionals told us that continued use of the service may depend on factors such as the independence of the agency and what prisoners want from a service.

“Because [name of service] is independent, the clients don’t see us as part of the system ... If this was, for example, part of the police or we were probation officers I don’t think we’d have the same rate of success.”

(Resettlement agency)

Continued engagement with services depended on the individual. Despite efforts from services, we were told that some released prisoners did not want to cooperate.

“Some of them will not engage, will not stick to the appointment ... I’ll say ‘I’m coming to see you’, or I’ll tell them ‘there’s an appointment, come to the hospital and see me’. If they don’t, I go there ... sometimes they don’t open the door and I’ll wait by the door until they open [it] eventually.”

(Forensic CPN)

Such difficulties may be caused by an individual’s poor mental health. This shows that it is important for professionals to persist in their attempts to engage with released prisoners.

A housing organisation suggested that some clients are committed to the service until they have received accommodation. After this the clients may not want the continued support that is also part of the service.

“They very much do engage initially when they get the flat, because obviously it’s in their interest and they want the help, but then people may not want the support, or not engage.”

(Accommodation agency)

One professional said that prisoners may want continued support with obtaining benefits or accommodation, but they do not want someone ordering them to take their medication or telling them not to do something.

One statutory service provider suggested that some released prisoners want to continue to commit offences and do not want any assistance from services.

“ Some of them just want to go back into their criminal behaviour, they want to be left alone you know.”

(Forensic CPN)

If prisoners are likely to return to their ‘criminal behaviour’ they may not want to be found on release.



Relationships between agencies

All the agencies stressed the benefits of communicating and sharing client information with other service providers. This helps to improve services and helps to ensure that the multiple needs of prisoners are met.

“ In an ideal world it makes it better if we do know everything and are able to liaise, so that we’re not going off on a tangent, and we’re not doing something in conflict. ”

(Accommodation agency)

Information sharing

The amount of information shared between service providers varied. Some organisations had to rely solely on the information given to them by the client. This information was reported to be often limited or distorted.

“ A lot of my job is to put together the information they give ... A lot of the time prisoners are very economical with the information they give. ”

(Resettlement agency)

Inter-agency communication would help to increase the amount of client information available to each organisation.

“ It would be really good if there was some way that I could talk to the other people involved in that person’s care ... if they could tell us more about what’s happening with a client ... so that, when somebody hasn’t been coming to class, I can find out if they’ve started using [substances] again. ”

(Employment agency)

Another agency suggested that the National Offender Management Service (NOMS) should take the lead in improving information sharing between agencies.

“ 80% of prisoners’ information isn’t transferred and the information that is transferred about probation clients is very, very cursory ... so there’s huge scope for improvement but it needs to be picked up, by NOMS essentially, and it needs to be commissioned, and it’s starting to go that way. ”

(Resettlement agency)

Working relationships

The quality of relationships and information sharing was reported to depend on individual good practice.

“When it’s a legal formal record, like prison, like probation, then sharing that information is restricted for security reasons. You might be able to access that but it’s driven by individual good practice ... rather than a system’s basis.”

(Resettlement agency)

Individual good practice also seemed to be the key to good working relationships with other organisations.

“It’s variable ... some agencies we have good relationships with ... I think it’s often individuals within those organisations.”

(Accommodation agency)

Good working relationships between individuals seem to facilitate good communication at many levels. For example, forming a good relationship with prison officers can help with sharing information.

“Informally you do get prison officers dealing with the situation who know the client in and out and say: this is what his background is.”

(Resettlement agency)

Communication difficulties

All the agencies reported some level of interaction with at least one other agency. However, communication problems and difficulties between organisations were frequently reported. Some professionals described resistance from statutory agencies to working with non-statutory agencies if no formal relationship existed.

“They [statutory agencies] don’t see why they should have to liaise with us.”

(Accommodation agency)

One professional from a statutory agency told us:

“I don’t normally give them everything. I just give them what they need.”

(Forensic CPN)

One non-statutory organisation implied that statutory agencies could benefit from the information gathered by voluntary organisations. They reported that statutory agencies never ask for information from the non-statutory agencies.

“ They tend to be voluntary organisations that ask us to share information. Statutory agencies tend to have absolutely no interest ... I think in the assumption that we couldn't possibly tell them [anything]. ”

(Employment agency)

“ Some statutory agencies wouldn't really understand what we do. ”

(Accommodation agency)

To address this lack of understanding, non-statutory agencies need to promote their work more widely and thoroughly by informing the statutory agencies of the role they play in resettling released prisoners.

“ I mean the ways to do it are sort of attending meetings, forums and doing reciprocal things, inviting other agencies to our agency and I suppose it's just trying to understand what we do. ”

(Employment agency)

Competitiveness

One non-statutory organisation reported competition between agencies working within prisons providing similar services. Non-statutory agencies experience a lot of competition for clients.

“ There are lots of agencies and it can be quite competitive because we all have similar clients that we are trying to pick up. ”

(Resettlement agency)

“ If you've got our clients' best interests at heart then people tend to work together well. But in some cases the environment doesn't support that, it supports competition, certainly in prison ... that issue of a whole unregulated raft of agencies coming in is a problem across the Prison Service. ”

(Resettlement agency)

A recent increase in formal relationships between prisons and non-statutory agencies should reduce the likelihood of agencies duplicating work.

“ The Prison Service allows it to happen largely because these people [the non-statutory agencies] come in and do things at no cost to the prison but we're moving towards nationalisation, so systems are being implemented for that not to happen any more. ”

(Resettlement agency)



15

Recommendations

Recommendations for the NHS

GP led health centres

Our findings support the Next Stage Review recommendation that GP led health centres should be developed to supplement existing services. These centres will enable people to walk in regardless of which local GP service they are registered with (Department of Health, 2008b). These would allow prisoners who are not registered with a GP to gain access to primary care on release, regardless of the area they have relocated to.

Need for a key care coordinator

Our findings support the need for a key co-ordinator who can help released prisoners to navigate through the large number of agencies they need to access, such as mental health, substance misuse, housing and employment services. It is also important for prisoners to have their needs met according to their own priorities, for example prisoners may want to organise benefits and a place to live before receiving treatment for substance misuse problems.

For some prisoners this role would be carried out by a CPA care coordinator. But for those prisoners with lower-level mental health problems, such as depression and anxiety combined with a number of other complex needs, this role should be fulfilled by an agency that can liaise between prison and the community. Our findings show the importance of engaging with a prisoner before release to ensure that care is arranged in the community.

Continuity into prison

Many of the prisoners we spoke to had been receiving a range of services in the community, for example, mental health and substance misuse treatment and support. However, information about the support they were receiving is often not passed on to the prison service. Therefore our findings would recommend that continuity into prison needs to be improved to ensure prisoners receive a seamless provision of care into and out of prison.

Improvements to primary care in prison

Most prisoners we spoke to had mental health problems such as depression and anxiety and were receiving care from the prison GP. However, the majority of prisoners were unhappy with the care they received, particularly the waiting times to see a GP, the short appointment times, and the lack of follow-up care. Therefore our findings would support the role of a primary mental health practitioner (as suggested by Durcan, 2008). Their functions would include screening for mental health problems, conducting brief interventions such as cognitive behavioural therapy, and liaison with internal and external agencies.

Recommendations for Government

Use of community sentences for female offenders

Our findings support the Corston Review (Home Office, 2007) recommendation that prison sentences should only be used for serious and violent female offenders, and that community sentences should be used to the extent that they make the need for short prison sentences redundant. A non-custodial sentence would give female offenders an opportunity to address their multiple needs for support with accommodation issues, substance misuse and mental health problems. A community sentence would also mean that the continuity of services received in the community would not be disrupted by a woman going into prison.

Specifically our findings would support the use of the Mental Health Treatment Requirement as part of a Community Order or Suspended Sentence Order. This would have been an appropriate non-custodial alternative for the prisoners we interviewed who had not received any support in prison for mental health problems, such as anxiety and depression, and a range of other complex needs.

Recommendations for HM Prison Service

Improve communication about End of Custody Licence dates

The End of Custody Licence was initially brought in by the Government as a temporary measure to reduce overcrowding but has now been in use for over a year. Prisoners and professionals should be informed as soon is practicable about a prisoner's release date so that plans for mental health treatment, accommodation and substance misuse can be arranged in advance of release.

Support for families

The mothers and partners described their role in caring for prisoners during their prison sentence and on release. These findings suggest that the Prison Service should recognise the importance of this role and ensure that they treat families with respect and provide appropriate support, for example, by providing families with appropriate legal advice.

Recommendations for local authorities

Importance of housing

Our findings support the need for Public Service Agreement 16 (Increase the proportion of socially excluded adults in settled accommodation and employment, education or training) (HM Government, 2007) which recognises the importance of settled accommodation for adult offenders under probation supervision and those in contact with secondary mental health services. With stable housing it would be much easier for released prisoners to gain access to health services (as well as employment and benefit services) and would improve continuity of care from prison to the community.

Opportunity for relocation

Prisoners and professionals highlighted the problem of relocation on release from prison, both in terms of trying to obtain accommodation and in accessing substance misuse treatment and support. Our findings suggest this process should be made easier and prisoners should be able to relocate to a new area on release from prison.



Glossary

Counselling, Assessment, Referral, Advice and Throughcare (CARAT)

All prisons have CARAT workers who act as keyworkers and coordinate the care of prisoners with substance misuse problems. They assess need, give advice about substance misuse and refer prisoners to appropriate services.

Care Programme Approach (CPA)

CPA is an approach to case management adopted by all secondary care mental health services in the community (i.e. outside prison) in England. A care coordinator is appointed to coordinate various elements of care and to organise multidisciplinary reviews. The CPA should involve both users and carers in the planning and reviewing of care.

Drug Intervention Programme (DIP)

The DIP is part of the Government's strategy to tackle drugs and reduce crime. The programme aims to get people out of crime and into treatment and support for substance misuse problems.

Drug Rehabilitation Requirement (DRR)

The DRR is one of the requirements which can be included in a community sentence. It involves treatment and regular drug testing.

End of Custody Licence (ECL)

This scheme was introduced in June 2007 to deal with overcrowding in prisons. It allows eligible prisoners to be released 18 days earlier than their expected sentence end date.

Listeners

These are prisoners trained and supported by Samaritans to provide peer support to prisoners.

Local Inmate Database System (LIDS)

HM Prison Service electronic database which holds information about prisoners.

National Offender Management Service (NOMS)

NOMS was created in 2004 and its key aim is to reduce reoffending through delivering end-to-end management of offenders.

Prison Service Order (PSO)

Prison Service Orders are mandatory instructions about how different aspects of the prison should be managed.

Reception

The area in a prison where all arrivals and discharges are processed.



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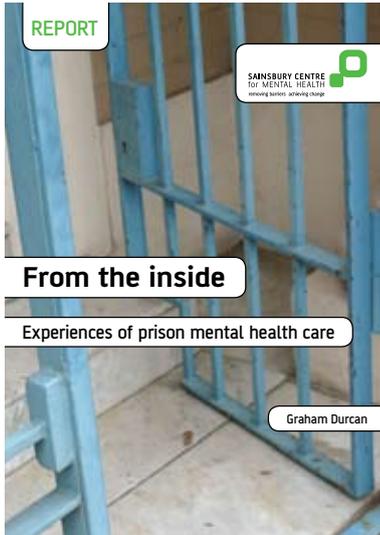
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