Restarting a prisoner's life onto a supportive path leading to RESETtlement in the community:

The RESET Study

Final Report

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1. Executive Summary

The potential of not having secure accommodation upon release from prison is a major problem for prisoners with mental health needs. This study focused on evaluating an intervention that supported prisoners upon their release from prison with the primary objective being to support them in finding accommodation release from prison service.

In September, 2019 there were 83,518 prisoners detained in England and Wales (Her Majesty's Prison and Probation Service, 2019).

The period of transition from prison to the community has been acknowledged as a confusing and chaotic experience for many which is intensified by being homeless. A recent survey ascertained that 36% of people found rough sleeping had previously been in prison (CHAIN, 2018). Being homeless is viewed as a major factor in the likelihood of reoffending (Homeless Link, 2018) and not engaging with support services (health services, GP services, welfare benefits) (Williamson, 2007).

It has been estimated that over 90% of prisoners have one or more psychiatric disorders (psychosis, neurosis, personality disorder, hazardous drinking and drug dependency). The period directly before and following release from prison is a highly stressful and isolating experience that exacerbates mental health problems (Theurer & Lovell, 2008; The Mental Welfare Commission for Scotland, 2017). Hopkins & Thornicroft (2014) have also reported that prisoners with mental health problems have twenty-nine times the rate of all-cause mortality during the first two weeks after release compared to the general population and are 8.3 times more likely to commit suicide in the twelve months following release from prison compared to the general population. Hancock et al (2018) has proposed that secure housing is the most important factor in ensuring a positive transition from prison to the community for people with mental health problems due to:

- It is impossible to address mental health support and treatment before a person has stable accommodation
- without housing they are lost to care. If someone does not have a fixed address, they are difficult to locate and connect with which makes it hard to provide support
- housing helps break a cycle of returning to poor previous relationships and routines

Providing support for prisoners with mental health needs upon their release has the potential to be an important factor in helping reintegrate this cohort into the community through helping to find secure accommodation, improving health and wellbeing, engaging with services, re-establishing contacts with family and friends and reducing reoffending. The Bradley Report (2009) noted if prisoners receive the support they need inside prisons, they were more likely to engage with services outside prison. The report added for the resettlement of prisoners with mental health needs into the community to be successful, it was important to ensure that the engagement that had started in prisons continued once prisoners leave the prison gate.

However, the evidence for the effectiveness of existing services approaches is limited. Hopkin et al (2018) undertook a systematic review examining interventions for prisoners with diagnosed mental health conditions that targeted the transition period between prison and the community. Thirteen studies were found (with only two in the UK). The conclusions drawn were that there was some evidence that the interventions examined could improve contact between service users and mental health and other services. However, evidence that it reduced reoffending was equivocal and none on of the studies had examined whether the intervention improved access to secure accommodation.

During the period of the study, the standard care package offered to prisoners upon their release was based on the government's Transforming Rehabilitation strategy aimed to reduce reoffending and to provide a seamless transition between prison and the community by developing "Through the Gate" services (Ministry of Justice, 2013). The Through the Gate service was delivered by the newly commissioned local Community Rehabilitation Companies (CRCs) to help prisoners maintain or find accommodation; aid with finance, benefits and debt; and to support them to enter education, training and employment. It has been noted that prisoners with mental health needs present different challenges, have multiple and complex needs and require a more focused approach than the support provided by the CRCs. In addition, limitations in the amount of support and assistance offered to prisoners with mental health needs and, in particular, the lack of planning and arrangements for suitable accommodation were identified by Her Majesty's Inspectorate of Probation reports (HMIP, 2019).

To provide intensive support to those who had offended but also have identified mental health needs, Oxleas NHS Foundation Trust commissioned Clarion Housing (at the time known as Centra) and Nacro to provide a resettlement service for prisoners with mental health needs upon their release; the Supporting Prisoners upon Release Service (RESET) Intervention service. Clarion Housing worked from HMP Elmley, HMP Rochester and HMP Stamford Hill, while Nacro and Clarion Housing operated in London from HMP ISIS, HMP Belmarsh and HMP Thameside. The threshold for meeting the criteria for receiving support was that service users must have had limited community support in place, high rates of reoffending, and meet at least step 3 on the Oxleas stepped care model. The RESET service was based on the principles of the Critical Time Intervention (CTI) approach. CTI is a structured, time limited intervention developed in the USA in the 1990s to prevent recurrent homelessness in transient individuals with severe and mental illness moving from hospital care into the community. In CTI, case managers provided support for up to nine months to strengthen times with family, friends and service providers and to provide practical and emotional support during the transition in to the community. Studies had found significantly reduced number of homelessness for those users receiving CTI (Susser et al, 1997). The main elements of the RESET service were:

- A short-term (12 week) support service to prisoners with an identified level of mental health need
- The focus was in obtaining appropriate safe and secure accommodation, access to welfare benefits, re-engagement with health services and strengthening links with family and community support services
- Referrals to the service were made through the Mental Health Inreach team at each prison
- Work began before release to develop rapport with service user, to try to secure accommodation, and start to fill out necessary paperwork
- On the day of release, the support co-ordinator would meet the service user at the gate
- The main aim in first day is to ensure the individual has some form of housing
- Any released prisoner would be escorted to all crucial appointments on the day, such as probation and local authority housing
- Support was provided to ensure that the service users had all the essentials for the first few days i.e. correct medication, scripts and planned appointments
- The support co-ordinator worked intensively during the first week of service users release and then gradually reduced their level of contact

The overall aim of this study was to evaluate the impact of the RESET service.

The specified objectives were to examine the:

- Participants' housing situation
- Rate of reoffending
- Number of hospital admissions
- Number on maintained benefits
- Number of contacts with mental health and GP services
- Level of engagement with services
- Number in employment or education
- The service user's views of the RESET service

1.1 Summary of work undertaken

A prospective cohort design was used with 62 prisoners recruited. The study population were those prisoners referred to the RESET support service provided by Clarion Housing and Nacro. To be eligible for inclusion into the study prisoners:

- had an agreed level of mental health need; Stepped level 3 or above on the Oxleas stepped level care approach
- no aftercare plan
- would be being released to Kent and Medway, or the London boroughs of Bexley, Bromley, or Greenwich

The participants in the intervention group were those who received the RESET support service. The project team were informed that approximately 50% of prisoners referred to the service did not end up in receipt of the RESET service due to being "lost" to the service for reasons such as being discharged earlier than planned or transferred to another prison outside the region. The comparison group were, therefore, those prisoners identified as suitable to receive for the service, and who agreed to take part in the study, but subsequently "lost". These participants received the standard care package provided by the CRCs.

The study involved:

Recruiting participants to the study

Data Collection

Initial baseline information

- Demographic,
- Clinical history prior to and in prison,
- Offending history
- Accommodation prior to prison

Quantitative data collection – Collected at 3 time points: 2 weeks post-release, 3 months post-release and 9 months post-release:

- Contact with RESET service
- Accommodation status
- Contact with services
- Offending
- Service engagement -through completion of the Service Engagement Scale (SES) (Tait et al, 2002) by the care co-ordinator of the participants

Statistical analysis – Using SPSSv24 to examine differences in the data for the variables between intervention and comparison groups at the three points.

Qualitative data collection - Following completion of support, each participant receiving the RESET intervention was invited to undertake an individual in-depth interview about their views and experiences of being released from prison and their perceptions of the support from the service.

Qualitative data analysis - Thematic analysis based on Braun and Clarke's (2013) framework.

1.2 Key findings

The main findings were:

Participants

- Sixty-two participants were recruited to the study
- Thirty-one (50%) received the RESET intervention
- Thirty-one (50%) received the standard care package

Contact with RESET service

- Service users receiving the RESET service remained engaged with the service with 29 out of 31 (94%) accessing the service still in contact at the proposed end of the support (3 months post-release)
- Qualitative interviews noted overwhelmingly positive views of the service from service users noting the service support being user focused, speedy, and consistent. The expertise of the co-ordinators in navigating their way around complex bureaucratic pathways was also seen as important.

Accommodation

- The group receiving the RESET intervention were significantly less likely to be homeless at 14 days post release and 3 months post release.
- At the nine months post-release time point, the RESET service group were recorded as having been in secure accommodation significantly longer than the comparison group; a mean of 244.48 (sd 59.72) days compared to 129 (sd 123.76) days for the comparison group receiving standard care planning

Contact with Services

- Significantly more of the intervention group were in receipt of state benefits and in contact with a GP at all three time points
- The RESET group significantly more likely to be in contact with health services (mostly mental health services) at three months post release

Offending

- Significantly less of the RESET group reoffended in the first 14 days post-release

Service Engagement

- At 14 days post-release and 3 months post-release, SES Collaboration sub-scale scores (the service user actively participating in the management of their illness) were significantly higher for RESET group. However, number of responses from the comparison group were small (n=11)

Limitations

Some limitations were noted:

- The number of participants included in the study is relatively small
- The participants were only followed up for nine months post release meaning the longer-term benefits of the RESET intervention were unable to be assessed
- The participants recruited to the study were those that had agreed to receive the service. Those who chose not receive the RESET service, or those not identified as applicable to receive the service, were excluded
- There were a lower number of BAME referrals than the proportion of BAME would be expected based on the proportion of recorded BAME prisoners in the system.
- The service is currently for men only
- The service did not examine the impact of the intervention on the re-engagement or development of family contacts

1.3 Recommendations

Recommendation One: To examine the funding provision of this service and whether it is possible to develop this service in other prisons.

Recommendation Two: To look at the rationale for offering a more flexible support period and to identify the criteria for providing a scaled approach with additional support beyond three months for those with particularly complex needs.

Recommendation Three: To have an extended evaluation to include a longer follow up period (i.e. after 18 or 24 months) to examine if, and when, the impact of the intervention decreases and for which outcomes.

Recommendation Four: The reasons for this lower than expected take up of BAME should be explored and remedial action taken based on any main findings.

Recommendation Five: To initiate and evaluate the intervention in women's services

Recommendation Six: To carry out a review of the best approaches to use to increase opportunities for released prisoners with mental health needs to be able to access education or employment.

Recommendation Seven: To include an examination of family contacts in any future evaluations of the service.

Recommendation Eight: To examine the ways in which the service can be opened up to more service users by ensuring that referrals to the RESET service from the Inreach team are received at least two weeks before release.

Recommendation Nine: To undertake a review of the potential for formal peer support workers to be employed by the RESET service.

2. Background

The prison population in England and Wales has rapidly increased over the last decade with a recorded prison population of 83,518 prisoners detained in September 2019 (Her Majesty's Prison and Probation Service, 2019). There is a higher prevalence of psychiatric morbidity amongst prisoners than currently found in the general population. The large-scale survey reported by the Office for National Statistics (Singleton et al, 1998) reported that over 90% of prisoners had one or more psychiatric disorders (psychosis, neurosis, personality disorder, hazardous drinking and drug dependency) with 7% of the male prison population being diagnosed with a psychotic illness. Prisoners also have high levels of suicidal behaviour with 24% of prisoners having attempted suicide at some point in their lives. This compares to a prevalence of psychotic disorder of 0.4% to 0.7% of the general population in the community (Melzer et al, 1995; McManus et al, 2016). Singleton et al (1998) also found increased rates of psychiatric co-morbidity with 70% of prisoners diagnosed with two or more mental health disorders. They also reported that 90% of prisoners did not receive treatment for their mental illness, alcohol misuse, or drug dependency.

Prisoners and Homelessness

The homeless charity Crisis (2019) state that people often lose accommodation when they enter custody. On release they can struggle to find accommodation with a private landlord or get the housing element of Universal Credit quickly enough and can wait months for payment. The charity further state that if someone leaving prison contacts their local council, they are likely to be turned away as they are not classed as 'priority need'. There might also be potential security and safety issues about living with other people. As a result, people often quickly become what Crisis (2019 refer to as the 'hidden homeless' (living in unsuitable temporary accommodation, sofa surfing or squatting) or sleep rough to avoid going back to an unstable family home or unsuitable temporary accommodation.

It is difficult to quantify the exact number of ex-prisoners who are homeless. It has been reported that over 75 per cent of homelessness services in England support clients who are prison leavers (Homeless Link, 2011). In 2012 a Ministry of Justice report found that 15 per cent of people in prison were homeless prior to custody while a third of people leaving prison said they had nowhere to go upon release (Centre for Social Justice, 2010). The Ministry of Justice (2013) concluded that, including those on remand, this could represent up to 50,000 people annually. The rough sleeping in London survey undertaken by Combined Homelessness and Information Network (CHAIN) in 2018 showed that 36% of people seen rough sleeping in 2017 to 2018 had experience of serving time in prison.

Cooper (2013) interviewed thirty-one people who were homeless and had been or were currently imprisoned and a further three interviews with practitioners. Almost all the male participants in the sample who received a sentence of 12 months or more were recalled to custody. They often chose not to stay in hostels due to concerns regarding safety and suitability, and this, along with strict licensing terms and conditions, meant that they often breached their bail and/or licence conditions due to having no fixed abode. They also claimed they would prefer to spend the whole of their sentence period in prison because of the restrictive terms and conditions in hostels which also excluded them from employment due to restrictions of Universal Credit and high rent charges for hostel placements.

The impact of homelessness for ex-prisoners has been examined. Those who report being homeless before being brought into custody were more likely to be reconvicted upon release as opposed to prisoners who did not report being homeless (79 per cent compared with 47 per cent in the first

year) (Ministry of Justice, 2012). The Ministry of Justice (2015) reported that the cost to the taxpayer is estimated to be between £9.5 to £13 billion per year with stable accommodation reducing the risk of reoffending by 20 per cent (Centre for Social Justice, 2010).

A health audit carried out by the homeless charity Homeless Link in 2014 found the proportion of homeless people with diagnosed mental health problems (45%) was nearly double that of the general population (around 25%). The audit also revealed that 12% of participants diagnosed with mental health issues reported drug and alcohol issues. This 'dual diagnosis' was viewed as problematic as it often restricted homeless people from accessing support, as services were unable or unwilling to provide support around mental health while someone was still using drugs or alcohol.

Supporting prisoners with mental health needs

There has been an increased acknowledgment of the importance of identifying and supporting prisoners with mental health needs. In 1999 the Department Health NHS and HMPS joined together to examine the best way to modernise the delivery of health care in prisons. The strategy document "Changing the Outlook" (2001) examined mental health provision in prisons and proposed that prisoners with mental health problems should be cared for on "normal" prisons wings through the establishment of multi-disciplinary in-reach teams. It was envisaged the focus of these in-reach teams would be to work with prisoners who has severe mental illness such as schizophrenia or major depression. However, the study by the Offender Health Research Network (OHRN) in 2009 found 60% of in-reach clients had no diagnosis of severe mental illness. The study also concluded the majority of prisoners with severe mental illness were not identified by prison in-reach services with only 23% of prisoners with a current severe mental illness assessed by in-reach services and only 14% of prisoners in the study with a current severe mental illness were accepted onto in-reach caseloads. It was concluded that in-reach teams had moved away from their original intention of serving those with severe mental illness. Many of the teams covered by the evaluation noted that their role had moved beyond involvement with those with severe mental illness to encompass assessment of and intervention with prisoners who self-harmed, those who had personality disorder and those with primary mental health needs. Other roles included consultancy to other staff, giving advice and information, linking prison and NHS services and providing clinical leadership and training. It was also noted that 85% of in-reach team leaders stated that their teams were not sufficiently well staffed to meet the needs of prisoners.

It has been put forward that people in contact with the Criminal Justice System are often socially disadvantaged and have poor engagement with community health care services. Prison offers many prisoners with mental health needs an opportunity to make active use of health and other services from within the prison (Senior et al, 2013). However, after release, many prisoners lack support within the community (Harty et al, 2012; Wilson, 2013). In addition, studies have demonstrated that there are high dropout rates in this period of transition from prison to the community and that even where there is communication and release planning between prison and community services, only a small minority of prisoners make contact with mental healthcare in the period after release (Lennox et al, 2012). The OHRN (2009) study reported that around half (51%) of the prisoners on the in-reach caseload had a discharge plan and that only 20% had contact with a Community Mental Health Team (CMHT) one-month post-release. The importance of maintaining contact with services has been noted by Hopkin and Thornicroft (2014) who commented that there is an increased frequency of severe negative health outcomes in the immediate post-release period. The suicide rate for prisoners with mental illness in the first 12 months post-release is 8.3 times higher than the overall general population with nearly a fifth of these suicides taking place within 28 days of release (Pratt et al, 2006). It has been suggested that the period directly before and following release from prison

is highly stressful due to uncertainty about legal restrictions and personal issues such as housing, benefits, and personal relationships and these are significant factors for this greater risk of suicide in prisoners in the first month post-release. This is an even greater risk for prisoners with mental health needs, as there is an added complexity due to transferring care teams, and being supported to community-based mental health services (Theurer & Lovell, 2008). Prisoners with mental health problems also have twenty-nine times the rate of all-cause mortality during the first two weeks after release compared to the general population (Hopkin and Thornicroft, 2014).

Williamson (2007) has stated there are there are multiple health and social care needs and factors that reflect the lifetime social disadvantages suffered by many prisoners all of which negatively impact establishment of a stable routine outside prison. A number of these disadvantages relate to problems surrounding housing with 42% of prisoners having no fixed abode upon release while 50% were not registered with a GP. Hartfree et al's (2008) qualitative study found that, if there was a lack of a co-ordinated service planning and advice, any goals were unlikely to be realised. Prisoners were unable to cope without this support and this impacted on their ability to access housing, with an increased likelihood of drug and alcohol abuse and reoffending becoming a coping mechanism. The importance of having a safe place to live, finding employment maintaining mental and physical wellbeing were also seen as high priorities for prisoners (Binswager et al, 2011; Woodall et al, 2013). Shaw et al (2017) also reported that housing and financial security were essential priorities for prisoners upon their release.

Lennox et al (2012) put forward the establishment of contact with prison-based services provides an excellent opportunity to nurture future contact with community teams upon release. This promotes continuity of community care with better engagement with health and social services helping to structure lifestyles and reduce re-offending.

The independent review carried out by Lord Bradley (2009) examined the difficulties faced by people with mental health problems detained in prison when planning for resettlement back in to the community upon release. The difficulties included the fact that, many prisoners had lost their own accommodation after starting a prison sentence, they often had difficulties with finding employment after release and had lost access to family and close support. The review concluded that for resettlement to be successful, it was important to ensure that the engagement continued once they leave the prison gate. It was also noted that, if prisoners received the support they needed inside prisons, they were more likely to engage with services outside prison. A number of key roles were suggested to be incorporated into any resettlement package. These included:

- assistance in release planning for those in custody
- provision of signposting to community facilities where appropriate
- advising and supporting approved premises
- supporting the client to re-engage with community services post discharge
- providing advice and support to third sector resettlement organisations
- providing support to offender managers and
- liaising with mental health service providers, social services and primary care services in support of the resettlement of the offender

In 2014 the Centre for Mental Health established a Commission to review what had changed since the Bradley report was published in 2009 and looked ahead to the next five years to see what was still required (Durcan et al, 2014). Gaps in the resettlement of prisoners with mental health needs were still found with many prisoners having no knowledge of where they would be released to until the day of their release. It was also concluded that not all mainstream community support and care

services (including mental health services) considered offenders as being part of 'their business'. The initiatives viewed as promising supported the general release from prison. The support offered included meeting and assessing need pre-release with a tailored package of support on release with follow-up. The Commission also noted the typical needs of people with mental health needs leaving prison were:

- Housing
- Accessing finance
- Crisis support
- Routes to employment
- Friendship and leisure
- Access to appropriate mental health and health care

The standard release-planning offered by prisons differs depending on the type of prisoner. For remand prisoners who are released from court, there is currently no support offered by the prison at the time of release. For sentenced prisoners who are conditionally released (i.e. with a license period) they are subject to probation supervision but may be recalled if they breach their license conditions. Prisoners on indeterminate or life sentences and IPP (Imprisonment for Public Protection) prisoners are subjected to a life license, where probation supervision will follow their conditional release by the parole board. However, for all prisoners leaving prison, prior to their release, the statutory CRC resettlement team at the prison will liaise with their local probation services to discuss any identified housing need and try to address this. For prisoners with mental health needs, this referral is usually to community mental health services for support.

The Government's policy paper "2010 to 2015 government policy: reoffending and rehabilitation" proposed a rehabilitation reform programme to change the way offenders were managed in the community. The programme encouraged rehabilitation providers from the private, voluntary and social sectors to become providers of this community service through 21 Community Rehabilitation Companies (CRCs). The focus of the CRCs work is the supervision of the 45,000 low and medium risk offenders a year. A significant proportion of this group previously received no statutory supervision if they were serving less than 12 months in custody, yet these offenders had the highest reoffending rates of any group. The CRCs work in tandem with the public sector National Probation Service (NPS) whose role is to manage high risk offenders. From February 2015, any offender sentenced to a custodial term of more than one day, received at least 12 months of supervision after release. The focus of the CRCs work was to:

- Deliver a resettlement service for all offenders released from custody (engaging with many of the offenders they will manage before release)
- Manage the majority of offenders in the community (most low to medium risk offenders)

Post-release support for prisoners with mental health needs

Shaw et al (2017) also acknowledged that prison provides an opportunity for individual with mental health problems to receive mental health treatment, but this is likely to be jeopardised on release if the person does not engage with community services to enable treatment started during imprisonment to be continued. They suggested that effective release planning and resettlement requires not only continuity of health care but also measures designed to meet the economic and

social needs of the prisoner. Hopkin and Thornicroft (2014) cautioned that engagement with services should not only consider the contact alone as this did not reflect the complexity of the concept of engagement and that issues such as acceptance of help, collaboration in treatment and openness with mental health workers are also integral aspects of engagement.

There has been only a limited amount of work undertaken to examine interventions designed to support prisoners with mental health needs upon their release from prison with existing research mainly focused on supported release from prison schemes using the general prison population (Netto et al, 2014; Scoones, 2012). The only current systematic review examining interventions for prisoners with diagnosed mental health conditions that targeted the transition period between prison and the community was undertaken by Hopkin et al (2018). Thirteen research studies were included. Randomised and non-randomised trials were included, as were trials with no comparison group, due to the lack of research in this area. The majority of the included studies were conducted in the United States of America (n = 10) with two studies conducted in the UK England (Jarrett et al, 2012; Shaw et al, 2017) and one in Australia. The majority of interventions lasted for between 3-6 months with the fewest 6 weeks and longest 12 months. No meta-analysis was conducted due to the heterogeneity of the studies. The conclusions drawn by the reviewers were there was some evidence that interventions could improve contact between service users and mental health and other services though evidence that it could reduce reoffending was equivocal. No information was made available as to whether any intervention improved access to secure accommodation for users.

Critical Time Intervention (CTI)

One approach that has been introduced is the Critical Time Intervention (CTI) (Hopkin and Thornicroft, 2014). The primary aim is to ensure continuity in care between prison and community services. The intervention can also address other issues and concerns such as housing, benefits, and employment. Critical Time Intervention was developed in the USA in the 1990s as a structured, time limited intervention to prevent recurrent homelessness in transient individuals with severe and enduring mental illness moving from hospital care into the community. The two main aims of the intervention were to strengthen times with family, friends and service providers and to provide practical and emotional support during the transition in to the community as noted below.

Strengthen ties with family, friends and service providers

- Making appointments with key service providers
- Accompanying service users to appointments
- Ensuring service users had a named contact at each service
- Supporting engagement with the family
- Supporting family in understanding mental health problems

Providing practical and emotional support

- Maintaining close contact with the service user
- Assessing the service users ability to adapt
- Providing practical and emotional support when necessary to develop skills to live independently

Case managers undertook the above roles for a period of up to nine months. Early trials showed a significantly reduced number of homelessness for those users receiving the CTI intervention (Susser et al, 1997). Jarrett et al (2012) undertook a pilot trial in English prisons and found that prisoners in the treatment arm of the pilot had better non-significant outcomes than controls. A further finding

was that qualitative studies exploring participants' own opinions and experiences of the transition from prison to the community were needed to allow a deeper understanding of the difficulties faced by prisoners when being released from prison as well as their views about engagement with services.

Following on from Jarrett et al's (2012) pilot study, Shaw et al (2017) designed a multisite trial (the CrISP study) utilising a model of CTI for male prisoners with severe mental illness. Case managers were employed and engaged with prisoners with severe mental illness approximately 4 weeks before release, agreeing a discharge plan, supporting the participant though the gate and liaising with community providers to ensure support for an individuals' needs and remaining in contact with service users for 6 weeks post release. The authors stated the intervention was heavily frontloaded with most of the liaison work undertaken while the person was still in prison. Five key areas were prioritised: (1) psychiatric treatment and medication management and, (2) money management, (3) substance abuse treatment, (4) housing crisis management and (5) life-skills training. 150 participants were randomised to either an intervention of control group with 78 allocated to the intervention group. The main outcome was engagement with mental health services which was determined as having a care co-ordinator, a current care plan and medical treatment. The results showed there were significantly greater levels of service engagement at six weeks and six months and a non-significant increase in engagement at 12 months with 33% of the of the intervention group engaged with mental health services at six weeks and 24% at 12 months. However, the team also noted a number of difficulties encountered whilst undertaking the study including recruitment shortfalls at several sites and delays in receiving R&D approvals. They also reported that the retendering processes at a number of prisons caused difficulties in gaining access to sites.

Lennox et al (2017) have also undertaken a pilot trial (the ENGAGER intervention) to develop a complex collaborative care intervention aimed at supporting men with common mental health problems near to and following release from prison. The ENGAGER intervention sets up a pathway of care up to 12 weeks prior to their release and for three to five months in the community. Engager practitioners meet with individuals at least weekly in prison and the community after release for 8–16 weeks, according to their needs. The pilot study focused on looking at the viability of the recruitment and retention strategy. Participants were followed up at one and three months post-release. 40 people were randomised to the intervention group, 31 (77%) continued to be engaged with the intervention at one month and 19 (47%) at three months. A full trial is now underway.

2.1 Supporting Prisoners upon Release Service (RESET) Intervention

Oxleas NHS Foundation Trust have commissioned Clarion Housing and Nacro to deliver pre and post release, wrap around support to service users with multiple and complex needs released from the Kent and Greenwich prisons. Clarion Housing work from HMP Elmley, HMP Rochester and HMP Stamford Hill, with Nacro and Clarion Housing operating in London from HMP ISIS, HMP Belmarsh and HMP Thameside. In order to meet the threshold for support service users must have limited community support in place, high rates of reoffending, and must meet at least step 3 on the Oxleas stepped care model. The stepped care model is described in greater detail below. They must also be at risk of homelessness.

The purpose of this support is to enable service user to positively prepare for release, providing join up between healthcare and statutory resettlement providers (CRC's) to ensure a smooth and coordinated transition into the community. Caseloads are relatively small compared with statutory resettlement caseloads and staff have no more than 20-30 cases at any one time. This includes both custody and community cases, allowing for approximately 50% of these to be in custody at any one

time. Custody work predominantly focuses on building motivation and rapport and engagement with statutory services to support their work, such as providing references and additional information for housing applications.

Given that it is known how critical the first 24 hours are in terms of providing support and potential reoffending, all service users are offered a collection on the day of release and if accepted, are escorted to all of their crucial appointments on the day, such as probation and local authority housing. Support is also provided to ensure that they have all of the essentials such as their correct medication, scripts and planned appointments for the first few days.

Once released support continues for 12 weeks to ensure that the service user obtains appropriate safe and secure accommodation, access to welfare benefits, re-engages with health services and strengthens links with family and community support services. Activity within this could include but is not limited to:

- Advocacy support throughout the housing application process
- Support to register with a GP and dentist
- Assistance to gain assessments for and engage with substance misuse and community mental health teams
- Ongoing liaison with housing departments to source permanent move on accommodation
- Registering with food banks and introducing service users to using food banks
- Sourcing and securing employment and training opportunities
- Liaison with family and friends to support the repairing and building of strained relationships
- Supporting service users to register with the job centre and claim relevant benefits
- Supporting service users to budget and open bank accounts
- Supporting service users to understand household bills
- Supporting the service user to attend all planned appointments

In addition, the staff teams work closely with a wide range of statutory agencies to ensure that we avoid duplication and provide holistic and joined up support to the service user. These agencies include the CRC's, NPS, community mental health teams and care coordinators, police, MAPPA, JIGSAW and CHANNEL teams, DWP, keyworkers at supported or temporary accommodation placements and support workers within treatment and recovery services.

Access to the RESET service

The prison mental health InReach teams determine a prisoner's level of mental health need using the prisoner's previous psychometric scores on General Anxiety Disorder (GAD7) and Patient Health Questionnaire (PHQ-9), and then determining their Stepped Level of Care. NICE recommendations states that a stepped-care model should be used as an approach in healthcare delivery by which different intensities of treatment are identified and a person is allocated to a specific intensity to treatment based on an assessment of their need. The least intensive intervention that is appropriate for that person should be provided first with the person able to step up or down the pathway according to changing needs and in response to treatment. There are five levels of care in this model:

- **Level One** is for individuals who have had a short term, mild or recent distress but feels or appears in control and able to maintain daily living activities.

- **Level Two** is for individuals with significant distress, and appears to have some degree of control, some impact on daily living activities, are at low risk of suicide, but present with ongoing crisis.
- **Level Three** is for individuals who have constant and significant distress, preoccupation with problems, feelings of hopelessness and little or no control, self-care and daily activities affected, moderate risk of harm to self and/or others.
- **Level Four** interventions are for individuals with longstanding complex problems; problematic behaviours affecting self and others, poorly cope with everyday life, recurrence of past problems, and poor previous outcomes to interventions.
- **Level Five** is for those individuals with severe and complex problems (e.g. psychosis, bi-polar and personality disorder). They will have persistent and severe problems with functioning independently and maintaining daily activities, requires 24-hour care, and need multi-professional care and range of resources.

The prison InReach team uses an adapted version of the stepped care model for their clients, which is based on Oxleas NHS Foundation Trust categorisation.

Those prisoners requiring a level of care of Level 3 or above, and identified by InReach as having no release planning, and not linked to a support service in the community, are referred to the RESET service provided by Clarion Housing and Nacro.

The supported release scheme differs from the services provided by the CRCs in that the Supporting Prisoners upon Release Service (RESET) is focused on a specific group of very complex and challenging individuals; providing intensive support to those who have offended but also have identified mental health needs. These prisoners with mental health needs present different challenges, have multiple and complex needs and require a more focused approach. The proposition put forward is that the supported release scheme is able to provide the necessary intervention and support to meet these challenges and address the needs of this particular prisoner population.

There has been no evaluation of this service and it is viewed as important to examine this efficiency to guide the development of the service. Oxleas NHS Foundation Trust funded the evaluation. The project team included representatives of Oxleas NHS Foundation trust, Clarion Housing, Nacro and Canterbury Christ Church University.

It was agreed the evaluation would look at the RESET service designed to support prisoners with mental health needs during their immediate post-release period into the community. Engagement with services post-release has been shown to be an excellent indicator of reducing reoffending (Senior et al, 2013). However, simply recording a prisoner's engagement or disengagement with services does not give a true representation of the success of an intervention. By examining hard data as well as the views and experiences from the participants themselves, the evaluation attempted to provide a comprehensive understanding of the difficulties prisoners face after leaving prison, and how best to support these individuals (Hopkin and Thornicroft, 2014).

The practitioners delivering the service suggested that approximately 50% of the prisoners meeting the eligibility criteria and originally assessed as suitable to receive the support service would become "lost" to the service due to various circumstances, such as being released unexpectedly at a remand hearing or being transferred to another prison. It was determined that this "lost" group would act as the comparison group to the intervention group rather than randomly assign prisoners to an intervention or control group in a controlled trial.

3. Aims and Objectives

The overall aim of the project was to evaluate the impact of the supported release from prison service. The primary objective was:

To examine the participants' housing situation at three months post-release.

The secondary objectives were to examine at 2 weeks post-release, 3 months post-release and 9 months post-release:

- Participants' housing situation (2 weeks post-release and 9 months post-release)
- Rate of reoffending
- Number of hospital admissions
- Number on maintained benefits
- Number of contacts with mental health and GP services
- Level of engagement with services
- Number in employment or education

For the intervention group only, there was also an examination of the service provided through an in-depth exploration of the participants' views and experiences of the service

4. Methodology

A prospective cohort design was adopted. In this type of study, a population who have a health outcome of interest (i.e. housing situation) are initially divided into two groups; those who are "exposed to a risk factor" and those who are not. Both groups are followed up over a defined period and at the end of the observation period the frequency of the health outcome of interest in the "exposed group" is compared to that in the "unexposed group". Cohort studies are generally prospective as they move away from examining potential cause to understanding consequence.

In this study, the study population were prisoners referred to the RESET support service provided by Clarion Housing and Nacro. The participants in the intervention group were those who received the RESET support service, while the comparison group were those prisoners identified as suitable to receive for the service, and who agreed to take part in the study, but subsequently "lost" due to reasons such as an unexpected release, being transferred to another prison, or being released outside of the RESET evaluation follow up area service area (Kent and Medway, or the London boroughs of Bexley, Bromley, or Greenwich).

It was also decided that a distinction should be made between those workers providing a support service as part of the RESET intervention and those workers providing a service outside of the RESET intervention. For this evaluation, the term support coordinator was used for the staff members from Clarion Housing and Nacro who provided the RESET support service to the intervention group. The term link worker referred to an individual who worked with and provided a support service to the participants who were part of the comparison group. These link workers were from a range of professional groups such as a probation officer or community psychiatric nurse.

4.1 Participants

The potential participants were male prisoners, over the age of 18, residing in HMP Elmley, HMP Rochester and HMP Stamford Hill, HMP ISIS, HMP Belmarsh and HMP Thameside and referred to the support service provided by Clarion Housing and Nacro.

The inclusion criteria of the project were;

- they required a stepped level care of 3 or above,
- they had no current release plan or support in place,
- the prisoners would be being released to Kent and Medway, or the London boroughs of Bexley, Bromley, or Greenwich,
- they were capable of giving informed consent.

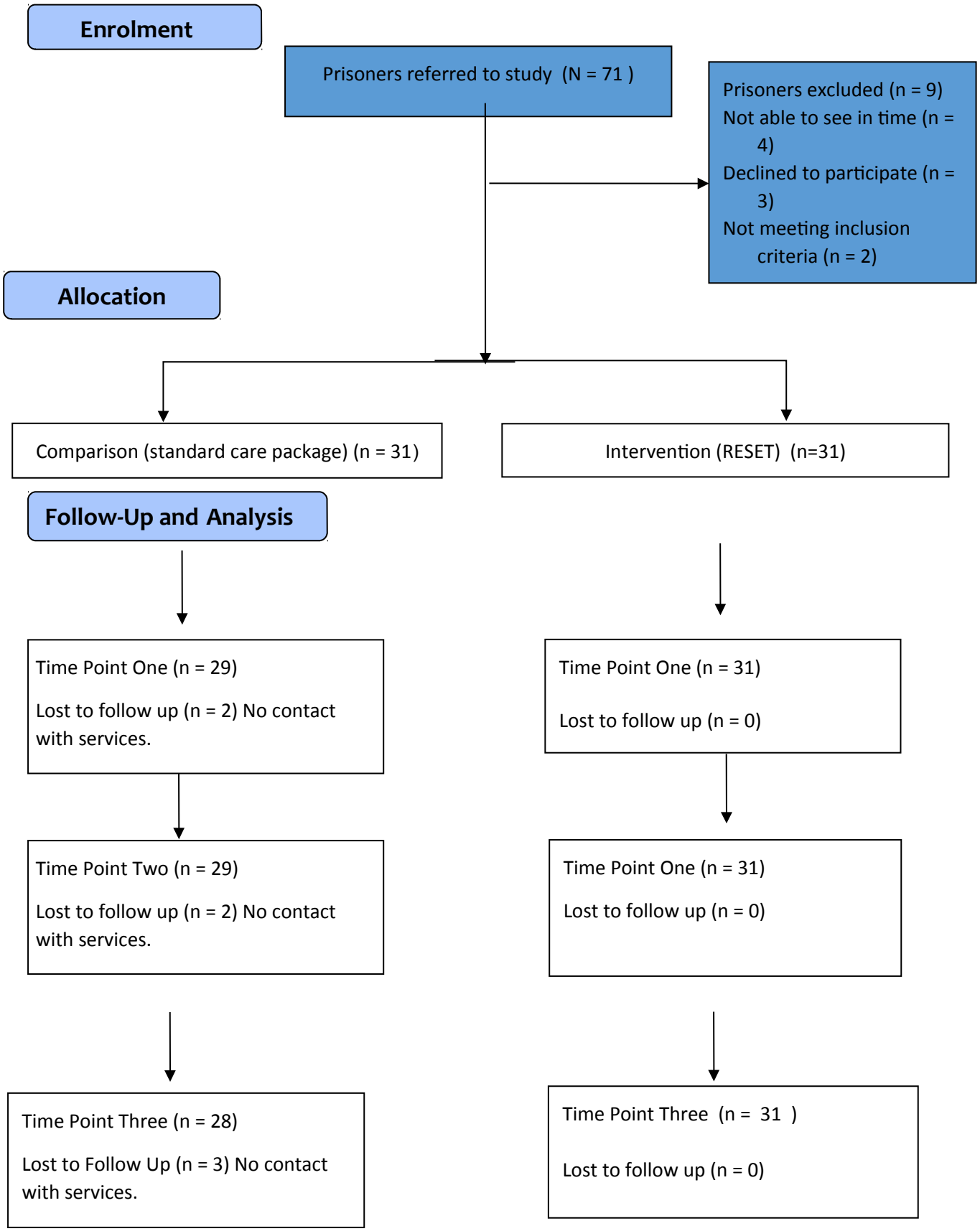
The exclusion criteria were:

- they required a stepped level care of less than 3,
- they had a current release plan in place and arrangements for release,
- the prisoners would be being released outside of Kent and Medway, or the London boroughs of Bexley, Bromley, or Greenwich,
- they were incapable of giving informed consent.

Recruitment Process

All referrals from the prison In Reach team received an initial screening and assessment by the RESET team worker to determine if the individual met the suitability criteria for the support service. Individuals found not suitable were referred back to the prison InReach team.

Figure 1: RESET Flow Diagram



There was a 12- month recruitment period from February 2017- January 2018. The participants were followed up for 9 months following release from prison. The Flow diagram for the study is outlined in Figure 1.

During the recruitment phase, the support coordinator invited each prisoner meeting the inclusion criteria if they would be interested in participating in the study. If interest was expressed, the support co-ordinator discussed the evaluation in more detail and went through the material on study information sheet (Appendix I). If the prisoner was happy to discuss their involvement further, his name was passed to the project researcher. Following this initial discussion about the study, the project researcher met with each potential participant

The participants were explicitly informed, verbally and in writing, that participation was voluntary, and the potential participant was free to withdraw at any point and their decision to participate, or not, would have no have no effect on the care they received or their legal rights.

All prisoners who participated gave written informed consent before any data was collected.

All support co-ordinators who delivered the RESET intervention and link workers for the comparison group were also invited to participate in the study. Invitations letters were sent to them and, if they agreed, they were asked if they could provide data across the three time points of the study (detailed below) to assess the progress of the participants in their caseload. In addition, relevant data was obtained through access to National Probation Service, Prison and NHS databases.

4.2 Data Collection

Initial Information

Demographic and initial information were obtained from the support coordinators and from suitability assessments made in the prison following a referral to the service. The following baseline data was collected using the form shown in Appendix II:

- Age
- Ethnicity
- Marital status
- Primary mental health diagnosis (and secondary diagnoses if applicable) (ICD-10)
    - Level of anxiety as denoted by the GAD-7 score. The GAD-7 total score can range from 0 to 21. Scores of 5, 10, and 15 represent cut-off points for mild, moderate, and severe anxiety, respectively.
    - Level of depression as denoted by PHQ-9 score. The PHQ-9 total score can range from between 0-27. Scores of 5, 10, 15, and 20 represent cut-off points for mild, moderate, moderately severe and severe depression, respectively
- History of substance abuse
- History of self-harm
- Whether on Assessment, Care in Custody and Teamwork (ACCT) upon release (where there is concern that an individual in prison is at risk of self-harm or suicide)
- Length of current sentence
- History of prison sentences
- Accommodation prior to prison
- Whether they were employed prior to prison

- Level of severity of need (stepped care level)
- Reasons for referral to Supporting Prisoners upon Release (RESET) Service
- Reason for not receiving service (for those in the comparison group)

Quantitative Data

The quantitative data was collected about both the intervention and comparison groups at baseline (within 2 weeks after release from prison), 3 months post release (when the active RESET intervention was due to finish), and 9 months post release. The data collection form is shown in Appendix III. The data was predominantly collected by the support coordinators and link workers with assistance via the support agencies and clinical services each participant was referred to at the time of their release from prison.

The specific data collected and recorded separately for the intervention group and comparison group were:

RESET Contact

Type of contact and frequency of contact with RESET service.

Accommodation

- Number homeless
- Number living with family and friends
- Number in independent accommodation
- Number in hostel
- Number in B&B accommodation
- Number in supported accommodation
- Number in temporary accommodation
- Number in prison
- Number in hospital
- Mean number of days housed
- Mean number of different accommodations

Offending

- Number reoffending

Contact with services

- Number admitted to hospital
- Number receiving benefits
- Number in employment/education
- Number in contact – health services
- Number in contact – GP
- Mean number of hospital admissions
- Mean number of days in hospital

Engagement with services

This was assessed using the Service Engagement Scale (SES) (Tait et al, 2002) (Appendix IV). It was completed by the RESET support coordinator or the link Worker involved in the participant's care. It is a multidimensional scale designed to assess the level and quality of client engagement with services. There are 14 items with four subscales: (a) availability (3 items) - the service users' availability for arranged appointments; (b) collaboration (3 items)- the service user actively participating in the management of their illness; (c) help seeking (4 items) – the service user seeking help when needed; and (d) treatment adherence (4 items) - the service user's attitude toward taking their medication. The answers are rated on a four-point Likert-type scale, with 0=not at all or rarely, 1=sometimes, 2=often, and 3=most of the time. The four scale scores and the overall scale scores were documented. The total score range was between 0-42 with a lower score indicative of greater engagement between the participant and service.

Qualitative data

After the completion of their support from the support coordinator, each participant receiving the intervention from the RESET service was invited to undertake an individual in-depth interview to examine their views and experiences of being released from prison and their perceptions of the support from the service. Individual semi-structured interviews were conducted with an interview schedule used to guide the discussion. These interviews lasted for between 20 minutes to an hour and were digitally recorded and transcribed. The venues for the interviews were agreed following discussions between the Project Researcher, study team, support teams, and participants. The majority of interviews were conducted in the participant's own homes or at a community venue (i.e. coffee shop).

4.3 Data Analysis

For the quantitative data, the data were entered in to IBM SPSS 24. Initially descriptive analysis was undertaken to examine the results of the intervention and comparison groups. Chi-square tests were conducted on all the categorical data sets and t-tests on the continuous data sets to examine whether there were any significant differences in the initial information collected between the intervention and comparison groups. Inferential statistics using chi-squared tests were then used to examine any differences in scores between the two groups in relation to the different measures at different time points where categorical data was collected. T-tests were used to examine differences in those data sets where continuous data was collected (number of days housed, number of different accommodations, number of hospital admissions, and number of days in hospital) as well as the Service Engagement Scale.

For the qualitative data obtained by the interviews with both the participants and the support co-ordinators, the thematic analysis approach detailed by Braun and Clarke (2013) was used to identify any consistent themes reported by the participants as being important in influencing their views of the service and their subsequent engagement (or not) with the support and clinical services. This analytic process has six phases:

1. Familiarisation with your data: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.

2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.

4. Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.

5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.

6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

In this study, each project team member read the same two transcripts to familiarise themselves with the data, before individually generating initial codes and developing emergent themes from these initial codes. The team then met up to develop a consensus view of the most appropriate themes. These were then more clearly defined and names given to the themes as the team read more transcripts. The themes were then reviewed and refined prior to being confirmed and detailed in the final report.

4.4 Ethics

Safety of project researchers

The project researcher met with participants in prison to recruit to the study and in the community to collect data. In the prison environment, the project researcher followed the prison's security procedures and policies, undertook the security awareness induction, and always carried a personal alarm.

In the community, the project researcher followed Oxleas NHS Foundation Trust's Lone Worker policy. The project researcher met participants in either local statutory service offices (i.e. Community Mental Health Team locations) or in appropriate public areas where confidentially could be maintained. The project researcher consulted with the RESET team before meeting any participants and was in contact with a member of the project team directly before and after each meeting.

To try and reduce any emotional fatigue, the project researcher met with the study supervisors (DM and JP) on a regular basis to be able to debrief on any issues that arose during the study.

Ethical Approval

Ethical Approval was obtained from the East of England – Essex Research Ethics Committee in December 2015 (reference number 15/EE/0414) and from the National Offender Management Service (NOMS) (reference number 2016-099) in August 2016.

5. Results

5.1 Quantitative Data

Results

62 prisoners with mental health needs were recruited to the study with 31 receiving the intervention and 31 prisoners, assessed as eligible to receive the service but not receiving the intervention, placed in the comparison group. The comparison group consisted of ten prisoners released without support, ten that did not engage with services upon release, three transferred out of the referring prison, four not supported for "other reasons" with missing data on four further prisoners. The participants' initial demographic, clinical, and offending information is detailed in Table One. The table documents the number of participants for each variable in each group with the percentage reported in parentheses. The two exceptions to this are the mean scores relating to age and length of current sentence where the standard deviation is reported in parentheses.

Table One: Demographic, clinical and offending characteristics

Information	Intervention group n=31	Comparison group n=31	Total N=62
Mean Age (sd)	37.9 (11.0)	34.4 (9.4)	36.2 (10.3)
Ethnicity White British(%) Black British(%) Other(%)	 27 (87.1%) 3 (9.7%) 1 (3.2%)	 27 (87.1%) 3 (9.7%) 1 (3.2%)	 54 (87.1%) 6 (9.7%) 2 (3.2%)
Marital status (%) Single Separated, Divorced or Widowed Married	 28 (90.3%) 3 (9.7%) 0 (0%)	 29 (93.5%) 1 (3.2%) 1 (3.2%)	 57 (91.9%) 4 (6.5%) 1 (1.6%)
Employed (%)	2 (6.5%)	4 (13%)	6 (9.7%)
History of Self Harm(%)	21 (67.7%)	24 (77.4%)	45 (72.6%)
Self-harm in last 3 months(%)	9 (29.0%)	8 (25.8%)	17 (27.4%)
ACCT at time of release(%)	5 (16.1%)	8 (25.8%)	13 (21.0%)
History of substance misuse(%)	24 (77.4%)	26 (83.9%)	50 (80.6%)
Mean length of current prison sentence in days (sd)	658.1 (811.5)	517.1 (779.6)	600.1 (793.7)
Previous prison sentence	22 (71.0%)	26 (83.9%)	48 (77.4%)
Step Care Level 1 2 3 5	 0 (0%) 2 (6.5%) 29 (93.5%) 0 (0%)	 1 (3.2%) 1 (3.2%) 28 (90.3%) 1 (3.2%)	 1 (1.6%) 3 (4.8%) 57 (91.9%) 1 (1.6%)

The clinical, demographic and offending characteristics of the two groups were similar with no statistically significant differences noted. The participants were predominantly white British men in their thirties who were single and unemployed when admitted to prison. Most participants also had a history of substance misuse and of self-harm and had also completed at least one previous prison sentence. The intervention group had been serving a slightly longer prison sentence (1.8 years vs 1.4 years) while there were slightly more in the comparison group who were subject to Assessment Care in Custody and Teamwork (ACTT) supervision at the time of their release to monitor their mental health and reduce the likelihood of self-harm.

The levels of anxiety and depression as reported by PHQ9 and GAD7 was recorded for less than half of the prisoners (intervention group n=12 and comparison group n=14). The mean levels of anxiety (GAD7) were 10.6 (sd 5.4) for intervention group and 9.6 (sd 4.9) for the comparison group while the mean levels of depression (PHQ9) were 13.1 (sd 5.7) for the intervention group and comparison group - 12.6 (sd 8.3). These mean scores suggest overall levels of moderate anxiety and moderate depression for the intervention group and mild/moderate anxiety and moderate depression for the comparison group. The differences between the two groups were not statistically significant.

Table Two: Referrals

Referral	Intervention group n=31	Comparison group n=31	Total N=62
Referral Service Clarion Housing Nacro	 22 (71.0%) 9 (29.0%)	 29 (93.5%) 2 (6.5%)	 51 (82.3%) 11 (17.7%)
Reason for Referral Housing Services Other	 24 (77.4%) 4 (12.9%) 3 (9.7%)	 26 (83.9%) 4 (12.9%) 1 (3.2%)	 50 (80.6%) 8 (12.9%) 4 (6.5%)

The reasons for referral to the RESET service are noted in Table Two. The majority were referred to Clarion Housing who provided the service for Kent prisons with the eligibility criteria for the London prisons being restricted to those released to three London boroughs where we could obtain participants' health data once released. The main reason for referral to the service was noted as being for help with housing though there were a few referrals for help in accessing services (mainly for mental health support).

Table Three: Housing situation prior to admission

Accommodation	Intervention group n=31	Comparison group n=31	Total N=62
Friends/Family (%)	9 (30.0%)	13 (41.9%)	22 (36.1%)
Independent (%)	4 (13.3%)	3 (9.7%)	7 (11.5%)
Homeless (%)	16 (53.3%)	10 (32.3%)	26 (42.6%)
Hostel (%)	0 (0%)	2 (6.5%)	2 (3.3%)
B&B (%)	1 (3.3%)	1 (3.3%)	2 (3.3%)
Supported (%)	0 (0%)	2 (6.5%)	2 (3.3%)

The housing situation prior to admission to prison was reported in Table Three. There were a greater number of participants who were homeless in the intervention group and greater number of participants living with friends or family in the comparison group. These were the two types of accommodation that recorded the highest number of responses. None of these differences were statistically significant. Overall the types of accommodation were similar.

The results of the assessments carried out at time points one, two and three are recorded in Tables Four to Eighteen. Tables Four, Nine and Fourteen report the frequency of contact with RESET services for the intervention group at 3 months post release, 14 days post-release and 9 months post-release. No statistical analysis is performed on this data. The other Tables detail the accommodation status, the numbers offending and engagement with services for both groups at the three time points. For each categorical variable, the tables document the number of participants for each variable in each group with the percentage reported in parentheses. The chi-squared score, the degrees of freedom (in parentheses) and significance levels are also detailed. For the four continuous variables being examined, the mean scores are reported with the standard deviations in parentheses. The t-test score is also reported with the degrees of freedom (in parenthesis) and the significance levels. Any t-test analysis where equal variances are not assumed are noted by an asterisk. Any statistically significant findings (where p =<0.05) are recorded in bold type.

5.2 Time Point Two Results

Tables four to eight record the findings from time point two which was approximately three months post-release). These findings are presented first as this was the time point where the primary objective was evaluated. It was also the time when the RESET intervention was due to finish. Twenty-nine participants were still in contact with the RESET service at 3 months post-release:

- 26 in person
- 3 via telephone
- 2 missing data

Table Four: Frequency of contact with RESET service at 3 months post-release

Frequency of contact	Number
Twice weekly	5
Weekly	22
Fortnightly	1
Monthly	1

Table Four records the frequency of contact between the participants and service. The majority of the 29 participants accessing the RESET service were having face-to-face contact with service users on a weekly basis.

Table Five: Accommodation at 3 months post-release

Type of accommodation	Intervention n=31	Comparison n=29	Chi square (df) and Sig
Number homeless (%)	**0 (0)**	**8 (27.6)**	**9.88 (1)** **p = 0.01**
Number living with family and friends (%)	3 (9.7)	2 (6.9)	0.15 (1) p = 0.7
Number in independent accommodation (%)	12 (38.7)	5 (17.2)	3.4 (1) p = 0.07
Number in hostel (%)	3 (9.7)	2 (6.9)	0.15 (1) p = 0.7
Number in B&B accommodation (%)	**5 (16.1)**	**0 (0)**	**5.1 (1)** **p = 0.02**
Number in supported accommodation (%)	3 (9.7)	3 (10.3)	0.01 (1) p = 0.93
Number in temporary accommodation (%)	3 (9.7)	0 (0)	2.96 (1) p = 0.09
Number in prison (%)	2 (6.5)	7 (24.1)	3.68 (1) p = 0.06
Number in hospital (%)	0 (0)	2 (6.9)	2.21 (1) p = 0.14
Number in other accommodation	1 (3.2)	1 (3.4)	0.02 (1) p = 0.96
	Intervention n=31	Comparison n=29	Ttest (df) and Sig
Mean number of days housed (sd)	**88.84 (8.25)**	**44.91 (44.39)**	**5.17 (28.69)*** **p = <0.01**
Mean number of accommodations (sd)	1.81 (1.01)	1.55 (0.78)	1.08 (58) p = 0.28

Table Five details the accommodation status of the two groups at 12 weeks. The RESET intervention group were housed for significantly more days with the mean number of days the intervention group were housed (88.84) equating to nearly the whole of the three month period. This is twice the number of days that the comparison group were housed. The RESET group were also significantly more likely to have accommodation with no-one receiving the service reported as homeless at three months post-release. The other significant difference was that higher numbers (5 vs 0) of the intervention group were in B&B accommodation. There were also (non-significant) trends showing more than twice the number of the RESET intervention group were in independent accommodation while three times the number were not in prison.

Table Six: Number re-offending 3 months post-release

Offending	Intervention n=30	Comparison n=29	Chi square (df) and Sig
Number reoffending (%)	5 (16.1)	6 (20)	0.16 (1) p = 0.69

Table Six notes the numbers of participants in each group who had offended in the first three months post-release and indicates the numbers were similar in both groups.

Table Seven: Contact with services 3 months post-release

	Intervention n=31	Comparison n=29	Chi square (df) and Sig
Number admitted to hospital (%)	3 (9.7)	4 (13.8)	0.25 (1) p = 0.62
Number receiving benefits (%)	**31 (100)**	**10 (35.7)**	**28.68 (1)** **p = <0.01**
Number in employment/ education (%)	3 (9.7)	1 (3.4)	0.93 (1) p = 0.33
Number in contact with health services (%)	**15 (48.4)**	**5 (17.2)**	**6.54 (1)** **p = 0.01**
Number in contact with GP (%)	**31 (100)**	**19 (65.5)**	**29.72 (1)** **p = <0.01**
	Intervention n=31	Comparison n=29	Ttest (df) and Sig
Mean number of hospital admissions (sd)	0.1 (0.3)	0.17 (0.47)	-0.75 (58) p = 0.46
Mean number of days in hospital (sd)	0.1 (0.26)	6.48 (23.69)	-1.45 (28)* p = 0.16

The level of contact with services at 3 months post-release is shown in Table Seven. Some significant differences are noted. Everyone in the intervention group were receiving benefits compared to just over a third of the comparison group. In addition, three times as many of the RESET group were in contact with health services and all the RESET group were in contact with a GP as opposed to 65% of the comparison group. There were also higher numbers of the comparison group admitted to hospital although the difference was not statistically significant. Although the numbers were small, more of the RESET group were in education or employment.

Table Eight: Service Engagement Scale Score 3 months post-release

Scale Domain	Intervention n=29	Comparison n =11	Ttest (df) and Sig
Availability (sd)	1.28 (1.94)	2 (3.01)	-0.89 (32) p = 0.38
Collaboration (sd)	**1.62 (1.57)**	**4.09 (2.07)**	**-4.07 (38)** **p = <0.01**
Help seeking (sd)	3.1 (2.8)	4.09 (3.41)	-0.94 (38) p = 0.35
Treatment adherence (sd)	0.79 (1.72)	1.09 (2.3)	-0.45 (38) p = 0.66
Total (sd)	6.92 (6.58)	11.27 (9.37)	-1.67 (38) p = 0.10

Table Eight records the Service Engagement Scales scores. Due to difficulties in getting information from services providing support to the comparison group, the numbers of responses for this group are small (n=11). From the information provided, the group receiving the intervention scored lower on each of the sub-scales and for the total score indicating greater engagement by this group. The scores on one of the sub-scales (collaboration sub-scale) were significantly different.

5.3 Time Point One Results

The Time Point One Results are shown in Tables Nine to Thirteen. This time-point was approximately 14 days after the participants were released from prison. Thirty participants were still in contact with the RESET service at this time:

- 28 in person
- 2 via telephone
- 1 missing data

Table Nine: Frequency of contact with RESET service at 14 days post-release

Frequency of contact	Number
Daily	1
Twice Weekly	11
Weekly	16
Fortnightly	2

Table Nine notes the frequency of contact between the participants and service. The majority of the 30 participants accessing the RESET service were having face-to-face contact with service users on a weekly or twice weekly basis.

Table Ten: Accommodation at 14 days post-release

Type of accommodation	Intervention n=31	Comparison n=29	Chi square (df) and Sig
Number homeless (%)	**0 (0)**	**8 (27.6)**	**9.87 (1)** **p = 0.01**
Number living with family and friends (%)	6 (19.4)	2 (6.9)	2.01 (1) P = 0.16
Number in independent accommodation (%)	8 (25.8)	5 (17.2)	0.65 (1) P = 0.42
Number in hostel (%)	2 (6.5)	3 (10.3)	0.3 (1) p =0.59
Number in B&B accommodation (%)	5 (16.1)	2 (6.9)	1.24 (1) p = 0.27
Number in supported accommodation (%)	3 (9.7)	4 (13.8)	0.25 (1) p = 0.62
Number in temporary accommodation (%)	**7 (22.6)**	**0 (0)**	**7.41 (1)** **p = 0.01**
Number in prison (%)	0 (0)	3 (10.3)	3.38 (1) p = 0.07
Number in hospital (%)	0 (0)	2 (6.9)	2.21 (1) p = 0.14
Number in other accommodation (%)	1 (3.2)	1 (3.4)	0.02 (1) p = 0.96
	Intervention n=31	Comparison n=29	Ttest (df) and Sig
Mean number of days housed (sd)	**13.58 (2.34)**	**8 (6.89)**	**4.14 (33.97)*** **p = <0.01**
Mean number of accommodations (sd)	1.16 (0.37)	1.17 (0.54)	-0.09 (58) p = 0.93

Table Ten documents the accommodation status of the two groups approximately two weeks post-release. There is clear evidence that the intervention has significantly impacted on a range of outcomes in this short time period. It shows the RESET intervention group were housed for significantly more days than the comparison group. There is also a significant difference in the number of those homeless in the two groups with none in the intervention group compared to over a quarter (27.6%) in the comparison group. There is also a significant difference in the number of participants in temporary accommodation with nearly a quarter (22.6%) of the intervention in short-term housing as opposed to none of comparison group. Although not statistically significant, three of the comparison group had returned to prison with the two weeks post-release as opposed to none of the intervention group.

Table Eleven: Number re-offending 14 days post-release

Offending	Intervention n=31	Comparison n=29	Chi square (df) and Sig
Number reoffending (%)	**0 (0)**	**4 (13.3)**	**4.42 (1)** **p = 0.04**

There was a significant difference in the number of participants in each group who had re-offended in the first 14 days post-release as shown in Table Eleven. None of the intervention group had re-offended compared to four (13.3%) of the comparison group.

Table Twelve: Contact with services 14 days post-release

	Intervention n=31	Comparison n=29	Chi square (df) and Sig
Number admitted to hospital	**0 (0)**	**4 (13.8)**	**4.58 (1)** **p = 0.03**
Number receiving benefits	**28 (90.3)**	**11 (37.9)**	**18.08 (1)** **p = <0.01**
Number in employment/ education	3 (9.7)	2 (6.9)	0.18 (1) p = 0.67
Number in contact with health services	9 (29)	5 (17.2)	1.16 (1) p = 0.28
Number in contact with GP (%)	**28 (90.2)**	**13 (44.8)**	**14.33 (1)** **p = <0.01**
	Intervention n=31	Comparison n=29	Ttest (df) and Sig
Mean number of hospital admissions (sd)	0 (0)	1.03 (3.6)	- 1.55 (28)* p = 0.13
Mean number of days in hospital (sd)	**0 (0)**	**0.14 (0.35)**	**-2.12 (28)*** **p = 0.04**

Table Twelve reports on the level of engagement with services 14 days post-release. The majority of the intervention group were receiving benefits with nearly three times as many as the number receiving benefits in the comparison group. Most of the intervention group (90.2%) were in contact with a GP and significantly more than the comparison group (44.8%). The number of members of the comparison group admitted to hospital (four) during this period was also significantly higher than the intervention group (none) with the mean number of days in hospital also significantly higher for the comparison group. This emphasises the importance of the critical time intervention approach.

Table Thirteen: Service Engagement Scale Score 14 days post-release

Scale Domain	Intervention n=30	Comparison n =13	Ttest (df) and Sig
Availability (sd)	1.2 (1.94)	2.23 (2.74)	-1.4 (41) p = 0.17
Collaboration (sd)	**1.80 (2.17)**	**3.77 (2.59)**	**-2.58 (41)** **p = 0.01**
Help seeking (sd)	2.8 (2.54)	4.54 (5.04)	-1.18 (14.7)* p = 0.25
Treatment adherence (sd)	0.97 (2.45)	2.23 (3.19)	-1.27 (18.7)* p = 0.22
Total (sd)	6.77 (6.73)	12.77 (12.33)	-1.65 (15.19)* p = 0.12

Table Thirteen details the Service Engagement Scales scores. As noted in the Table Eight results, there were problems getting information from services providing support to the comparison group resulting in less than half of the comparison group participants being rated on the scale. The intervention group scored lower on every sub-scale and the total score indicating greater engagement by this group. The collaboration sub-scale scores were significantly different.

5.4 Time Point Three Results

Tables fourteen to eighteen report the Time Point Three results. This time-point was nine months after the participants were released from prison and six months following the formal end of the RESET intervention. However, five participants were still in contact with the RESET service at this time:

- 4 in person
- 1 via telephone

Table Fourteen: Frequency of contact with RESET service at 9 months post-release

Frequency of contact	Number
Daily	0
Twice weekly	0
Weekly	2
Monthly	3

Table Fourteen notes the frequency of contact between the participants still in contact with the RESET service at nine months post-release. There were still two participants in weekly contact with the service with three more having less frequent contact.

Table Fifteen: Accommodation at 9 months post-release

Type of accommodation	Intervention n=31	Comparison n=28	Chi square (df) and Sig
Number homeless (%)	2 (6.5)	6 (21.4)	2.82 (1) p = 0.09
Number living with family and friends (%)	3 (9.7)	1 (3.6)	0.87 (1) p = 0.35
Number in independent accommodation (%)	11 (35.5)	5 (17.9)	2.31 (1) p =0.13
Number in hostel (%)	1 (3.2)	1 (3.5)	1.1 (1) p = 0.96
Number in B&B accommodation (%)	3 (9.7)	0 (0)	2.86 (1) p = 0.09
Number in supported accommodation (%)	5 (16.1)	5 (17.9)	0.31 (1) p = 0.86
Number in temporary accommodation (%)	2 (6.5)	0 (0)	1.87 (1) p = 0.17
Number in prison (%)	5 (16.1)	9 (32.1)	2.08 (1) p = 0.15
Number in hospital (%)	0 (0)	2 (7.1)	2.3 (1) p = 0.13
	Intervention n=31	Comparison n=28	Ttest (df) and Sig
Mean number of days housed (sd)	**244.48 (59.72)**	**129 (123.76)**	**4.49 (38.04)* p = <0.01**
Mean number of accommodations (sd)	2.45 (1.23)	2.29 (1.56)	0.46 (57) p = 0.65

The accommodation status of the two groups approximately at none months post-release is shown in Table Fifteen. The intervention group were housed for significantly more days than the comparison group with the cohort receiving the RESET intervention being housed for around twice as many days than the comparison group. There are no further significant differences. There are some recorded differences in the number of participants in prison and homeless (higher of the comparison group) and those in independent n and B&B accommodation (higher in the intervention group).

Table Sixteen: Number re-offending 9 months post-release

Offending	Intervention n=31	Comparison n=28	Chi square (df) and Sig
Number reoffending (%)	7 (22.6)	9 (32.1)	0.68 (1) p = 0.41

Table Sixteen reports on the number of partiapnts who had re-offended by the 9 month post-release time point. Overall, 16 of the 59 participants had reoffended (27.1%). Although slightly more of the comparison group had re-offended, this was not statistically significant.

Table Seventeen: Contact with services 9 months post-release

	Intervention n=31	Comparison n=28	Chi square (df) and Sig
Number admitted to hospital (%)	4 (12.9)	6 (21.4)	0.76 (1) p = 0.38
Number receiving benefits (%)	**28 (90.3)**	**11 (39.3)**	**17.1 (1)** **p = <0.01**
Number in employment/ education (%)	4 (12.9)	3 (10.7)	0.07 (1) p = 0.7
Number in contact with health services (%)	8 (25.8)	4 (14.3)	1.21 (1) p = 0.27
Number in contact with GP (%)	**27 (87.1)**	**11 (39.3)**	**14.67 (1)** **p = <0.01**
	Intervention n=31	Comparison n=28	Ttest (df) and Sig
Mean number of hospital admissions (sd)	0.13 (0.34)	0.59 (1.91)	-1.26 (29.65)* p = 0.22
Mean number of days in hospital (sd)	2 (7.48)	19.71 (70.5)	-1.35 (28.59)* p = 0.19

The level of engagement with services 9 months post-release is noted in Table Seventeen. There are two significant findings. The number of participants receiving benefits and those in contact with a GP are significantly higher in the intervention group. There comparison group have a much higher number of mean days in hospital though the number of participants who had been admitted to hospital over the 9 months was similar for both groups.

Table Eighteen: Service Engagement Scale Score 9 months post-release

Scale Domain	Intervention n =24	Comparison n =9	Ttest (df) and Sig
Availability (sd)	1.63 (2.53)	1.67 (3.04)	-0.04 (31) p = 0.97
Collaboration (sd)	3.04 (2.35)	4.33 (2.24)	-1.42 (31) p = 0.16
Help seeking (sd)	3.42 (2.96)	4.89 (4.29)	-1.12 (31)

			p = 0.27
Treatment adherence (sd)	1.54 (3.39)	2.11 (3.92)	-0.41 (31) p = 0.68
Total (sd)	9.63 (8.26)	12.33 (10.11)	-0.79 (31) p = 0.49

Table Eighteen details the Service Engagement Scales scores. The intervention group recorded lower scores on all the sub-scales and the total score though none of these were statistically significant. This is likely to be due to the low numbers of scores recorded for the comparison group.

5.5 Qualitative results

Nine interviews were analysed. Braun and Clarke's advice was heeded with the names of the themes being well known phrases or titles that were able to capture the essence of what was contained within the themes.

Three overarching themes were distinguished:

- Someone to watch over me
- Time is relative
- It's a wild world

Several sub-themes were also noted with these described in greater detail below.

Theme One - Someone to watch over me

Sub-themes (Support, Trust)

The theme related to the participants views that they had someone who was looking out for them and supporting them in their endeavours. This was the overwhelming view of all the participants. The support co-ordinators were viewed as people who were "on their side". There were a lot of comments made by participants relating to the positive support the service provided and the support being received by their support worker. The fact that there was a dedicated person who was consistently there for the service user was an important feature of this. The comments below are indicative of the general comments made about this sense of having someone who was working for them and with them.

I'm really grateful for it. I wouldn't be where I am now, getting my life back on track if it wasn't for them. PID 5

I really wouldn't know where I'd be without it. Possibly back inside, you never know because she's with her support she's got me over so many hurdles like….. I wouldn't know what to have done. I'd be literally on the street the second day of my release. So it would have been I don't know. I wouldn't like to say crime this that and the other but probably. PID 58

She's lovely, she really was. She was one in a million…she always helped me and she was always there to support me whether I needed help. PID 59

Support sub-theme.

This support included practical and emotional support to giving space to discuss issues and included issues such as helping with applying for financial benefits, housing forms, getting in contact with friends.

She was very supportive. She'd listen to what, if I was like needed to get things off my chest, she'd sit there and listen to me and everything like that and she was very supportive. PID 59

There was a couple of things I asked about, nothing real serious. She would bring it up straight away, not play it down but make it sound like not such a big deal and that made me feel better. PID 5

So (my ex) tried giving up the house but (*name of support co-ordinator*) was the one who did the paperwork and rung him up a few times and managed to keep my house. Between (*name of support co-ordinators*) really. I would have lost the house. Without a doubt. PID 5

There were also comments about the positive experiences of the support received from RESET compared with their experiences of other services.

Because of my experience with prison in the past and working with people like (*names of prison charities*). I didn't have any hope, it that makes sense. Because these people, not RESET, have said "oh yeah, we are going to do this, we are going to do that" and at that time I thought you ain't going to do nothing. PID 8

I've been to jail a few times and I've come out and not had help like this. It makes the difference. PID 14

Yeah, pushed around and things, and tossed to the side. They carry on doing whatever, and just leave me to do whatever to my own accord. PID 7

An example of how this on-going support had helped one participant progress is noted:

Like the main thing is when you first come out and that's when you have go to sort everything out. And (*name of support co-ordinator*) was there. He took all day with me. He took me everywhere. And then afterwards, he's telling me about the open day in college and that. And without (*name of support co-ordinator*) I'm telling, I was sitting here on the first day and I thought "oh it's the open day this Thursday and I'm going to nip down there". And I went down there 'cos even though there's a telly there and it ain't mine and it don't work. Yeah, I know. So it's a bit of a tease, you know what I mean? So I'm sitting here and without (*name of support co-ordinator*) telling me about that open day, so I went down there and so hopefully… so now…'cause (name of support co-ordinator) pushes you, and I do need a bit of a nudge, because sometimes I won't want to do it, but unless (name of support co-ordinator) was there, I won't do it. And he told me about it, and I didn't want to let him down and I wanted it, so I went down there and went to the open day. So now, hopefully, I can get on that art course in September. See that's what I mean, it did work, I swear to God. 'Cause I know I've got to do it for myself, but I still don't want to let other people down. If people are running around putting their time and effort in me, I've got to stay willing, you know what I mean. And help myself, you know. PID 28

Trust sub-theme

It also seemed that having someone who was consistently supporting them resulted in the participants forming bonds with the support workers but also that this allowed a trust in the support co-ordinator to develop. The users also spoke about trusting the support workers and of them being perceived as honest in their approach. This made them feel confident that the support workers were looking out for what was best for them rather than delivering the objectives of the service the support co-coordinators worked for. This also led to the users being honest with the support workers about their wishes but also their actions and behaviours. This sense that there was an openness from the support co-ordinators led to the users also feeling able to be open in expressing their views to the support co-ordinator. This compared to traditional services which they viewed as having ulterior motives and focusing on the needs of the service rather than the users which led to users not trusting workers in these services and not engaging with these services. It was also evident that this group were keen on receiving support. There were also clear benefits that could be seen from accessing the service from the start so that the support was immediate. An example was that difficulties in accommodation (which was the main reason for a referral) were supported from the

beginning with clear information and support given in the steps to take to gain accommodation. The issue of trust in reflected in the comments below:

I could open up to *(name of support co-ordinator)* and talk to her like I'd known her for years…….. I don't know. It was just something about *(name of support co-ordinator)* that I could talk to her. PID 59

She explained what was going on. We was always honest with each other, open and that. PID 58

Um…he's shown me belief if that makes sense as well. He like believed in me, yeah…….Prison is a very restricted environment and- and regime. A lot of things are right out of my hand. Do you know what I mean? I am being told when to be behind my door, when to eat. …… It's like *(name of support co-ordinator)* comes to me, and everyone will be scared to undo the flap and all that. But *(name of support co-ordinator)* will come, and he doesn't have a problem opening his flap. …….. And he's come to me like "you can do it. You will do it. You need to do it." And other people will be like "I'm not interested" or "I don't care" and that. ……. He'll come to the door and be like "can I undo his flap?". Because at one point I wouldn't open my flap. And they will go "no, no, no, no, because his behaviour" and I can hear *(name of support co-ordinator)* going "No, he's never done anything to me and that". So yeah, belief, hope, yeah. PID 8

The impact of this trust is that the service users would be more willing to work with the RESET service:

Yeah, it wasn't about jumping through hoops. And that's what sort of put me off initially, but I thought "oh (*name of support co-ordinator*) is going to make you do this, do that". But then again saying that, he has made me do this and do that. And it's worked out. So yeah, so it works. So, all me…like spitting my dummy out saying I don't want to do this, and it turned out for the best. PID 28

Theme Two - Time is relative

Sub-themes (Immediate support, Waiting)

This theme notes how the immediate nature of the support given is very important for not only in helping them access resources and services but in also in their engagement with the RESET service. The theme reflects the contrast between the constant and quick initial service and the slow process often associated with other services.

Immediate Support sub-theme

A positive element of the service was the immediacy of the contact and in the support given. Users would talk about the fact that support workers would be there for them at any time. This resulted in problems faced able to be talked through quickly or remedial action taken thus reducing levels of anxiety. The following comments are representative of the views expressed:

She was always there to help me. PID 59

In the first couple weeks? He was around quite a lot. Yeah, it was every week…….Every week! Every week, I swear to God. I'm going to move in with him. PID 28

It was like seven o'clock when we went down to *(name of new house)*…he dropped me off a down the XXXXXX Road, that way. And he (*support co-ordinator)* dropped me off down there, late, and we had to wait for someone come with keys to let me in. PID 28

She's understanding, she takes her time if I've got a problem she does try to help and solve it and not just leaving it PID 14

Waiting sub-theme

The immediacy of the contact with the REST service was contrasted with the perceived limited amount of time the service was offered to the participants. The 12-week period was seen as too short a period of time by many users.

Its not long enough. PID 14

I think it's only for the first three months… I wish there was more support. PID 7

Um, probably go on for longer for the people that need it. Yeah, 'cause some people obviously that ain't got a support worker that's so nice, they have to say, 'hey look I've got to leave ya'. And probably they are fucked aren't they. I was lucky I've got (name of support co-ordinator). PID 23

This also contrasted with the time frames for other services such as housing. The quickness of the responses by support workers was seen as a reinforcement of the fact that the veracity of the support and the commitment to the user and again contrasted with the slowness of the official services responses particularly with regards to decisions such as housing which many found were still being processed at the time of the interviews (3 months post-release).

In the meantime and then they said "right, here's a temporary house in Gillingham" which is where I am now. So it's all just very unsettled and not knowing that I am going to be there for very long. PID 58

They haven't given a reason. They've just said they've asked for an extension on the time to make a decision and I'm allowed to refuse it. But it might be going in my favour so what can I do? I've got to give them their time haven't I? PID 58

I think there could be room for improvement, because they just said to me like basically *(name of NHS Trust)* has just said the next appointment is in three months. So that's quite far away. PID 7

Theme Three - It's a wild world

Sub-Themes (Impenetrable bureaucracy, Uncertainty)

This theme focused on the complexities of trying to deal with the administrative and bureaucratic processes that many users found when communicating with various services. This was often due to not being able to understand the processes to use when trying to access services such as the benefits system or accommodation services. Many did not have the skills to deal with these situations and time in prison had resulted in others not keeping up with changes to the various government or service procedures during their incarceration. This led a lack of knowledge of the different services that were available and uncertainty and confusion as to how to negotiate the system. The consequence of this was users had reduced communications with relevant agencies. This resulted in a lack of services being provided or increased the time line for decisions and support to be offered.

Impenetrable bureaucracy sub-theme

Various agencies appeared to have systems in place that were difficult for the service users to understand. The comments below give a flavour of the difficulties encountered:

We went to probation. I went to the doctors. Rang up ESA for the job centre and um…went to the council. So we were really busy. PID 28

And they keep sending the forms back, coming up with excuse after excuse. And that's the only way I can get photo ID. My birth certificate is in another name because when my mum was married, I was re-adopted so I wouldn't have got a birth certificate in XXXXXX, it would be in YYYYYY. So, they are asking for a birth certificate, but that's not in my name, that's in my birth name, which I am not using anymore. My national insurance is in XXXXXX and everything, but my birth certificate is in YYYYYY. PID 23

I've got the problem going on at the moment where we didn't apply for the Council Tax reduction until later in the day maybe January. So they're saying that they don't want to backdate it and all this sort of things. So that's what I've got going on at the moment with that. PID 58

Uncertainty sub-theme

The difficulties encountered through administrative and bureaucratic procedures faced by service users faced were often exacerbated by the fact that they did not have the experience or skills to deal with these procedures. The support co-ordinators had the necessary skills to both understand the complexities of the system and the time to help the user. This meant that they were able to help the user work through the system but also help the user gain confidence in engaging with these systems and develop skills for future contacts. The following comments illustrate this:

I do feel like I'm institutionalised a little bit because I do struggle to function on the outside. PID 58

Like helping with like benefits, supporting me with forms and stuff like that because I can't read and write. PID 59

(Name of ex-partner) used to deal with all finances. She had my bank card for the best part of 22 years. I forgot what colour it was. She used to deal with all the paperwork and finances. So coming out, it was like woah. I had piles of paperwork, (*name of support co-ordinator*) sorted it all out, got in touch with everyone for me, sorted out the housing benefit, the CSA. PID 5

Um, yeah. The property that I was in in Enfield was um, literally as big as a prison cell. It was a bed-sit, I'd probably say it was, but it weren't that big. Um, as I said, it was as big as a prison cell. I didn't have hot water for six weeks. I didn't even have shower working for six weeks either. I didn't have no heating for six or seven weeks. It was only because (*name of support co-ordinator*) again on my behalf, complained to the estate agents and the landlord to solve these issues and problems out, because the estate agents were fobbing me off, telling me there was nothing wrong with the water, there was nothing wrong with that shower. But the only people that could back me up was *(name of support co-ordinators)* . They took the evidence to prove there was nothing- there was something wrong with the hot water and the shower. And like I said, I had problems with that. It was only because (*name of support co-ordinators*) kept putting pressure on the council and the estate agents for them to come round. They actually sorted out my hot water, sorted my shower out, and even put a heating light, like a heating- heating-heating system in- in my flat. PID 8

The link between the three themes

The three identified themes were interlinked with the trust and confidence in the support worker resulting in a willingness to receive the support offered. The support workers consistent and quick responses to try and resolve any issues and their ability to negotiate through the various systems of different services further developed confidence and appreciation in the resettlement service. The

specific implications of receiving this support was that the users of the service were able to access a range of support services (particularly in relation to gaining support for housing and financial benefits) which in turn gave them some sense of safety having "the security of knowing where you live". This then allowed users the time and space to engage with other services such as GP and mental health services which were positive indicators for their ongoing for their future health and wellbeing and reduced likelihood of recidivism.

Family Support

There were a few respondents who noted they engaged and were supported by other family members. Although some participants commented on contact between the support co-ordinator and family members, the support workers role in this was unclear from the interviews. Further work to examine how much the support workers role influenced the re-engagement or development of family contacts would be helpful.

6. Discussion

The overall aim of the project was to evaluate the impact of the supported release from prison service. To achieve this aim, sixty-two participants were recruited to the study with thirty one prisoners allocated to both the intervention and comparison groups. There were no significant differences in the demographic, clinical and offending characteristics of the two groups. The main reason for referral to the RESET service, offered by Clarion Housing and Nacro, was for housing support. The RESET intervention was of 12 weeks duration and focused on ensuring service users obtained appropriate safe and secure accommodation, access to welfare benefits, re-engagement with health services and strengthening links with family and community support services. Data was collected from virtually all participants at the three time points (14 days post-release – 60 (97%), 3 months post-release – 60 (97%), 9 months post-release – 59 (95%). In the nine months post-release period, no deaths were reported of any participants recruited to the study. The follow up rates compare favourably to other studies. The CrISP intervention (Shaw et al, 2017) followed up 76% (55 out of 72 allocated) of the intervention group at 6 weeks and 78% (61 out of 78) of the TAU group while 57% (n=41) of the intervention group and 56% (n = 44) of the TAU cohort were able to be followed up at 12 months. The team also noted they experienced severe delays outside the team's control particularly in gaining research and governance permissions. This resulted in the CrISP study not being able to achieve all its original objectives with analysis unable to be undertaken on hospital admissions, reoffending and overall community tenure.

Quinn et al (2018) has stated that sustained engagement on release, and therefore achievement of adequate follow-up rates, has been problematic for both descriptive studies and trials of both health and criminal justice interventions. Following up released prisoners is demanding, particularly for those prisoners with mental health problems, for whom stigma and chaotic lifestyles are problematic. This is exacerbated by the fact offenders often distrust healthcare professionals and do not want to perceive themselves as having potentially stigmatising mental health problems. Additionally, housing, relationships, and employment are often higher priorities for prisoners on their release than accessing health services (Social Exclusion Unit, 2002). Quinn and colleagues note that the main exception is for prisoners receiving interventions that they particularly value, such as opiate substitution for substance misuse (99% and 65% follow-up rates) (Dolan et al, 2005; Gordon et al, 2010). The high retention rate in the RESET intervention group (and the rate of engagement with services throughout the intervention period) may well reflect the value placed on the service by the participants in this study.

6.1 Accommodation

The primary objective of the study was to examine the participants' housing situation at three months post-release with the accommodation status at 2 weeks post-release and 9 months post-release among the secondary objectives. The results of the study show that at 3 months post-release the intervention group receiving the RESET service had significantly more days of secure housing (mean 88 vs 44 days) and that significantly fewer of this group were homeless with none of the intervention group without accommodation compared to eight of the comparison group. There were also significantly more of the intervention group in B&B accommodation. This is likely to be a result of the RESET service getting the participants into temporary accommodation while applying for more permanent accommodation. At the three-month post-release timepoint, more of the RESET intervention group were in independent accommodation while more of the comparison group were in prison. The significant differences of fewer homeless participants and a greater number of days housed in the intervention group were also found at the 14 days post-release and nine-month post-

release time points. The results also showed that more of the comparison group were in prison at all three time points. These findings support the view that the intervention was successful in accommodating participants in permanent accommodation and reducing the likelihood of homelessness. The Centre for Social Justice (2010) reported that up to third of people leave prison with nowhere to go. This problem is even more acute in London as different London authorities have different thresholds for providing housing support. It is also the case that the quality of accommodation offered is often variable. Homeless Link (2018) reported the majority of people leaving prison have somewhere to stay initially though this can often be insecure, unsuitable or temporary and that most prisoners who end up sleeping rough do so after their initial accommodation has fallen through. Support from the outset is therefore important. The RESET intervention, whereby a released prisoner is met at the prison gates and supported to obtain accommodation from that point is therefore vital. The importance of this support offered by the service can be gauged by the fact that none of the intervention group were homeless at the 14 days post-release compared to eight (27.6%) of the comparison group. It is likely that the role of the service in obtaining accommodation for released prisoners at this early stage helped establish a secure base for service users to then be able to liaise and access other services.

The comments made in the qualitative interviews suggest ongoing support from the support co-ordinators may also have provided hope and encouragement to the participants in this study to enable them to continue to receive the service and consequently ensure that significantly more of the intervention group were in permanent accommodation at the three month and nine-month post-release time points.

Between (name of support co-ordinators) really. I would have lost the house. Without a doubt. PID 5

The adverse effects of homelessness on mental health can be magnified when an ex-prisoner has mental health problems as well. Thomas (2012) found that anxiety and depression is twice as common and psychosis up to 15 times more likely in the homeless population than in the general population. Reeve et al's (2018) examination of the mental health needs of homeless people in Nottingham, found that virtually all had been stuck in the temporary accommodation system for years. Consequently, without secure accommodation, daily survival was a constant struggle so their mental health was not always prioritised. The Mental Welfare Commission for Scotland (2017) have stated that homelessness is a stressful and isolating experience that exacerbates mental health problems with Shaw et al (2017) reporting service users talked about how poor mental health disrupted function and prevented them from working.

Reeve et al (2018) also reported that people who are homeless and have mental health problems have increased levels of stigma from the general public. This was also noted by Shaw et al (2017) who found that service users highlighted their feelings that the stigma of being an (ex)-offender permeated every aspect of their lives. They reported that stigma negatively impacted quality of life, hindered their job prospects and increased the risk of reincarceration. They also reported self-stigma in relation to mental illness, which often kept them from disclosing difficulties and from seeking mental health treatment in prison.

The importance of securing accommodation for prisoners with mental health needs has been highlighted by several studies. Hancock et al (2018) interviewed workers providing support for ex-prisoners with mental health problems. The importance of secure housing was the most important factor in ensuring a positive transition from prison to the community due to three main reasons:

(1) somewhere to live is the person's absolute priority. It was impossible to address mental health support and treatment before a person had stable accommodation

(2) without housing they are lost to care. If someone does not have a fixed address, they become difficult to locate and connect with which makes it hard to provide support

(3) housing helps break a cycle of returning to poor previous relationships and routines.

The importance of suitable accommodation was also noted by both users and health professionals in Shaw et al's (2017) study. Service users stated felt that securing accommodation was a vital part of the resettlement process as this was a key aspect of being able to access services. Experience had also taught them that a lack of accommodation increased their risk of reoffending. Health professionals stated that securing suitable accommodation was arguably the number one priority for many released prisoners because it established a stable base from which to address other resettlement concerns.

6.2 Contact and Engagement with Services

In terms of the participants' contact with services, the results show there significantly more of the intervention group in receipt of state benefits and in contact with a GP at all three time points. The RESET group also were significantly more likely to be in contact with health services (mostly mental health services) at time point two though the number of participants engaged with health services was less than half 15 (48.4%) and this number reduced to 25.8% of participants at time point three. The intervention group were also significantly less likely to be admitted to hospital in the first two weeks post-release with the number of days spent in hospital significantly higher for the comparison group at two weeks and continuing to be higher at time point two. Although there were more of the intervention group in education or employment at 2 weeks post-release, the numbers in the other two time points were similar across both groups. The overall numbers were low with only four participants (12.7%) of the intervention group in employment or education at time point three. This could be explained by their need to address ongoing mental health and other concerns and maintain some level of stability in the community prior to engaging in education or training. In terms of the scores on the Service Engagement Scale, the intervention group were consistently scoring lower on all sub-scales and total scale scores at all three time points meaning that there was greater engagement between the RESET intervention participants and services as opposed to the comparison group. The collaboration sub-scale showed significantly better engagement at time points 1 and 2. The results of this scale should be treated with some caution as the number of responses from the comparison group were small (n=11 at time points 1 and 2 and n=9 at time point three).

The engagement of prisoners with mental health needs with mental health services has been problematic. Only a small minority of prisoners make contact with mental healthcare in the period after release (Lennox et al, 2012) with the OHRN (2009) study reporting that only 20% had contact with a Community Mental Health Team (CMHT) one-month post-release. The fact that nearly 50% of users in the RESET cohort were in contact with mental health services at time point two is, therefore, encouraging. Additionally, five users were still in contact with the RESET service nine-months post-release with the service noting this was for clients with particularly high needs who were deemed to require ongoing support. This suggests that some service users would benefit from a period of support longer than the current 12 weeks. The results of CrISP intervention (Shaw et al, 2017) also showed significantly greater levels of service engagement at 6 weeks and 6 months and a non-significant increase in engagement at 12 months. However, only a third of the intervention group

were engaged with mental health services at 6 weeks (at the end of the intervention period) and only 24% at 12 months. In Lennox et al's (2017) ENGAGER pilot trial, participants were followed up at one and three months post release. 31 (77%) of the 40 people randomised to the intervention were engaged at one month and 19 (47%) at 3 months. The numbers of the CrISP and ENGAGER intervention groups in contact with mental health services at the intervention end-point were much less than the RESET intervention cohort at three months and similar at the nine-month post-release time point. The previous experiences of accessing health services may have influenced this lack of contact. Reeve et al (2018) found that previous experiences of support services were often poor and resulted in a lack of trust with mental health services. Only 27% received support or treatment that met their needs with 51% stating that they had required mental health support within the last year but were unable to access this many due to not having their mental health needs recognised. They also noted many ex-prisoners with mental health needs had been referred to services that would not support them (often as their needs were deemed as too complex for the service). The Mental Welfare Commission for Scotland (2017) also found that accessing services was difficult to arrange, especially psychological therapies, with many placed on waiting lists. The results also suggest that a significant number of service users who were initially in contact with mental health services stayed in contact with the support of RESET thus helping to engage with mental health services.

100% of the RESET intervention group were in contact with a GP at three-months post-release and 90% in contact within the first two weeks of release. This contrasts with the findings of Williamson's (2007) study where only 50% of were registered with a GP upon release. The CrISP intervention group were also significantly more likely to be registered with a GP at six weeks. The value of having access to a GP is in their central role as the co-ordinator of helping with mental and physical needs and liaising with other health services. There are negative consequences for those who are unable to contact a GP. The Mental Welfare Commission for Scotland (2017) interviewed homeless people with mental illness and found that the participants reported many problems getting registered with a GP and, because of this, in gaining medication particularly. This was a specific problem for newly released prisoners as many were released without any prescribed medication. The Centre of Social Justice (2010) also reported that homeless people with mental health problems had difficulties registering with a GP if they did not have a permanent address.

Crisis (2019) have noted the importance of being able to access benefits stating that people often struggle to find accommodation with a private landlord upon release or get the housing element of Universal Credit quickly enough and can wait months for payment. The Mental Welfare Commission for Scotland (2017) also detailed difficulties in obtaining benefits and noted that interviews for Personal Independent Payments (PIPs) were often arranged at inaccessible venues for people with mental health problems with sanction applied if the appointments are missed.

The value of having the RESET service to help with situations like this was evident in the qualitative interviews.

Like helping with like benefits, supporting me with forms and stuff like that because I can't read and write. PID 59

The collaboration sub-scale score of the SES at three months post-release showed significantly better engagement by the intervention group. The differences between the intervention and comparison group SES scores need to be treated with caution due to the low numbers of respondents in the comparison group. However, there were high response rates from the RESET intervention group supervisors at time point one (n=30) and time point 2 (n=29) so these scores can be examined from the perspective of the how well the participants receiving the RESET service

engaged with the service. The collaboration sub-scale questions are focused on the willingness of the participant take an active part in their care and treatment and to accept advice. The score at the formal endpoint of the RESET intervention (time point two) was 1.62. This compares to a mean score of 3.24 from the cohort who undertook the measure when it was developed - people with first episode psychosis in an inner city in the UK (Tait et al, 2002). In addition, the other sub-scales scores (actively seeking help, being able to receive services, and adhering to treatment (medication) all indicate greater levels of engagement by the RESET group when compared to the comparison group. This supports the view the cohort receiving the RESET intervention were more actively involved in engaging with the RESET service compared to both the comparison group in this study and the cohort in the Tait et al study. It also suggests the areas Hopkin & Thornicroft, (2014) consider as essential to consider when making a judgment about the true level of engagement (acceptance of help, collaboration in treatment, and openness with mental health workers) are enhanced in the group in receipt of the RESET service. This positive engagement can be seen as a constructive base for their future relationships with services.

6.3 Participants Views of Services

There have been several studies examining the views of ex-prisoners with mental health needs and what they viewed as helpful of the support required in the transition between prison and the community. Many of these are reflected in the views expressed by users of the RESET services when interviewed. The results indicate that there are consistent views expressed about what constitutes a good or a poor service, as well as suggestions for future service developments.

Positive advocacy

The recipients of the CrISP intervention in Shaw et al's (2017) study noted the importance of positive support from their case manager (equivalent to the support co-ordinator in the RESET study). Those recipients viewed receiving positive and ongoing support from the case manager reduced the risk of reoffending and provided a realistic hope of a future outside prison. The value of the support co-ordinators providing advocacy to recipients of the service was an important part of this support with participants reporting that the CrISP case managers, acting as advocates on their behalf, had been instrumental in improving access to services. From these participants' perspectives, there was a direct correlation between levels of support, continuity of care provided by services and a reduction in the likelihood of reoffending. Reeve et al (2018) has reported that advocacy was an important element of service provision as this gave ex-prisoners s confidence when approaching services. This was particularly important when dealing with the complex landscape of mental health and support services. The Mental Welfare Commission for Scotland (2017) also concluded that independent advocates help individuals make their voice stronger and have control over their life. It was also viewed as important to be in contact with professionals who were able to demonstrate empathy and care. This helped develop trust between individuals and services and this was reinforced when there was continuity of care with keyworkers who they could get to know, trust and understand. The role of being an advocate for service users was clearly was something that the RESET support co-ordinators took on. It was also recognised by service users:

She's understanding, she takes her time if I've got a problem she does try to help and solve it and not just leaving it PID 14

This can be seen as a reason why twenty-nine of the thirty one participants (94%) who received the RESET intervention continued to be in contact with the service for the scheduled three-month duration of the intervention. In fact, five of the participants were still in contact with the service at

nine-months post-release time point. The ability of the support co-ordinators to give immediate and consistent support was an important factor in the positive views of the service:

I felt supported a bit this time more than usual. Because if he hadn't of been there, they basically kicked me out of prison without no mental health referral, nothing. And if he weren't there, I wouldn't have got that referral. I wouldn't have stuck at it. I wouldn't have stuck at my housing. I wouldn't have stuck at my rent. I wouldn't have stuck at my benefits. PID 28

This was reinforced by the fact that the participants believed the support co-ordinators were working in their best interests and had the skills and competencies to help them. The outcome of this was as important as it allowed service users to access a range services to help with accommodation, benefits and health:

It was only because (*name of support co-ordinators*) kept putting pressure on the council and the estate agents for them to come round. They actually sorted out my hot water, sorted my shower out, and even put a heating like…..like a heating……..heating……heating system in- in my flat. PID 8

This compared to previous support packages, following release from prison as well as other services that were viewed as distant, unhelpful and ineffective.

Well probation aren't supporting me full stop. They're not helping me. And they're meant to, they keep on telling me to look for properties and everything like that and try and find my own place to live. But so far everywhere I've found hasn't been good enough for probation and they keep on refusing it and so on. PID 59

Continuity of services

Shaw et al (2017) reported that participants in their TAU group frequently reported a lack of continuity both between and within services. This was most evident at the point of release. Reeve et al (2018) noted that service personnel were often changing so they could not build a rapport. It also resulted in service users having to tell and re-tell their story to different people. The lack of continuity and intensity of support made them feel let down by services. The London Assembly report (2017) found that staff shortages were often the reason that prisoners might not be able to access support services as there was no-one to accompany them. They concluded continuity of care between prison settings and the community is and improvements in mental health outcomes that took place whilst in prison can be lost if support is not around upon release. Additionally, prisoners report that they have difficulties in arranging their own care after release due to lack of knowledge of services and how to engage with them and sending referrals prior to release may not be sufficient to ensure that continuity is realised (Binswanger et al, 2011). This uncertainty was also noted by Shaw et al (2017) who stated that this made it virtually impossible to implement meaningful discharge planning. The return to community living was associated with anxiety about the likelihood of negative outcomes and some service users found their experiences so stressful that they considered reoffending in order to return to prison.

That's not my final place. It's stressful. It's very, very stressful and so she's talking to the Council on my behalf and landlords and everything else and managed to get another hold on it. So I'm just waiting to hear any day they could say "no you have got to move out" Then my mum she's just said to me that a letter's come through. Because some people post letters to my mum's house because when I first came out I didn't have an address so I've used my mum's address. So just yesterday my mum said they've got an overpayment for housing benefit. It's ridiculous. So I'm like well it's nothing to do with me. Because I've never seen it, don't know anything about it. The Council are paying the housing

benefit as far as I know for this place, straight to the Landlord's/ I don't know anything about it. So I've got that in the pipeline as well. I don't know what is going on really. And dealing with all these different councils is so stressful. I don't feel settled at all. PID 58

The London Assembly (2017) found many through the gate services were compromised by a lack of joined up thinking between agencies. Consequently, the support offered was often insufficient. Reeve et al (2018) also found information between services was often poor preventing joined up care resulting in different services (i.e. health and housing) having to be accessed separately. Interestingly, this concern was also repeated by health professionals interviewed in Shaw et al's study. A lack of information sharing was identified as a major contributor to gaps in service between prison and community. The importance of liaison between individuals and agencies was highlighted if interdisciplinary approaches were to prove effective. In study of health professionals attitudes to community services for prisoners, similar concerns were raised. Hancock et al (2018). Respondents talked about the necessity of having strong and clearly defined communication pathways for facilitating an individual's transition to the community. Invariably participants described difficulties accessing the information they needed from other sectors in order to do their job. The study looked at three different service sectors involved in supporting the transition of prisoners into the community. Staff within each of the three sectors repeatedly talked about staff from the other two sectors not valuing their role, not being clear about what their role was, or not understanding the limits to their role. Participants working in community contexts also repeatedly talked about the time-consuming and arduous process of getting clearance and approval to enter the correctional facility. Poor understanding and communication between agencies also led to miscommunication and seriously affected the ability of the services to support people being released. Community-based staff talked about the need to better prepare people who had been in prison for extended periods for what had changed outside of the prison walls.

Basically what happened was my landlords are saying that they want to move me to Maidstone but I didn't know why. So anyway I was telling (name of support co-ordinator) they want to move me to Maidstone, this and that. So she on my behalf contacted the Council because they'd said, in the end they said it was a council requested move. There's a reason for that. So (name of support co-ordinator) was speaking to the Council yesterday and the day before saying who was requesting this move basically……She said she spoke to the landlords as well and managed to put it on hold until we've made them sort it out or whatever. PID 7

There were also specific problems reported to the London Assembly (2017) for those only serving short sentences with the London Rehabilitation Company (CRC) informing the report team that prisoners receiving support from their service were in custody for such a limited time, they did not have a full assessment and there is no continuity of care once they are released into the community. The Revolving Doors Agency and Centre for Mental Health (2019) state this is highly significant given that 250,000 people go through prison annually with 57% serving sentences of 12 months or less meaning very high numbers of people continue to leave prison without the support that they need and that the responsibility for care was not being effectively passed on to relevant services. HMI Probation has also been critical of the quality of 'through the gate' services provided by Community Rehabilitation Companies and, in particular, the lack of planning and arrangements for suitable accommodation (HMIP, 2019).

The difficulties in communication and access between services also influences how research is able to be conducted to examine the impact of interventions designed to improve the transitions of prisoners with mental health needs into the community. It took a considerable amount of time to

gain permission to undertake the recruitment in the prisons and, when permission was obtained there were still occasions when the project researcher was unable to gain access to Inreach services to talk about the study with potential participants. In addition, communications with different agencies to assist in getting post-release data was also a lengthy and difficult process. Similar issues were also reported by Shaw et al (2017) and were reported as reasons for the study being unable to achieve all its original objectives

Time limitations

Another limitation with services was noted by Reeve et al (2018) in that service support was time limited and ex-prisoners wanted more frequent and longer-term support. The main criticism of the RESET service was that its time limited duration meant, that some users participants were still in the process of trying to obtain secure accommodation when the service was due to finish. Some of the RESET recipients interviewed commented that they required a longer period of support. The main reasons given were that they were still in the process of applying for secure accommodation or benefits and wanted the continued support of the link co-ordinator until this was resolved and that they had formed a trusting positive relationship with the link co-ordinator.

Interviewer: And how would you like to see the service change for future service users?

Um, probably go on for longer for the people that need it. Yeah, 'cause some people obviously that ain't got a support worker that's so nice, they have to say, 'hey look I've got to leave ya'. And probably they are fucked aren't they. I was lucky I've got (name of support co-ordinator). PID 23

Shaw et al's (2017) CrISP intervention lasted for six weeks and the team also discussed the period of the intervention and whether six weeks of intensive support was sufficient to assure the attainment of long-term benefits. A proposal put forward was whether a step down in intensity might be more appropriate than a 6-week cut-off point. The team also noted that the ending of any episode of care or therapeutic engagement needed to be prepared for and properly managed though no conclusions were drawn as to how this could be achieved.

Peer Workers

One proposed development discussed mainly in the literature was the possibility of using ex-prisoners with mental health needs as peer support workers. Reeve et al's (2018) interviewees suggested that it may easier to discuss their personal issues with someone who had been through the same experiences as they might have a deeper understanding of their experiences and feelings. Reeve et al stated further that this may enhance levels of trust especially if previous experiences of professional services had been negative. The London Assembly (2017) also suggested the development of this role would help in the employment of ex-prisoners with mental health needs. Interestingly, this suggestion was only put forward in one of the interviews with recipients of the RESET service. The RESET service team noted that some staff are ex-offenders and so technically peer workers, although the service users might not know this and might not be as 'visible' as formal peer support workers. However, it may be a fruitful area to explore with regards to potential developments of the service.

I think they should look up, for example someone like me, who's come out of prison. Not now, but someone who has come out of prison and gone through the ropes and offer them voluntary contracts. And then if I'm working, well not me, but say someone- I'm just using me as a pretext, if I worked well for example and got on with it, I mean I could go and meet these people from prison like (name of support co-ordinator) does, and say look I've been there. I know the process. From when I

first gone into prison to the day I get released from prison. I know from the first day to the last day what happens. PID 8

6.4 Reoffending

Reoffending rates tended to be similar for both groups except for time point one where significantly less of the intervention group reoffended. Ministry of Justice figures report that prisoners who were homeless before being brought into custody were more likely to be reconvicted upon release as opposed to prisoners who did not report being homeless (79 per cent compared with 47 per cent in the first year) (Ministry of Justice, 2012). This compares to a figure of 22.6% of the RESET group who had offended in the first nine-months post release and also of 25% (four out of sixteen) of those who were homeless at the time of imprisonment and had re-offended at the nine-month time point. The importance of finding suitable accommodation for released prisoners is important with Shelter Scotland (2015) noting prisoners with mental health problems were often released without housing and that if the right housing was able to be found this reduced the risk of reoffending. Homeless Link (2018) also stated that leaving prison is a confusing and chaotic experience for many people and experiencing homelessness could be a major factor in re-offending. The benefits of this were noted by the London Assembly (2017) who noted the individual and the wider society costs would benefit if the needs of offenders with mental health needs could be addressed.

Hopkin et al (2018) noted in their systematic review that the primary outcome of the majority of the included studies was based on forensic outcomes, such as lowering recidivism rates. However, a key rationale for interventions aimed at reducing re-offending was through the prevention of severe negative mental health outcomes of prisoners after release though these were rarely assessed. The review also stated it was possible that interventions aimed at improving health outcomes in transition have a negative impact on return to prison after release as contact with services increases monitoring, including drug testing, and this greater awareness leads to increased probation violations and higher rates of parole revocation. It is unclear whether this greater scrutiny affected the scores of the RESET intervention group though it may be useful to examine whether staff involved in the delivery of an intervention such as RESET could be provided with alternatives to reincarceration if violations to probation or parole take place.

6.5 Black Asian and Minority Ethnic (BAME) groups

All but eight (13%) of the participants in the study were White British. People of minority ethnicities made up 27% of the prison population in March 2019 (Ministry of Justice, 2019). Lennox et al (2018) also reported that 95% of their sample were white while Shaw et al (2017) stated that approximately half of the sample were from BAME groups. BAME communities are disproportionally represented in both the mental health care and criminal justice systems (Rutherford and Duggan, 2007). They are also 40% more likely to access mental health services via the criminal justice system (Bradley 2009) with the proportion of Black Britons in prison three times more than the proportion in the general population (Ministry of Justice, 2012). However, there is evidence that Black and other BAME prisoners are under-represented in prison mental health caseloads (Centre for Mental Health, 2013). It has been proposed this may be due to a cultural difference in concepts of what constitutes mental ill-health (Keating, 2007) and, in particular, an inability to recognise symptoms of mental illness and unwillingness to accept a diagnosis of mental illness (Memom et al (2016). The negative perception of how mental illness is viewed in some cultures and resultant fear of stigmatisation have also been put forward as reasons why BAME groups may not wish to seek help from services. This has been exacerbated by the fact many BAME individuals have negative perceptions of mental health services due to perceived racism, language barriers and the lack of cultural competency of mental health

services (Cooper et al, 2012; Memom et al, 2016). Memom also noted there were "sex differences" with BAME men less likely to talk about their mental health. It is difficult to know the specific reasons behind the lower than expected number of BAME participants recruited to the study without identifying a breakdown of the ethnicity of eligible individuals in the prisons involved but it is clear this is a problem if it reflects a true pattern of referral and recruitment to the RESET service. The Bradley Commission (Durcan et al, 2014) noted there is a lack evidence about what intervention works work this groups of service users. The commission report suggests that five components were needed to achieve positive outcomes:

- Cultural competence – taking an individual's background into consideration
- Person Centred Intervention – tailored to the needs of the individual.
- Holistic engagement – working to look at housing, addiction issues, employment, parenting, ill-health and importantly racism.
- Mentoring and service user involvement – particularly using service users into the organisation's decision making.
- Working in Partnership - formalised links with BAMR+E groups.

In the first instance, it may be useful to retrospectively examine the ethnicity of the people recruited to the RESET service, including those who were unable to or unwilling to participate in the study, and to compare this to the proportion number of prisoners in Inreach services from BAME groups. Discussion with BAME prisoners about their views of accessing support from RESET services may also be a helpful way of receiving feedback about how the service is viewed (and accessed) by BAME prisoners.

6.6 Women

The RESET service currently only supports male prisoners from some prisons where Oxleas NHS Foundation Trust provides the mental health care. Consequently, this study did not include women as participants so was unable to comment on the efficacy of the service to women with mental health needs transitioning out of prison. It is recorded that 5% of the prison population are women (Ministry of Justice, 2019). Women in prison would clearly benefit from having more support upon release and assistance in obtaining suitable housing with the Corston Report (2007) stating housing is the most important resettlement need for women in the criminal justice system. The Prison Reform Trust report (2016) noted that in England and Wales, women are imprisoned on average 64 miles away from their home. This makes it harder to liaise with relevant housing associations and often means women in prison are unable to meet the eligibility criteria for housing in that area. The report further stated that 60% of women may be homeless upon release from prison and the failure to solve a chronic shortage of suitable housing options for women who offend leads to more crime. Safe supportive housing was, therefore, crucial in breaking the cycle of reoffending. An additional consequence of women being incarcerated is the impact of parenting. Only 5% of children with a mother in prison are able to stay in their own home with 17,000 children separated from their mother by imprisonment in 2010 (Prison Reform Trust, 2016). The Corston Report (2007) also noted there were a number of specific challenges with regards BAME women transitioning from prison to the community who face similar resettlement needs as other women prisoners but face further disadvantages similar to those detailed in the previous section; racial discrimination, stigma, isolation and (at times) language barriers.

Women with mental health needs in prison would benefit from having a support package in the transition from prison to the community. They would also greatly benefit from being able to access specialist support to obtain safe, secure accommodation. The findings from this study suggest that

the RESET service could provide this although it is acknowledged there may be different challenges presented when supporting women as opposed to men. However, the potential benefits are substantial.

6.7 Family involvement

There were a few comments made in our study about the support offered by family and friends. It is likely that this is due to the focus of the study being one the stated objectives and that this was not an area where in-depth quantitative or qualitative date was collected. Some users commented on their contacts and interactions with family members. In Shaw et al's (2007) study, participants reported receiving mostly practical compared with emotional support from family members. This was most apparent in relation to providing accommodation. They also reported reliance on their families for financial support. Future work to examine how much the support workers role influenced the re-engagement or development of family contacts would be beneficial.

6.8 Limitations

There were some limitations to the study. These are:

- The number of participants relatively small. It is recognised that the number recruited allowed for significant findings to be reported. However, larger numbers would have given more robust information.
- The follow up period only lasted for six months following the cessation of the intervention. It is unclear what the impact of the intervention would be over a longer period of time.
- The study focused on those who had agreed to receive the service.
- There was a lower number of BAME referrals than would be expected
- The RESET service evaluated was a service only for men.
- There was no examination of the impact of the intervention on the re-engagement or development of family contacts.

7. Conclusions

The study was able to recruit 62 prisoners with mental health needs who were released into the community and followed up for nine months following their release from prison. Half of these prisoners received the RESET service and half received the standard care package. 95% of those recruited were able to be followed up for the duration of the study (nine months post-release). A range of data was collected relating to accommodation status, engagement with RESET, engagement with other services and levels of reoffending. The data was collected over three time points. The results indicate the main objective of the service was achieved and the intervention was successful in accommodating participants in permanent accommodation and reducing the likelihood of homelessness. Those who received the RESET services were also significantly more likely to be in contact with other services (for the receipt of state benefits, accessing GPs and engaging with mental health services) and that there was a greater level of engagement from those service users in the receipt of the RESET intervention. The numbers in the intervention group maintaining contact with benefit agencies and GPs was maintained at the nine-month post-release time point but the numbers in contact with mental health services halved in the six months following the formal end of the intervention posing the question whether the impact of the intervention is time limited. It was also noticeable that the RESET intervention had significantly positive impact on a range of outcomes in the first two weeks following release from prison indicating that being able to access the service at the time of release from prison is important. There was also a great deal of positivity about the RESET service from the recipients of the service. This was shown by the fact that over 95% of partiapnts were in contact with the RESET service until the formal end of the RESET support at 12 weeks. The comments about the service that were expressed during the intervention also reveal an overwhelmingly upbeat view of the service. There were areas that might benefit from further examination. The number of BAME accessing the service was lower than expected and it would be helpful to ascertain the reasons for this reduced take up of the service. In addition, the number of service users from the intervention and comparison groups going in to education or employment was small.

Overall, the service has shown itself to be a valuable resource in engaging and supporting prisoners with mental health needs upon their release in to the community with a range of social, clinical and personal benefits supported by the findings of this evaluation.

8. Recommendations

There are several recommendations the team would like to propose to Oxleas NHS Foundation Trust following this evaluation. These are noted below:

- The results of the evaluation indicate the RESET service is providing a valuable service.
  Recommendation One: To examine the funding provision of this service and whether it is possible to develop this service in other prisons.
  A number of users of the service expressed disappointment that the service only supported service users for three months. In addition, there is some evidence the effect of the intervention on certain outcomes had diminished by the time of the nine-month time point.
  Recommendation Two: To look at the rationale for offering a more flexible support period and to identify the criteria for providing a scaled approach with additional support beyond three months for those with particularly complex needs.
  Recommendation Three: To have an extended evaluation to include a longer follow up period (i.e. after 18 or 24 months) to examine if and when the impact of the intervention decreases and for which outcomes.
- There was a lower than expected take up of people reeving the service by BAME prisoners.
  Recommendation Four: The reasons for this lower than expected take up of BAME should be explored and remedial action taken based on any main findings.
- The RESET service evaluated was a service only for men.
  Recommendation Five: To initiate and evaluate the intervention in women's services
- The number of participants who went in to education or employment was small.
  Recommendation Six: To carry out a review of the best approaches to use to increase opportunities for released prisoners with mental health needs to be able to access education or employment.
- There was no examination of the impact of the intervention on the re-engagement or development of family contacts.
  Recommendation Seven: To include an examination of family contacts in any future evaluations of the service.
- The study focused on those who had agreed to receive the service.
  Recommendation Eight: To examine the ways in which the service can be opened up to more service users by ensuring that referrals to the RESET service from the Inreach team are received at least two weeks before release.
- A proposed development was the possibility of using ex-prisoners with mental health needs as formal peer support workers.
  Recommendation Nine: To undertake a review of the potential for formal peer support workers to be employed by the RESET service.

9. Additional resources

The project team developed two information guides during the study to help practitioners working with prisoners with mental health problems in prisons and upon their release into the community. They are attached. These two guides are:

Mental Health Awareness Training booklet

This booklet contains guidance for all staff working in the prison environment. It describes the mental health problems that may affect individuals in prison as well as detailing the signs and symptoms that underpin a range of different mental health difficulties.

Mental Health Awareness Training.

Resettlement Guide for Health Care Staff

This guide is an introduction for healthcare professionals working in the prison environment to the challenges service users face when leaving custody, and the support that can be provided by healthcare professionals to overcome some of these challenges.

Resettlement Guide Healthcare.pdf

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11. Appendices

Appendix I

An Evaluation of the Supporting Prisoners upon Release Service (RESET) Intervention

1st December 2015 – Version 5

We would like to invite you to take part in our study. This study is funded by Oxleas NHS Foundation Trust and sponsored by Canterbury Christ Church University. Centra and Nacro will provide the short-term supported release service. Before you decide to take part, we would like you to understand why the study is being done and what participation involves. A member from the study team will go through the information sheet with you and answer any questions you have.

Purpose of the Study

Prisoners with mental health needs have access to support from services in the prison. However, after leaving prison, prisoners often lack support in the community. Research examining prisoners released from prison report that almost half those released will be reconvicted within the first year of release. This can lead to further re-offending, a decline in their mental health causing admission to hospital, and an increased suicide risk. It has been shown that prisoners who have access to housing on release have better outcomes in the community.

Why have I been asked to take part?

Recently, you met with a member of Centra or Nacro to assess your suitability for their supported release service. During this meeting, Centra or Nacro informed you about this study, and you agreed for the study team to contact you. We are inviting all prisoners who have been accepted onto the Centra /Nacro supported release service in order to gain an understanding of how best to support prisoners in the community. We are asking you because we want to hear your views about your release, and the support you receive.

Do I have to take part?

No. It is up to you to join the study. If you prefer not to take part then you do not have to give a reason, you will not be under any pressure to change your mind, and this decision will not affect the service Centra or Nacro provided as part of their supported release service, or the normal help and services you receive when leaving prison.

If you decide to take part, the study team will describe the study and go through this information sheet, and you will be asked to sign a consent form. You are free to leave the study at any time without giving a reason, but any information you have already given will remain part of the study.

What does taking part involve?

If you agree to take part, you will be in either the 'Supported Intervention', or the 'Standard Discharge Planning' group. We will be recruiting everyone who is accepted onto the Centra /Nacro supported release service. However, we are aware that some prisoners may be unable to receive this service for a variety of reason, such as transferred to another prison or released without notice. These individuals will not be able to receive the supported release service, but will still be followed up by the study team.

Standard Discharge Planning

If you are in the 'Standard Discharge Planning' group, you will be involved in the regular discharge planning within the prison. Nothing different will happen to you and you will received all the services that you would normally receive leading up to and following your release from prison. We will be in contact with your "Link Worker" (i.e. Probation Officer, or Community Psychiatric Nurse) to follow you up in the community, however the study team will not be involved with ensuring you have a "Link Worker".

Supported Intervention

If you are in the 'Supported Intervention' group, you will receive all the regular discharge planning that you would normally receive, but you will also work with Centra or Nacro. Whilst in prison, Centra or Nacro will work with you to look at what your needs might be on release from prison, and develop a supportive care plan for you. This will include supporting you in your release from prison including help with housing, finances, relationships, and health and wellbeing. Local community services to help you when you are released will also be explored. Centra or Nacro will allocate you to one of their Support Coordinators. The Support Coordinator will collect you at the gates on the day of your release and take you to your temporary housing. They will continue to meet with you on a regular basis a duration of three months. Their contact with you will primarily be face-to-face contact although telephone support is available. After completing the 'Supported Intervention', there will be the facility for offering "floating support" to other services.

We will also ask you for permission for Centra and Nacro to access your criminal justice and health records in order to help with the study and to keep up with how you are doing upon release.

Will I have to do anything else?

If you are allocated to the 'Supported Intervention', a member of the study team will stay in touch and meet with you after you have been released from prison to ask you some questions to see how you are getting on.

The first meeting will take place two weeks after leaving prison. This meeting will explore your experiences of being in the supported intervention, your thoughts and opinions about how the service could be made better, and what went well or could be change. Your social networks will also be explored, in order to gain an idea of the support around you.

The second meeting will occur after completion of the supported release service. This meeting will mirror the previous meeting explore your experiences of completing the supported intervention. Your current social network will be explored to see if the support around you has changed.

Both these meeting will be further discussed nearer the time, and all meetings will be jointly arranged.

If you are allocated to the 'Standard Discharge Planning' group, you will be followed up by the study team, but not required to be interviewed.

What are the possible benefits of taking part?

We can't promise that the study will help you directly, but we hope that for those in the 'Supported Intervention' group, taking part in the study may help you to manage your transition from prison into the community more effectively, and improve the contact you have with services after release from prison. The findings from this study may also help to improve services for future prisoners when they are released from prison.

What are the possible risks or disadvantages to taking part?

You will be asked to give up some of your time to take part. We do not see any serious risks in taking part in the study. Occasionally some people may experience some emotional distress when they are asked to think about

their experiences. If you are upset, you will be able to talk to the Project Researcher about it. If you feel you require further support, they will be able to tell you about other possible sources of help or advice.

What happens when the study stops?

The 'Supported Intervention' is due to last for three months then standard services with resume. The study will continue for six months following completion of the intervention, but this will not affect the care you receive.

What if there is a problem?

If you are in prison or under probation supervision then you should direct any requests for information complaints, concerns, and queries through the prison establishment or the probation services.

If you are not in prison or under probation supervision and have a problem or concern about the way you have been approached or treated during this study, then you should ask to speak to the Chief Investigator of the project (Miss Jacqueline Mansfield) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the representative of the organization overseeing the study, Canterbury Christ Church University. Details can be obtained from Professor Douglas MacInnes, Faculty of Health and Wellbeing, North Holmes Road, Canterbury, Kent, CT1 1QU.

In the event that something does go wrong and you are harmed during the study and this is due to someone's negligence, then you may have grounds for a legal action for compensation against the sponsor of the study, Canterbury Christ Church University, but you may have to pay your legal costs. The normal National Health Service complaint mechanisms will still be available to you (if appropriate).

Will my taking part in the study be kept confidential?

Yes. Any information collected about you will be kept strictly confidential and will not be disclosed outside the study team without your permission. You will be given a unique personal code and only members of the study team will be aware of your identity. Any personal information that we collect about you, and any consent forms will be stored securely and will only be used for the purpose of the study. Transcription of audio recordings of any meetings between yourself and the study team will only be done by members of the study team or other individuals who have signed confidentiality agreements. Any quotations from study participants used in the final written report will be anonymised and no real names will be used, but absolute confidentiality cannot be guaranteed.

Some parts of the data collected for the study may be looked at by authorised representatives of regulatory authorities to check that the study is being correctly carried out, but this information will remain anonymous. Should this occur, all such individuals have a duty of confidentiality to you as a study participant. The data will be securely disposed of after 5 years.

Are there any circumstances in which confidentiality would be broken?

Yes. You should be aware that the study team has a duty to inform an appropriate person should you disclose any risk of harm to yourself or others. If there is concern about your safety or the safety of others around you, the study team will inform you that they will be breaking confidentiality. The most appropriate individual will be informed (i.e. Mental Health team, probation, GP). This information will be fed back to Centra /Nacro. If you are found to be unfit to participate, the intervention will be stopped and delayed until a time where you have been assessed as fit to participate.

What will happen to the results of the study?

The results of the study may be published in a report or criminal justice or medical journal. The Chief Investigator/Project Researcher (Jacqueline Mansfield) will be using portions of the project to be written up into a PhD dissertation. If you would like a copy of any publication, or a summary of the results, please let the Project Researcher know. You will not be identified in any report or publication arising from the study.

Who has reviewed this study?

The study has been reviewed by an independent group of people called Research Ethics Committee (REC) to protect your safety, rights, wellbeing, and dignity. This study was reviewed and given a favourable opinion by the East of England – Essex Research Ethics Committee (Reference: 15/EE/0414). The study has also been reviewed and approved by the Research & Development Offices of your local NHS Trust and the National Offender Management Service (NOMS).

Additional Information

Please keep a copy of this information sheet for future reference. In addition, you and a member of the study team will be asked to sign a consent form, which you should also keep.

Thank you for your interest in participating in the study. If you require any further information about the project, please do not hesitate to contact any of the people named below.

Jacqueline Mansfield – Chief Investigator/Project Researcher/PhD Student, Canterbury Christ Church University:

Tel XXXXXXXXX

Prof Douglas MacInnes – Director of PhD Studies/Academic Supervisor, Canterbury Christ Church University:

Tel XXXXXXXXX

Dr Janet Parrott – Consultant Forensic Psychiatrist/Clinical Supervisor, Oxleas NHS Foundation Trust:

Tel XXXXXXXX

Appendix II

Demographic Information
RESET Study

Prison ID: _____ PID: _____ Date: _____

Age	_____Years old	
Gender	Male o	Female o
Ethnicity	**White** British o Irish o Any other White background o _____ **Asian or British Asian** Indian o Pakistani o Bangladeshi o Any other Asian background o _____ **Chinese and Other Ethnic Group** Chinese o Any other ethnic group o _____	**Black or Black British** Caribbean o African o Any other Black background o _____ **Mixed** White & Black – Caribbean o White & Black – African o White & Asian o Any other Mixed background o _____
Marital Status	Single o Divorced o Widowed o	Married/Civil partner o Separated o Not disclosed o
Primary Mental Health Diagnosis (and secondary if applicable)	Schizophrenia, Schizotypal, and Delusional Disorder o Organic Mental Disorder o Mood (affective) Disorder o Level of anxiety (GAD-7): _____	Neurotic, Stress-Related and Somatoform Disorder o Behavioural Syndromes o Personality Disorder o Level of depression (PHQ-9): _____
Contact with Mental Health Services	Any previous history of contact with Mental Health services? Yes o No o Currently under care of Mental Health InReach team?	

	Yes o	No o
Substance abuse history	Yes o	No o
History of self-harm	Previous history of self-harm? Yes o Self-harmed in the past three months? Yes o	No o No o
On ACCT upon release	Yes o	No o
Index Offence	Class A o Class B o Class C o Class D o Class E o	Class F o Class G o Class H o Class I o Class J o
Length of current sentence	_____Days/Months/Years	
History of prison sentences	Yes o First sentence: _____ Second sentence: _____ Third sentence: _____	No o Fourth sentence: _____ Fifth sentence: _____ Sixth sentence: _____
Accommodation Prior to Prison	Independent tenancy o Hostel o Living with family/friends o	Temporary Bed and Breakfast o Homeless o
Previous Employment	Employed (37+ hrs/week) o Self-employed o Unemployed (looking for work) o Student o Disabled/Unable to work o	Employed (>37hrs/week) o Military o Unemployed (NOT looking for work) o Retired o
Level of severity of need (stepped care level)	Step One o Step Two o Step Three o	Step Four o Step Five o Not required o

	What was the problem: _____ _____ _ What was provided: _____ _____ _
Referrer to Supported Release from Prison Service	Name: _____ Job Title: _____ Reason for referral: _____ _____ _
Reason for not receiving service *(for those in the control group only)*	Reason: _____ _____ _ _____ _ _____ _

Appendix III

Data Collection Tool RESET Study

Time-Point: _____

Prison ID: _____ PID: _____

Date:_____

1. Level of Re-offending	Yes o No o If yes, Type of offence: Class A o Class F o Class B o Class G o Class C o Class H o Class D o Class I o Class E o Class J o Date of Offence: _____ Convicted?: Yes o No o
2. Hospital Admission	Yes o No o If yes, Type of hospital: Acute o Secure o Number of Admission(s): _____ Date of Admission(s): _____ _____ _____ Total admission duration: _____days
3. Maintained Housing	Yes o No o If yes, Type of housing: Living with family/friends o Hostel o Independent tenancy o Bed and Breakfast o Homeless o Number of different accommodation(s): _____ Date(s) of housing: _____

	_____ _____
4. Maintained Benefits	Yes o No o If yes, Type of benefits: Housing Benefit o Job Seekers Allowance o Personal Independence Payment (PIP) o Employment & Support Allowance o Income Support o Local Council Tax Support o Child Benefits o Working Tax Credit o Date of obtained benefits: _____
5. Contact with Support Worker	Yes o No o If yes, Type of contact: In person o Telephone call o Text message/SMS o Group meeting o Frequency of contact: Daily o Several times/week o Weekly o Monthly o Date(s) of contact: _____ _____ _____
6. Contact with Services	Yes o No o If yes, Type of service(s) IAPT o Early Intervention for Psychosis o Community team o Homeless Service o Forensic Mental Health o Frequency of contact: Daily o Several times/week o Weekly o Monthly o Date(s) of contact: _____ _____ _____
7. Contact with GPs	Yes o No o If yes, Frequency of contact:

	Daily o Several times/week o Weekly o Monthly o Date(s) of contact: _____ _____ _____
8. Service Engagement Scale (SES)	(see Appendix IV) Availability score: _____ Collaboration score: _____ Total score: Help Seeking score: _____ _____ Treatment Adherence score: _____
9. Employment/ Education Opportunities	Yes o No o If yes, Work o Education o Contract of work/education: Full-time o Part-time o Volunteer o Self-employed o Causal o Type of education: University o Open University o Apprentice o Technical College o A-Level o Distance Learning o GSCEs o Frequency of contact: Daily o Several times/week o Weekly o Monthly o Start date: _____

Appendix IV

Service Engagement Scale Questions

Availability

1. The client seems to make it difficult to arrange appointments
2. When a visit is arranged, the client is available[a]
3. The client seems to avoid making appointments

Collaboration

4. If you offer advice, does the client usually resist it?
5. The client takes an active part in the setting of goals or treatment plans[a]
6. The client actively participates in managing his/her illness[a]

Help seeking

7. The client seeks help when assistance is needed[a]
8. The client finds it difficult to ask for help
9. The client seeks help to prevent a crisis[a]
10. The client does not actively seek help

Treatment adherence

11. The client agrees to take prescribed medication[a]
12. The client is clear about what medications he/she is taking and why[a]
13. The client refuses to co-operate with treatment
14. The client has difficulty in adhering to the prescribed medication

Note: Items are rated 0 (not at all or rarely), 1 (sometimes), 2 (often), 3 (most of the time).

[a]Reverse scored.

Tait, L., Birchwood, M. & Trower, P. (2002). A new scale (SES) to measure engagement with community mental health services. Journal of Mental Health, 11(2), 191–198.