

From Custody to Community:

Transitioning people with mental ill-health from the criminal justice system to the community.



Authors: Jennifer Smith-Merry, Nicola Hancock, Kirsty McKenzie.



THE UNIVERSITY OF
SYDNEY

**Centre for
Disability Research
and Policy**

ACKNOWLEDGEMENTS:

This research was funded by a grant provided by Inner West Sydney Partners in Recovery. We would like to acknowledge the core C2C implementation team led by Paul Clenaghan and also including Cecy Bradley, John Downie and Trevor Perry. We also acknowledge our interview participants and the work of all the other people who helped to facilitate the research project.

SUGGESTED CITATION:

Smith-Merry, J., Hancock, N., McKenzie, K. (2017) *From Custody to Community: Transitioning people with mental ill-health from the criminal justice system to the community*. Centre for Disability Research and Policy, Faculty of Health Sciences, University of Sydney.

FOR FURTHER INFORMATION ABOUT THE RESEARCH:

Please contact Associate Professor Jennifer Smith-Merry: jennifer.smith-merry@sydney.edu.au

Image by © Jen Smith-Merry

Executive summary

Care for people experiencing mental ill-health transitioning from the criminal justice system is uncoordinated and lacks over-arching policy direction. This results in care that, despite the best efforts of a range of actors is not individualised and recovery-oriented and does not deliver treatment that keeps people safe and well.

The Corrections to Community (C2) project was a community-derived project which aimed to address the frequent issues encountered by staff attempting to work with people with mental ill-health exiting correctional facilities and transitioning into the community within the Sydney Local Health District. The C2C intervention identified best-practice in transition support and attempted to implement this practice for people with mental ill-health transitioning from the criminal justice system into the Sydney Local Health District (LHD). For C2C participants the following were prioritised: in-reach where contact is made by community mental health prior to release, stable accommodation, that the individual has a GP, the individual is seen by community mental health within seven days of release and if an individual moves out of catchment referral is made to services in new region. Inclusion in Partners in Recovery (PIR) was also prioritised for all participants. Fourteen individuals were included in the C2C intervention.

The research component of the C2C study was carried out by the Centre for Disability Research and Policy within the Faculty of Health Sciences at the University of Sydney. The research involved three phases:

1. a systematic review of literature on recovery oriented transition services for people exiting criminal justice settings
2. an analysis of aggregated data collected on C2C participants at release, seven days post release and 28 days post release.
3. qualitative interviews with key stakeholders to understand the existing barriers and facilitators of effective transition from custody to the community.

C2C participants: aggregated data.

The data on the C2C participants showed that individuals released into Sydney LHD came from a very broad range of correctional facilities. Notification of future release to Sydney LHD took place an average of 27 days before release. Despite prioritisation of in-reach and a long lead-time before release in-reach only occurred for three of the 14 participants. Individuals at release had very variable relationships with family and friends and most were released into unstable accommodation. Only four remained in the same accommodation from release to the 28 day follow up.

At the end of the C2C data collection period at 28 days half of the clients where engagement had been attempted were still engaged with the program. For those who had disengaged this was due to two main factors: 1) drug problems (which led to disengagement or reincarceration) and 2) accommodation changes which saw them move out of catchment. For most of the clients accommodation was very unstable. Of those clients who remained engaged after seven days all were well engaged with mental health services.

Results from interviews with key stakeholders.

The qualitative interviews with key stakeholders in Justice Health, Sydney Local Health District Community Mental Health and Inner West Partners in Recovery revealed a range of pressing service and consumer-related factors which hampered effective transition.

Service related factors included poor communication, a lack of understanding between organisations, poor information sharing systems and unstable connections based on individuals rather than system roles. Interview participants also emphasised the importance of in-reach and through-care (where the community mental health team or other service continues to meet with someone while they are incarcerated) but a

lack of support for accomplishing this. Staff also reported that consumers are released through the courts without any individuals involved in their care being informed, including Justice Health nurses, PIR and the community mental health team. This increases the likelihood of the consumer being lost to care.

Consumer-related factors related to unstable accommodation and consumer preoccupation with the immediate needs of housing and subsistence upon release which forces a deprioritisation of engagement with mental health supports. Consumers also had additional problems such as substance misuse and intellectual disability that impacts on their engagement with services. Engaging consumers once in the community is often very hard and requires long-term persistence and management of risky behaviours.

Participants did not point to any existing effective system-wide or local programs which were currently addressing the system or consumer-related factors that were raised.

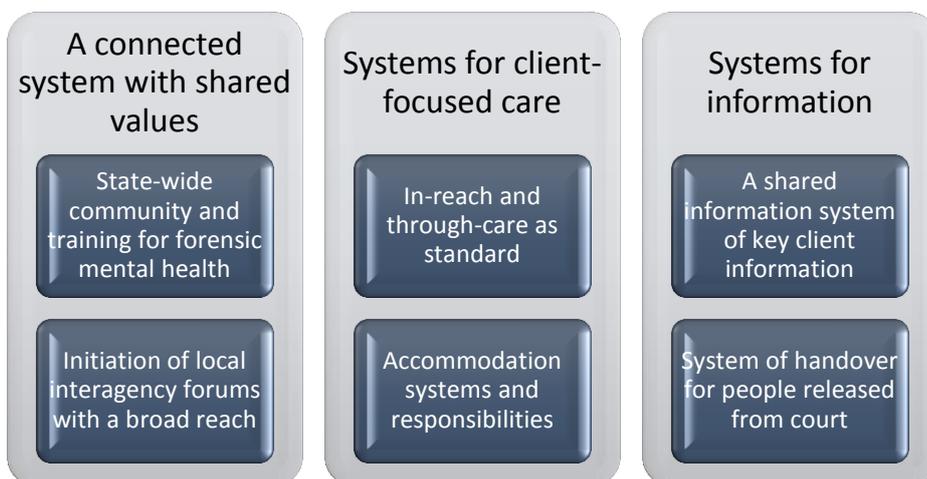
Recommendations for reform.

While the data identifies many points of action we make six key recommendations about reform which will serve to develop a better integrated system resulting in more effective outcomes for those people with mental ill-health transitioning from correctional facilities.

Recommendations:

- 1. Development of a shared information system.**
- 2. Creation of a state-wide forensic care community.**
- 3. Active development of local communities of practice.**
- 4. Development of an accommodation strategy for former inmates with mental ill-health.**
- 5. In-reach and through-care as standard practice.**
- 6. Court hand-over when an individual is released directly from a court hearing.**

These recommendations are explained in further detail in the full version of the report.



These recommendations will lead to the development of a more connected system united around shared values and individualised consumer care facilitated through shared information systems.

Essential to reform is a strong policy prioritisation. This is because these recommendations can only be implemented through a multi-agency approach. We call for action on these issues by high level actors including the New South Wales Mental Health Commission, the NSW Government, Justice Health and Corrections NSW.

Table of Contents

From Custody to Community:	1
Transitioning people with mental ill-health from the criminal justice system to the community.	1
Executive summary.....	3
C2C participants: aggregated data.	3
Results from interviews with key stakeholders.....	3
Recommendations for reform.....	4
Background.....	7
The C2C intervention.....	7
The project team	7
Partners in Recovery.....	7
The Community Mental Health Team	8
Justice Health.....	8
Academic literature	9
Background to the topic:	9
Incarceration may both help or hinder mental health.....	9
Recovery and transition support	9
Transition support	10
Review of existing programs	11
Method and results.	11
Results of the literature review:.....	11
Conclusions based on literature:.....	15
Project Methodology.....	16
Qualitative data	16
Quantitative data.....	16
Quantitative data results.....	17
Prior to release:	17
At release.....	17
Process at release	17
At seven days post-release	18
At 28 days post-release	18
Summary.....	18
Qualitative data findings.	19
Main findings from C2C stakeholder interviews	19
Stakeholder interviews – in depth data analysis.....	20

Interagency communication and understanding	20
Inter-agency understanding:	20
Working relationships and communication:	21
Consistent processes needed for information sharing:	22
Shared values are important:	23
In-reach and continuity of care	23
Positive impact of in-reach:	23
Hard to get in the door:	24
Continuity of care is currently limited but important:	25
Information and referral pathways	27
Communication gaps:	27
Confusion about release:	28
Systemic barriers to communication:	28
Engaging consumers in the community	29
Accessing consumers in the community is difficult:	29
Building relationships with consumers:	29
Substance use and cognitive impairments:	30
Relationships and friendships post release:	31
Consumer attitude to recovery and services:	31
Concerns of everyday life preventing engagement around mental health:	32
Accommodation stability is key:	32
Responsibility for housing is not well understood:	33
Consumer decision-making and catchments:	34
Concluding thoughts and recommendations	35
Recommendations	35
Responsibility for action:	36
Appendix 1: Data collection sheet C2C client data	38
Appendix 2: Interview questions qualitative interviews	40
References	41

Background

The C2C intervention.

The Corrections to Community (C2C) intervention identified best-practice in transition support and attempted to implement this practice for people with mental ill-health transitioning from the criminal justice system into the Sydney Local Health District (LHD).

For C2C participants the following were prioritised: in-reach where contact is made by community mental health prior to release, stable accommodation, that the individual has a GP, the individual is seen by community mental health within seven days of release and if an individual moves out of catchment referral is made to services in new region. Inclusion in Partners in Recovery (PIR) was also prioritised for all participants. Fourteen individuals were included in the C2C intervention.

The research component of the C2C study was carried out by researchers from the Centre for Disability Research and Policy within the Faculty of Health Sciences at the University of Sydney.

The research involved three phases:

1. a systematic review of literature on recovery oriented transition services for people exiting criminal justice settings
2. an analysis of aggregated data collected on C2C participants at release, seven days post release and 28 days post release.
3. qualitative interviews with key stakeholders to understand the existing barriers and facilitators of effective transition from custody to the community.

The project team

This project was funded through Inner Western Sydney Partners in Recovery flexible funding. The core C2C implementation advisory team throughout the life of the project included the following members:

- Paul Clenaghan (Sydney LHD Community Mental Health). C2C project lead.
- Cecy Bradley (Partners in Recovery Team leader, Mission Australia)
- John Downie (New Horizons, Partners in Recovery)
- Trevor Perry (Justice Health)
- Associate Professor Jen Smith-Merry (University of Sydney) Research lead
- Dr Nicola Hancock (University of Sydney) Research lead
- Dr Kirsty McKenzie (University of Sydney) Research assistant
- Other members of the project group who were not involved over the course of the project included Lance Takiari, Joanne Andreolas, Damien Eggleton and Ashnan Ponniah. Dr Damian Mellifont was employed as a consumer researcher and helped to develop the literature review.

The research team's role evolved over the course of the project in relation to the changing scope of the C2C project.

Partners in Recovery

Partners in Recovery (PIR) is an Australian Federal Government initiative which targets the unmet needs of people with severe and complex mental ill-health. Individuals who access PIR are provided with a Support Facilitator who assesses their needs and links them with services which meets these needs. Services are

purchased when necessary. Research on the implementation of PIR in Inner Western Sydney has been found to successfully meet the needs of the PIR target group (Hancock et al 2017, forthcoming).

The role of the Inner Western Sydney PIR team in this project was to make contact with services in order encourage referral of consumers into the C2C program, to offer PIR support to consumers and meet with those who had accepted this support. They also coordinated data collection of statistical data on C2C participants.

The Community Mental Health Team

Community Mental Health teams provide community-based mental health services for people within the Sydney Local Health District (LHD).

A member of the community mental health team coordinated the C2C program. They provided administrative support to the program and made contact with consumers who had accepted involvement in C2C to offer support.

Justice Health

The Justice Health and Forensic Mental Health Network (Justice Health) is a state-wide organisation which with a statutory responsibility to provide mental health related support to people within the criminal justice system. It provides health support to adults involved in the criminal justice system including the forensic system, those detained by police and people on remand.

Their role in C2C was to provide advice on the implementation of the C2C program to encourage referrals into the program.

Academic literature

Background to the topic:

Incarceration, forensic care and the subsequent period of community transition is a time of opportunity for supporting a group of people who may otherwise receive little help for their mental health. Many individuals who are incarcerated experience mental ill-health (White & Chant, 2006; Wolff, 2005), with a large proportion of correctional facility inmates experiencing severe psychiatric disorders (Held, Brown, Frost, Hickey & Buck, 2012). A review of existing research investigating the mental health of individuals on probation found that levels of mental ill-health were also high (Sirdifield, 2012). The incarcerated population also have levels of complexity much higher than the general public with inmates experiencing high levels of multi-morbidity alongside mental ill-health, including intellectual and physical disability and substance misuse (Fazel and Seewald, 2012; Baldry, 2011; Prins, 2014). Complexity, by its very nature necessitates a personalised approach to mental health care and treatment.

The complex needs of this population exist against a background of increasing incarceration rates for some racial minorities and a concomitant increase in the mental health needs of inmates (White and Whiteford, 2006). In Australia for example the incarceration rate is 208 inmates per 100,000 in 2016 (Australian Bureau of Statistics [ABS], 2016a). However the Aboriginal and Torres Strait Islander (ATSI) incarcerations rate is 2,346 per 100,000 (ABS, 2016b). Indigenous inmates also have higher rates of mental ill-health and multi-morbidity compared to non-indigenous inmates (Baldry, 2011). A significant increase in the UK inmate population has been accompanied by an increase in inmate self-harm particularly amongst those serving open-ended sentences, which have sometimes been viewed as de facto mental health orders for people with complex mental health needs (Bartlett and McGauley, 2010; Prison Reform Trust, 2016).

Incarceration may both help or hinder mental health

Inmates are confronted with significant stressors to their mental health within correctional facilities and mental ill-health can therefore worsen during stays in correctional facilities (Glowa-Kollisch et al., 2014; Cuellar and Cheema (2012). Conversely correctional facilities have significant capacity to improve the health of inmates (Lincoln et al. 2006). As inmates tend to come from disadvantaged social backgrounds (Lee, Connolly & Dietz, 2005), for many of these people being incarcerated can be their first opportunity to have their mental health assessed (Olley, Nicholls & Brink, 2009). Mental health care during incarceration therefore has the potential to improve the mental health of individuals experiencing mental ill-health (Baillargeon, Hoge & Penn, 2010; Lennox et al., 2012; Mallik-Kane & Visher, 2008). However programs supporting an individual's ongoing mental health as they re-enter the community are often lacking, meaning that care received in a correctional facility is not often carried on into the community (White and Whiteford, 2006). Reestablishment in the community can also cause stressors of its own as individuals may be displaced from their community or confronted with those factors which led to their initial incarceration. Programs and policies have been put in place to try and address these issues but examples of good practice remain isolated and are often unevaluated so there remains little evidence of what works (e.g. NAAJA, 2012; State of Victoria, 2016). It is within this context that the C2C project was developed.

Recovery and transition support

Recovery is the concept that individuals are able to lead a meaningful life with or without the symptoms of mental ill-health. Key to this is a focus on individualisation and person-centred care with an understanding that recovery is only possible when strategies put in place are able to meet an individual's own needs (Anthony, Rogers and Farkas, 2003).

While recovery and person-centred care have not been highly visible as part of the academic literature on inmate mental health there is a growing recognition of the need for recovery-oriented practice to inform work in this area (Olson & Schon, 2016). These are just one facet of effective mental health care but present a firm starting point upon which to build mental health support as they promote care which starts from the individual's specific needs, rather than the imperatives of the system.

Transition support

Mental health care is important during periods of transition back into the community as transition is a time of vulnerability for people experiencing mental ill-health and uptake of support is low (Glowa-Kollisch et al., 2014). In the US for example, only 50% of people experiencing 'serious' (i.e. severe and enduring) mental ill-health receive treatment after leaving a correctional facility, and medication adherence declines upon release (Mallik-Kane & Visher, 2008). While all individuals who have recently been released from a correctional facility are at increased risk of homelessness and unnatural death including from suicide and drug overdose (Baldry, McDonnell, Maplestone & Peeters, 2006; Jones & Maynard, 2013; Kariminia et al, 2007), having serious mental ill-health compounds these problems (Baillargeon et al., 2010). In addition, mental health conditions may worsen immediately following release, with the burden of additional stresses related to finding accommodation, welfare and other services increasing the likelihood of decompensation and other risks such as suicide (Mallik-Kane & Visher, 2008). Compared to those without a serious mental ill-health, recently released inmates in the US with a serious mental ill-health are more likely to live in inappropriate accommodation upon release, with increased rates of homelessness or other unstable accommodation such as share housing with other former inmates and current drug users (Mallik-Kane & Visher, 2008). Australian figures showed that suicide risk amongst people exiting correctional facilities was highest in the first two weeks following release (507 per 100,000 person years) than at 6 months release (118 per 100,000 person years) (Kariminia et al 2007). For those housed within the correctional facility psychiatric wing the rate was 1234 per 100,000 person years (Kariminia et al 2007). These findings are supported by studies carried out in the UK and the United States (US) (Kariminia et al 2007; Pratt et al 2006; Binswanger et al 2007). According to Lennox et al. (2012) 'robust' re-entry planning and access to community based services can help to address suicide among individuals who have been recently released.

Systemic and social problems arise from an absence of services specifically targeting periods of transition into the community (Olley, Nicholls & Brink, 2009). Drawing upon the 2002 US *Survey of Inmates in Local Jails* survey results, Olley et al. (2009) note that those inmates experiencing mental ill-health are more likely than other inmates to face charges of breaching institution rules and to be involved in verbal and physical confrontations. Lack of contact with mental health treatment teams is associated with an increased risk of violence in recently released inmates with a psychotic disorder, compared to those receiving treatment (Keers, Ullrich, DeStavola & Coid, 2014). Efforts to address the mental health needs of recently released inmates can also assist in breaking an unproductive cycle of reoffending and re-incarceration (Held et al., 2012; Norton, Yoon, Domino & Morrissey, 2006). Accordingly Lincoln, et al (2006) call for programs that are capable of 'spanning the fence' so as to encourage an ongoing availability of mental health services.

Gaps in care experienced by people upon their release from correctional facilities may occur for practice-based reasons including lack of services or long waiting times to access services (Binswanger et al., 2011), but also because of stigma, with staff in correctional facilities having a "perception that offenders with mental illness are not responsive to services" (Dennis, Ware & Steadman, 2014, p.1081). Baillargeon et al (2010) also warn that the stigma associated with having been incarcerated can stand in the way of former inmates accessing community based mental health support programs. People with mental ill-health exiting correctional facilities may face stigma on two fronts: having a diagnosis of mental ill-health and incarceration. There is also evidence that needs related to mental health are not the main priority for

individuals leaving incarceration, who may be more concerned with subsistence issues such as finding suitable accommodation and accessing benefits. For example, survey research conducted in the US with 115 individuals with serious mental ill-health both before and immediately after leaving a correctional facility revealed that finding housing was the single most important need they identified. Almost three-quarters (70%) of individuals mentioned this need, and 63% indicated it was one of their two most important needs (Wilson, 2013). Wilson (2013) also found that only 24% of the participants mentioned assistance with making contact with mental health services, and only 8% listed this as one of the two most important needs.

This literature outlines significant levels of mortality and morbidity associated with poor transition and low provision or uptake of appropriate services. This points to a clear need for better targeted services which can improve access and uptake of mental health-related transition support.

Review of existing programs

We conducted a systematic review of existing recovery-oriented programs relevant to the C2C context. This was produced as a draft journal manuscript which has been submitted to the *Journal of Mental Health*. The review process and findings are summarised here.

The aim of the review was to identify papers which evaluated models of transition from forensic mental health facilities or correctional facilities where an inmate had been receiving mental health related care which were recovery oriented.

Method and results.

We carried out a systematic narrative review of recovery oriented or person-centred mental health support programs supporting transition from incarceration or forensic care to the community. Results were obtained from a systematic search of Medline, Pubmed and Scopus databases.

We found 23 papers which met the paper inclusion criteria along with four other papers which were identified incidentally. We found no papers which focused specifically on care within forensic mental health facilities. All other papers related to mental health care which had been available within standard correctional facilities.

Results of the literature review:

Various programs and models have been established to provide mental health support during transition including the recently released Californian Department of Corrections *Division of Adult Parole Operations Mental Health Services Continuum Program Transitional Case Management Program*. The Massachusetts Department of Mental Health developed a transition team to assist individuals with serious mental ill-health leaving incarceration (Hartwell, Fisher & Deng, 2009). This re-entry planning program commences three months prior to an inmate's release in order to comprehensively assess mental health service needs. Individuals are subsequently supported in the three months after release to assist with living arrangements, medication adherence, and psychiatric and other appointments, and in making referrals to other services as required. In 2002 the transition teams were regionalised in an endeavour to improve coordination of services. Regionalising services meant that "...more attention can be given to service connections and the population being served at the local level, and there is a greater level of regional familiarity, local access, and clear lines of professional accountability and authority for service providers within each area" (Hartwell et al., 2009). In an evaluation of the impact of regionalisation on outcomes, Hartwell et al. (2009) found that a significantly higher percentage of individuals in the post-regionalisation sample were actively engaged with services at the three month follow up than in the pre-regionalisation sample. This was true for individuals who had been released from correctional facilities who were serving longer sentences, as

well as for individuals who had served shorter sentences for misdemeanours. However, they also found that in the group who had been released after a shorter sentence, the number of individuals lost to follow up increased significantly after regionalisation. The authors note barriers to providing transition support for individuals leaving incarceration after shorter sentences, including abrupt releases resulting in truncated pre-release planning, and they conclude that transition programs may have differential outcomes depending on correctional setting (Hartwell et al., 2009).

Some re-entry programs have been developed to serve the needs of specific sub-groups of inmates with mental ill-health. The Connecticut Offender Re-entry Program (CORP) responds to the recognition that those incarcerated for serious and violent crimes with mental health problems and comorbid substance abuse required a specialised program to improve service continuity during transition to the community (Kesten et al., 2012). The program includes a life-skills curriculum that is delivered by a CORP therapist in a group format within the correctional facility and re-entry planning aimed at linking the individual to services in the community. The CORP model emphasises housing and inmates at risk of homelessness were proactively placed on waiting lists while incarcerated, in an effort to access appropriate residential services such as mental-health related group homes. Traditional re-entry services involve identifying needs and creating linkages while the individual is still in custody, but that contact often ends after release which impacts on successful engagement with services (Kesten et al., 2012). By contrast, CORP therapists remain in contact with the individual after release until linkages have been successfully established. The authors do not report whether the CORP program increased contact with community-based mental health services, however they did find that recidivism rates were decreased in this population, compared to practice as usual.

Assertive Community Treatment (ACT) programs have also been adapted to ensure ongoing care for individuals leaving incarceration (California Board of Corrections, 2005). ACT involves the provision of services by a multi-disciplinary team rather than by individual providers, with low staff-client ratios. Services are often available 24 hours a day and usually for extended periods of time. McKenna et al. (2015) evaluated a program that employed ACT principals as part of the Prison Model of Care (PMOC) implemented in New Zealand. The program involved five components: “screening, referral, assessment, treatment and release planning” which were carried out by mental health nurses in collaboration with correctional facility officers (McKenna et al., 2015). The program established explicit processes governing the release process, combined with a clearer definition of roles and collaboration between mental health staff and correctional staff. Clinicians engaged CMHTs and other social services such as housing and employment in the three months prior to release. After the implementation of the program, there was a marked increase in contacts with the CMHT after release (McKenna et al., 2015).

Critical Time Interventions (CTIs) for transition support are focussed, time-limited interventions that aim “to set in place a strategy for connecting individuals to housing, employment, and education and creating positive social ties to reinforce these connections” (Draine & Herman, 2007, p.1578). The premise of CTIs is not to provide ongoing support but to re-establish existing supports where available, and build new connections. Draine and Herman (2007, p. 1578) describe a CTI where the case manager assists the individual leaving incarceration to develop a support network that may include community behavioural or mental health services and family and friends, and that “fits the individual and the community into which the individual returns”. A UK-based CTI intervention put in place a program in which inmates worked with the CTI facilitator to identify their top three post-release needs, who then worked as a broker to ensure that these needs were met (Jarrett et al., 2012). Jarrett et al. (2012) conducted a randomised controlled trial of CTI versus treatment as usual and found that individuals in the CTI group had higher contact with a CMHT compared to the control group, and that contact with a GP and medication adherence was

significantly higher in the CTI group. This study also assessed the feasibility of two CTI models, one where the CTI case manager was located in the correctional system, and the other in which they were community based. The study found that the community based CTI model was unfeasible due to the need to meet regularly with clients while still in incarcerated (Jarrett et al., 2012).

Angell, et al (2014) compared the engagement strategies used in CTIs with those used in Forensic Assertive Community Treatment (FACT), which is a version of ACT modified for use with consumers leaving correctional facilities. ACT and FACT generally differ from CTI in that mental health (including in some cases residential treatment programs) and other services are provided in-house by the FACT team, and that it is not time-limited. According to Angell et al. (2014), in both models, facilitating client engagement with mental health services operated within a broader holistic framework in which trust was built through the provision of non-mental health related services such as accommodation. The authors suggest this is an important strategy as many individuals with mental ill-health leaving correctional facilities consider mental health care to be of secondary importance compared to finding housing and employment and/or accessing benefits. Angell et al. (2014) note that where community resources are scarce, the CTI model may be less effective, as it is dependent on facilitating connections with existing community services. This is less of a problem for the ACT approach, in which services occur in-house. However, the authors also note that ACT services are “increasingly considered unsustainable” due to the intensity and indefinite nature of service provision (Angell et al., 2014, p.499).

Individuals with mental ill-health leaving incarceration may prioritise immediate needs such as housing and accessing benefits rather than mental health care. Continuity of mental health care during transition to the community can therefore be facilitated by pre-release approval of social security and medical benefits (Dennis, Lassiter, Connelly, & Lupfer, 2014). The US-based SOAR program (Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Outreach, Access and Recovery program) involves collaboration between health and correctional systems to assist inmates in applying for these benefits. Staff trained in the SOAR program prepare SSI/SSDI applications, and evidence suggests that applications prepared by SOAR trained staff are approved in 71% of cases, compared to 29% of cases prepared by untrained individuals (Dennis, Lassiter, et al., 2014). Timely access to SSI and SSDI benefits enables utilisation of appropriate programs after release, including supported housing programs, for individuals with mental ill-health. The authors acknowledge program implementation challenges that are posed by new administrations along with staffing resource shortfalls, but argue that the SOAR program offers a solid footing upon which an inmate re-entry to community support process can build (Dennis, Lassiter et al., 2014).

Other projects have attempted to link individuals leaving incarceration with a medical home, which is a patient-centred model of primary care that offers team-based, comprehensive services including clinical care (Cuellar & Cheema, 2012; Buck et al., 2011; Held, Brown, Frost, Hickey and Buck, 2012). This model of care encourages personalised clinical and social support for former inmates while also promoting the understanding of court order requirements (Cuellar & Cheema, 2012). According to statistical analysis of data from the American 2004 Survey of Inmates, medical homes are dependent on a strong collaboration with mental health service providers (Cuellar & Cheema, 2012). Recognising that this collaboration is not a given, Cuellar and Cheema (2012) nevertheless support the strategic potential of this measure. Medical homes are also a feature of a US-based correctional facility in-reach project that is a component of the Healthcare of the Homeless – Houston (HHH) initiative. HHH provides a medical home for homeless people in the Houston region, including access to primary and behavioural (including mental) health care. It is based on the understanding that connections with primary care services are a key portal to mental health care (Buck et al., 2011). Program staff meet with individuals with mental ill-health at risk of homelessness

prior to leaving the correctional facility to establish a discharge plan including identifying primary and mental health services (Buck et al., 2011). Individuals are offered a choice of self-release, or supported release in which the individual is met at point of release from incarceration by a case worker, and escorted to the HHH clinic, where they are assessed and given opportunities for treatment. A preliminary evaluation of results based on a sample of 492 project participants suggest that over 50% of participants remain in contact with appropriate services once they leave incarceration (Buck et al., 2011). In addition, 86% of those who opted for supported release were successfully linked with services, compared to only 26% of those who opted for self-release. Buck et al. (2011) describe the project as best-practice in terms of supporting continuity of care and worthy of future services research, but dependent on availability of community resources after release. In addition, they described several constraints on staffing/resources including time taken to move clients from cells to interview rooms during in-reach, and uncertain release dates. Expanding upon the preliminary project evaluation of HHH, Held et al. (2012) analysed a sample of 207 program participants. This study reinforced the preliminary project evaluation of patient-centred medical homes as supporting efficient transitions from correctional facilities to community however project potential was constrained by a lack of ongoing community resources (Held et al., 2012).

Supporting the primary care-based orientation of several of the interventions already mentioned here interviews with workers facilitating transition have suggested that early contact with primary care providers may facilitate contact with mental health services (Johnson et al., 2014). This is supported by a study of 847 former inmates in Queensland, Australia (Young et al., 2015). Young, et al. (2015) posit that early post-release contact with primary care physicians (PCPs) such as General Practitioners can serve as a gateway for individuals transitioning into the community, and foster the development of attainable health plans along with assisting in health system navigation and literacy. They found that contact with a PCP in the first month after release was positively associated with seeking treatment for mental health issues and other health services. The authors suggested that connecting PCP services with inmates pre-release may therefore help to lower the public health costs attributed to former inmates (Young et al., 2015). Recognising a need for greater equity and access to PCP programs by Indigenous Australians who are exiting facilities and who are over-represented in Australian correctional facilities, Young et al. (2015) call for culturally sensitive measures to encourage participation for this particular group.

Several studies found that recovery-oriented planning is also supported by nurse-led health promotion interventions (Colbert, Sekula, Zoucha and Cohen, 2013; Lee et al., 2005; McKenna et al 2015). Colbert, et al's (2013) mixed methods study of the year long, post-incarceration experiences of 34 women found nurses to be uniquely situated to encourage health promotion activities during this transition period. Implementation of these activities in a way which target a woman's own recovery needs motivates women to maintain these behaviours following their release. Surveying 55 nurses who were employed across 14 Californian correctional facilities, Lee et al. (2005) found that 42% of respondents considered nurses to have the largest influence on inmates in relation to their medication compliance. This research also identifies administrative gaps that can have significant consequences for inmates transitioning to the community. For example medications were unavailable at discharge in 43% of the correctional facilities studied (Lee et al., 2005:37). In addition over one-third of the nurses (35%) surveyed perceived policy and procedural deficiencies to be blocking discharge summaries from being made available to community-based clinics (Lee et al., 2005:37). As with many of the other studies mentioned here administrative problems within correctional facilities which limit access and knowledge sharing stymied the good intention of transition this program.

Individuals with a lived experience of both mental ill-health and incarceration are also able to support clients transitioning out of correctional facilities. Ashcraft and Anthony (2011) describe a correctional

facility-based peer support training initiative targeting 100 inmates across 26 US correctional facilities. Program graduates reported experiencing notable intrinsic rewards as they assist fellow inmates in developing their recovery-oriented release plans. The Welcome Home Ministries (WHM) initiative offers 'in-reach' peer-guided release planning assistance for female inmates as well as post incarceration support (Goldstein, Warner-Robbins, McClean, Macatula, and Conklin, 2009). A small San Diego based study of the program involving 44 women participating in mentoring and case management reported a 77% drop in recidivism calculated over a timespan of one year after re-entry to the community (Goldstein et al., 2009:312). Goldstein et al. (2009) position this initiative as an exemplar of recovery-oriented transition to community support. While acknowledging the localised and small-scale nature of these studies they do show that peer-support, one of the key practices of recovery, is effective in a transition support context.

Conclusions based on literature:

Based on these findings we have identified several important considerations for any program aimed at availing individuals of mental health treatment after release from incarceration. Pre-release planning needs to be routine for all individuals with mental ill-health leaving incarceration. This requires the ability of correctional facilities to identify individuals who require mental health care after release. As many individuals may fail to make contact with community mental health services even when referrals occur, there is a need for some level of assertive follow-up by staff involved in pre-release planning. Buck et al. (2012) found that supported release was a particularly effective measure to increase likelihood of engagement. Mental health support planning needs to occur in concert with consideration of all the identified needs of the individual, and may require prior attention to housing, employment, accessing benefits and other issues. Ideally, this should occur while the individual is still incarcerated to minimise the risk of homelessness, which is a factor in poor post-release engagement with mental health services. In addition, attention to subsistence issues may increase trust in case workers, who may then be more able to facilitate engagement with mental health services. Programs identified in the review did not focus on multi-morbidity or co-existing disorders such as substance misuse. This limits program effectiveness and genuine person-centeredness. No identified studies reflected on transition support for those exiting short term stays of incarceration, despite suggestions that support during this period may offer a form of community diversion which improve mental health support and decrease recidivism (Ogloff et al 2006; Centre for Addiction and Mental Health, 2013)

Although aiming to provide personalised or recovery-oriented support, the programs initially identified in our review showed mixed success at doing so. As implied by the naming of these approaches inmates should be at the centre of charting their mental health goals and in determining the individualised measures suited to attaining these but many programs offered standardised care. The individual's personalised needs, whether in a correctional facility or in the community should be primary in any program aiming to successfully transition an individual back into their community. Otherwise the supports offered could be misplaced and the individual unresponsive, as identified in several of the studies presented here. They should also draw on the knowledge of former prisoners with mental health problems, ideally as peer-support workers. Future research is needed to identify the effectiveness of programs which are clearly oriented to person-centred and recovery oriented care during periods of transition to the community.

Project Methodology

A mixed methods approach was used in order to explore the different facets of the project. We gathered aggregated statistics from C2C clients and conducted qualitative interviews with key stakeholders.

Ethics approval was gained from Sydney LHD and the Justice Health and Forensic Mental Health Network.

All data collection took place in 2016.

Qualitative data

Qualitative data were collected through semi-structured interviews with 12 members of staff working within Justice Health, Sydney LHD community mental health and PIR. We interviewed four participants from each of these three organisations.

The authors developed an interview guide (see Appendix 2) with broad questions focused around the research topic, including facilitators and barriers to successful transition support. The guide was designed to be used flexibly so that participants had the opportunity to delve into and further discuss topics or experiences they deemed to be most pertinent. Probing questions encouraged deeper explanations and elaborations. As interviews progressed, the guide was modified to include new topics or concepts raised by earlier interviews and emerging analyses. Interviews were recorded, transcribed verbatim, and coded as soon as possible after each interview.

Data were analysed using constant comparative analysis to compare data within transcripts and between transcripts (Charmaz, 2014). Two authors independently coded the first two transcripts, and then met to discuss and find consensus in early coding decisions. Subsequent transcripts were then coded by KT. Throughout data analysis, regular reflexive discussions between authors ensured emerging codes were representative of the data, enhancing coding rigour (Charmaz, 2014). NVivo computer software (QSR International, 20150) was used to aid with data management and team collaboration throughout the analysis process.

Quantitative data

A total of 14 consumers were enrolled into the C2C program. Data were collected from C2C clients at release, one week post release and 28 days following release. A form was developed to collect quantitative data on C2C participants. This is included at Appendix 1.

For privacy reasons and to comply with ethics approval we are not able to include non-aggregated data for clients in this report. The quantitative data is described in narrative form below.

Quantitative data results.

Prior to release:

Time spent incarcerated prior to release was recorded for nine clients. Time spent in jail ranged from four months to 24 months with an average of 12 months.

Clients came from a broad range of facilities including the South Coast Correctional Centre, Dilwynnia, Silverwater, Parklea, Silverwater men's prison, Silverwater women's prison, the Metro Remand and Reception Centre, Cooma Correctional Centre, John Moroney Correction Complex, and Long Bay. As this list shows they were not necessarily already located in a prison close to Sydney LHD. This is an important consideration for in-reach and through-care (discussed in qualitative data below) which relies on staff from community mental health facilities being able to meet with individuals while they are incarcerated.

At least one diagnosis was listed for 13 of the clients. Nine clients had a diagnosis of schizophrenia, two had a diagnosis of depression and anxiety and one had a diagnosis of bipolar disorder. Secondary diagnoses included attention deficit disorder, depression, anti-social personality disorder and anxiety.

At release

The time from which contact was made with PIR or the community mental health team prior to release ranged from 55 days to 2 days. The average was 27 days, but the actual number of days was generally under a week or over a month. No data were available for two clients.

Legal status at release was not collected for five of the participants but for others their status was on parole, on remand or under a community treatment order. Five had no legal restrictions.

Accommodation status at release was varied. Four were in mental health or drug and alcohol rehabilitation related accommodation in the community, one was released into homelessness, one had a private rental and six were staying with family members or a carer. One person living with their family was sleeping on a couch. One client moved directly out of catchment because they had no other option but to live with family outside of Sydney LHD.

When asked about family and carers five had good relationships with their family. Seven had strained or negative relationships with family members. One did not have any carer or family relationships and another was unknown.

Process at release

The spreadsheet collected information from the client's C2C supporter regarding the referral from corrections. For eleven of the clients the referral process was seen to be a good one with appropriate information about the client provided at referral. For the other clients either no information or limited information was provided by corrections or other relevant authorities.

In-reach, where contact (preferably in person) was made with the consumer prior to release occurred with community mental health or PIR for only three of the fourteen participants and for one of these it was by phone only. This demonstrates the difficulty of in-reach given that this was prioritised within C2C and yet it still did not occur for most clients. Eight of the participants accepted PIR at the time of release.

Two clients were not released or were released but no contact was made with the community mental health team or PIR so there was no information about them after release and they were lost to follow-up care

At seven days post-release

At seven days post-release contact had been lost with one additional client. This client appeared to have a stable relationship with a carer and had accepted involvement in C2C. It is unclear why no further contact was made. Accommodation at seven days post release was the same as at release for all but three of the remaining 11 clients. Of those whose accommodation had changed one was now receiving accommodation through the department of housing instead of living with their family. One also moved from accommodation with their family to a community-based supported accommodation service for people transitioning out of prison. The individual who was released into homelessness was then moved into a boarding house.

The individual who was living with family out of catchment was still living out of catchment and was unhappy about this situation.

Of the 11 clients still engaged four had seen the community mental health team within seven days. Three had seen PIR within seven days. Five of the clients had named a GP.

Clients were engaging with a range of services post release including parole, alcohol and other drug services, generic community transition services, boarding house outreach services, community corrections, community health services, disability services and Centrelink.

At 28 days post-release

At 28 days post-release a further four clients had disengaged with C2C, leaving seven engaged. Two clients stopped attending appointments due to drug problems. One client was returned to jail for breaching conditions of release. The individual who was living out of catchment was actively referred to services in that region.

Accommodation had changed for three of the remaining seven clients. One who had been sleeping on a family member's couch moved in with another family member. One moved from a residential rehabilitation program to crisis accommodation and another was removed from residential rehabilitation due to drug use and moved to a family member's house.

Two clients moved out of catchment and referral to services in the new areas were made or in progress for both. For those still in catchment all had seen the community mental health team either two or three times. Four clients were engaging with their GP.

Other services that clients were engaged with were a psychologist, drug health services, dental services, housing NSW, Centrelink, a Methadone clinic, community corrections, support.org and the Salvation Army.

Summary

At the end of the C2C data collection period (28 days) half of the clients where engagement had been attempted were still engaged with the program. For those who had disengaged this was due to two main factors: 1) drug problems (which led to disengagement or reincarceration) and, 2) accommodation changes which saw them move out of catchment. For most of the clients accommodation was very unstable. Of those clients who remained engaged after seven days all were well engaged with mental health services.

Qualitative data findings.

Main findings from C2C stakeholder interviews

Interviews with key stakeholders revealed several main factors that impact effective transition. These can be generally characterised as either systemic factors (factors due to the operation of the systems operating around a consumer) or consumer factors (factors arising from the consumer's own situation). These are summarised in dot points here and illustrated further below with examples from the data collected.

Service related factors:

- Communication between organisations is inefficient.
 - Staff in community based services are not routinely informed of important information (including information about release dates, medication, accommodation) and have to proactively seek it out.
 - Staff in Justice Health may lack easy access to information that is requested by other organisations.
- There is a lack of understanding between organisations of the roles and responsibilities of individuals and organisations.
- Staff rely on developing working relationships with staff in other organisations but would like a consistent and integrated process for transferring information or making referrals.
- Where working relationships do not occur collaboration is very difficult.
- In-reach is important for establishing therapeutic relationships and increasing the likelihood of engagement with services once the consumer is released.
- Through-care, where community mental health staff continue to see consumers while they are in a correctional facility, is important for maintaining therapeutic relationships and ensuring a more effective transition for consumers moving back into the community.
- Staff reported problems “getting in the door” of a facility to conduct in-reach or through-care due to the security environment and internal organisational problems within correctional facilities.
- Consumers are released through the courts without any individuals involved in their care being informed, including Justice Health nurses, PIR and the community mental health team. This increases the likelihood of the consumer being lost to care.
- Participants did not point to any existing effective system-wide or local programs which were currently addressing these issues.

Consumer-related factors:

- Unstable accommodation is very problematic for engagement with mental health services. Often consumers are released into unsuitable or very short term accommodation.
- Many consumers are preoccupied with immediate needs of housing and subsistence upon release and may therefore deprioritise engagement with mental health supports.
- Consumers have additional problems such as substance misuse and intellectual disability that impacts on their engagement with services.
- Relationships need to be developed with consumers because they may distrust services or only accept them when still in jail to “look good” but do not understand the reality of the service engagement and what it can offer them
- Engaging consumers once they are in the community is often very hard and requires long-term persistence and management of risky behaviours.

Stakeholder interviews – in depth data analysis.

Interagency communication and understanding

Several general themes emerged around factors impacting successful inter-agency working. These included poor understanding of each other's organisational contexts and poor systems in place to facilitate cooperation between people working within different sectors or organisations. Participants also spoke about communication, release confusion and jurisdictional boundaries (s7, s10, s11¹).

Inter-agency understanding:

Staff frequently expressed the belief that other agencies did not understand either the central role of their organisation, or the limitations inherent within the systems within which they worked. Staff felt that this put expectations on them which it was difficult to meet. Staff also expressed the need to have a greater understanding of what other organisations could provide in the way of services. For several staff, lack of clarity about what PIR could provide caused problems (s8, s6). One PIR staff member indicated that they felt that a community mental health staff member had been disappointed about PIR's lack of support for a consumer due to confusion about their role. They had thought that PIR was a "direct support service" and this is not primarily their role (s8). Another participant confirmed that they were not sure what PIR provided (s6).

Another participant stated that corrections facilities were releasing people with only short term services arranged and that this meant that they were left with trying to find follow up services which sometimes weren't available:

... there's nothing else has been organised, the rest is up to us. The services that we can access in the community are already full so we end up with a number of consumers on our hands that we don't have any immediate response to our referrals. What that does is that puts the responsibility upon us to do the casework and case management. We are just facilitators; we only are required to do a small amount. (s1)

It also causes problems for clients who are promised by corrections that community based services will arrange support for them which is not actually feasible in practice:

I have had consumers coming to us asking what are you going to do for me, and then when they are explained these are some limitations, they become disappointed. Because they have been told that once they get out they are - in reference to PIR - going to get you a house, they're going to get you on the pension, they're going to get you this, they're going to get you that. That is not a realistic outcome. (s1)

This participant indicated that they were being put in a position where they were being required to do more than their normal roles.

Justice Health staff indicated that staff in the community did not understand the constraints on their access to information about clients, and their ability to communicate within their own organisation and externally (e.g. they are not allowed to carry mobile phones) (s7, s10, s11). There was a general feeling amongst the Justice Health staff interviewed that those working in the community did not realise the extent to which their work was constrained by working within a corrections facility (s7, s10, s11). For example:

¹ Respondents are referred to by a unique alpha-numerical identifier.

But communication is not always the easiest to do and people that never work in the jail don't understand what it's like to try to communicate between somebody working within the confines of a secure environment like a jail to outside. (s11)

They reported confusion about jurisdictional boundaries which did not demonstrate an understanding of the limited capacity that Justice Health has to operate within a community based setting (s11). Justice Health also had limited ability to be able to predict release dates (s7). This was frustrating for those working in community mental health who were unable to set up timely and appropriate accommodation or other services for those who needed them (s3). Justice Health were blamed for this lack of warning about release dates and this was frustrating for Justice Health staff (s10, s7). For example:

...they don't understand the process. If someone was released from court yesterday, I could not possibly do a referral the day before, because we don't know that the person will be released and they will often say, 'well why didn't you do the referral earlier?' (s7)

These results point to a clear need for greater interagency understanding.

Working relationships and communication:

The importance of good working relationships for effective inter-agency working was a very strong theme. Staff relied on their existing relationships to find out about release dates, and where clients were in the system or what services they were receiving. In the absence of such relationships, staff indicated that access to information was dependent on who they were able to speak to on the day. This perception was mainly directed at staff working within Justice Health (s2, s6, s5, s1, s3). This is demonstrated in the following quotations:

It's so idiosyncratic. I mean some people are fantastic. Other people are brutally indifferent. It just isn't consistent. (s6)

One of the things that ... the medical director and who is our doctor - he said look, just ring them tomorrow and you'll get someone else. (s5)

There are some people within the justice system that are spot on and we want more of them [laughs], and some of them are willing to collaborate and coordinate and help us, and there are others which unfortunately at times can seem like it's the majority, which do not. (s1)

Relationships needed to be built over longer periods so that they can be drawn on when necessary. One Justice Health staff member mentioned that existing working relationships with staff in community mental health teams helped establish trust.

...it's a lot easier if I know the person like I'm working in health for so many decades I do get on the phone to people that may know me and it's a lot easier, they can then trust to leave their name and email address. [otherwise] I mean I may have the patient's name, date of birth, and a local address and they're still a bit reluctant to give me information... I find networking is probably one of my best tools. (s11)

Justice Health staff also mentioned the importance of working relationships with corrections staff for knowing when people would be released. These relationships relied "on good communication" between staff in different agencies and throughout correctional facilities (s10). Because of the speed of release for some people these relationships needed to already be in place for so that they could be accessed when needed (s10).

Consistent processes needed for information sharing:

The development of working relationships, while important, was seen as only part of the solution to poor understanding and communication across the sectors. Participants described a desire for a more systematic, consistent and effective approach to the transfer of information between agencies (s1). Two participants spoke about the need to receive information in a consistent way:

... the minimum standard of information transfer needs to be identified and published. (s6)

... we've got about 10 clients that have been in and out of gaol the last few years, and every experience is different. There's not a consistent approach about that. So consistent process about how to receive the information would be good. Either we devise something with people, or they let us know how they give us that information or how we can find out that information, and that's how we'll proceed. (s4).

One Justice Health staff member expressed the desire for an integrated online information system like the Community Health and Outpatient Clinic database that would mean that staff did not have to chase around finding information.

I know other health organisations are [using]... the Community Health and Outpatient Clinic and everything is done on database, progress notes, is all done on computer. So if I want to find out how a patient was in the mental health intensive care unit which is a mission with [one facility] and I'm working in [another facility] just to see how the patient is, an ex-patient, I can go online and find it. The same sort of system would be great here, I could log in and ... I know what's going on with this patient. Sometimes we say, well we don't know until the patient gets out and I've had community mental health teams on the phone asking, 'well when was the last time they had their medication, their depot?' I go, 'I don't know, I'm not - joint records is outside this jail and I have nothing to do with joint records.' I'll give you a telephone number or whatever. So it would be a lot easier if we could just log straight in to their system and find out what medication they've had, when was the last time they had their depot and likewise for us to them. (s11).

Two participants, wanted a mutually accessible list of responsibilities and contacts that enabled them to know who to talk to or how in the system to follow up specific issues (s5, s2). They called for:

...a website you could go to and you could find out who you talk to for particular issues at a particular location providing specifics of. I had a patient ... gone into jail, and I know about that, he's a diabetic, and I want to let them know about that. If I could figure who to talk to and tell that stuff and pass it along, beautiful. Equivalent to a person going in who is on a depot. If I can get to the right person, tell the guys over in [the jail], here's what his treatment history is, current medication, his last depot date, ... his side effect profile and so on, would be very nice. (s5)

[jails are] huge big entities and incorporations. Just even finding out who you've got to talk to even organise something like that. It can be really challenging to track down the appropriate person because you still have to send through requests to do that. It has to be signed off by the manager of security, you need to identify yourself. It's not just ringing up and going hey, I want to talk to this person. So yeah, that can be quite a convoluted confusing process if you've never done it before. (s2)

As this example shows such a system is important in ensuring consistency for the consumer which would in turn provide a smoother transition for all involved.

Shared values are important:

Several participants expressed the desire for a shared ethic which prioritised the consumer, or that this group of consumers should be a high priority for care. It was felt that the system would be more cohesive or work better for consumers if there was a shared ethic or set of values in operation. This would allow time to be spent on people and for individual's journeys to be valued and supported:

I think everybody just having an understanding that it's a priority. ... I think it's just a matter of it's so far down on the priority list for people. They've got limited time, they've got limited resources. They've got big caseloads. They're working with a lot of people. My understanding is of the justice system as well, it's very impersonal. So I think people having an understanding that there is supports out there for people to access and making it a priority on their list. (s2)

I've always valued this community of clients as being high priority for getting access to care, because when we go back to their history, we find long histories of systemic disadvantage and abuse and neglect, and they are the completion of DOCS and juvenile justice and police and housing and unemployment.... They really should be a high priority for corrective care in the community, not what they [start off with] which is lowest priority. (s5)

If they're not the priority - if they're not seen as the person to consider when decisions are made then they're going to lose out and it's going to be worse for them. Their new experience of being outside is a negative one. That's a tragedy. I think that can happen. (s8)

An appropriate way forward would be to develop interagency working groups which are sponsored by key agencies with staff provided with time in their positions to attend. This would help to foster those 'working relationships' which could be drawn on when necessary. It would also help to foster a shared community with shared values about care. It would also help develop an understanding of who to speak to and what information can be shared and by what means. An online information system of the type requested by respondents would also enforce these connections.

In-reach and continuity of care

Access to consumers while they were still incarcerated facilitated engagement with services after release. This is called 'in-reach' and was seen as important to establish or maintain therapeutic alliance. However, staff reported problems 'getting in the door' and with having ongoing access to consumers while in jail. The effectiveness of in-reach was impacted on by problems encountered with physically accessing the consumer in jail due to institutional circumstances, identification-related complexities for staff and poor communication.

Positive impact of in-reach:

In-reach was seen as important by PIR and Sydney LHD staff. Staff indicated that consumers appreciated in-reach, that it helped establish rapport between staff and consumers and that it facilitated timely engagement once the consumer was in the community (s1, s2, s4, s5, s6).

Yeah. It encouraged contact, in-reach and that was good. I mean she was certainly very pleased to see me. She kept on saying could she come with me? (s6)

Look, if we meet with someone while he or she is in jail, the rapport is established. If they like us, they like us; if they don't like us, they don't like us which also a good outcome for assessment processes. (s1)

I know that we've worked with a lot of people I suppose who would be really considered as success stories. Where we've provide In Reach, developed some sort of rapport with them, talked a bit about what they want to do, how we can support them. (s2)

...they know us, so if we're coming to see them it's like their lifeline to being outside gaol. When we do get to see people that's been - when we get through the doors we're able to see people, and that's always helpful. (s4)

Hard to get in the door:

Despite the importance of in-reach/access, the majority of PIR and Sydney LHD staff reported problems accessing clients while in custody due to barriers associated with security systems or organisational problems within the correctional facilities. Justice Health staff also mentioned that it could be hard for staff from the community to get into jail to see consumers. The procedures were described as arduous and convoluted, and often involved lots of ringing around. In addition, both Sydney LHD and PIR staff mentioned turning up to appointments and being turned away by correctional staff, who had no knowledge of the appointment.

Systems for accessing facilities were not consistent across the system, with different access requirements making it difficult for community staff to meet with consumers in jail (s1, s2). Systems also frequently changed requirements meaning that staff had to go through changed processes or went to visit but were turned away.

... it varies from centre to centre. some of them are very strict on giving us access, but that's never been denied, it's just the process of getting access, applying for access, having to present, fill in a form for your own criminal history should you have one, clearance. Clearance issues, providing identification and then having to go through that, waiting for them to accept it and let you know that you are now registered as a visitor so the next time it will be a lot easier. But that can take four weeks (s1).

[one prison] just recently - I don't know why - but just recently they actually changed their process of getting in and out of prison. So you actually have to register as an individual as opposed to other prisons that you don't. You're issued with a VIN number and your - I think your biometrics I think it is, where they take your fingerprints and your eyes and eye scans and all of that kind of stuff. So you do that at every prison. Every entry and every exit you do it there. But what [this prison] has done is then even as an individual, you then have to register, on top of getting a VIN number, and on top of all the biometrics and all of that kind of stuff, you actually have to register. Then also get clearance from the manager of security, you have to produce a lot of ID and things like that as well. (s2).

Complex systems mean that there can be long time frames involved in meeting with consumers prior to release. This can hamper their transition to the community because important issues for successful transition cannot be worked through in a timely manner. High-level security systems for accessing people in jail are understandably important, however a consistent system throughout the NSW correctional system would make it easier to provide transition support given the wide-range of correctional facilities that any LHD will receive referrals from.

Poor internal communication systems within correctional facilities were also seen to be a barrier to work (s3, s4, s5). One participant working in the community relayed an occasion when they arrived at a facility to carry out an in-reach activity and encountered significant difficulties because their name was not on the

door, the staff members at the desk did not know who the corrections staff member that they were meant to meet was and how they could be contacted:

Went into the booth where you get scanned and they have to do all that stuff and they had no idea who this person was, who works with them. I was this is the person, her name is [removed] she works here. It took us an hour to actually get in, which usually it takes around half an hour. They couldn't find who this person was. They didn't even know who the staff member was. They didn't even know that staff existed. So, afterwards, the next day, I sent an email to [name] to go; hey this is what's happened. I've got some questions about the client. She's like - oh yeah I kind of fly under the radar there. You think you'd want to put my name down somewhere in a clipboard or let the staff know the security staff. (s3)

Others recounted being sent away because of poor internal communication:

We've shown up, we've talked to people about going to see people in custody and we show up and they didn't know that we were coming, and we've been turned away at the door. That's happened several times as well. (s4)

I submitted the approvals, faxed through my deeds and everything two weeks before. Organised the date to come over, I get there, it's four in the afternoon, mate, sorry, I don't know what you're talking about. I haven't seen that form. I can't find it. (s5).

Jails are also unpredictable places to work, with 'lock downs' or other security situations hindering work:

Of course the other thing is all the other internal barriers, where you set up a time for the NGO provider to come in, and they get in and find that Corrective Services have locked the place down because of an incident or whatever. There's numerous barriers to even getting access to people in jail. So there's that kind of thing. (s10)

I had to leave. And mind you, I'd taken up my afternoon to go and do this. Luckily I was still around for a week longer, so I could resend the stuff, talk to the guy the next day, not complain of course, because that would be foolish of me (s5).

These security situations are inevitable and have to be factored into work in this setting, however, the disorganisation of the system encountered by others can be addressed through more efficient internal communication systems.

Continuity of care is currently limited but important:

Three participants spoke about 'through care' where they continued to provide an in-reach service for consumers who were already accessing their service prior to incarceration (s3, s4, s6). In these instances the consumers were not automatically discharged from the service, and were still seen by community mental health clinicians and characterised as being in the care of Sydney LHD. Mental health workers stressed that they often had a longstanding relationship with consumers and that in some cases they might be the only person who knew or cared about the consumer. This made through care a very important therapeutic tool which needed to be utilised to ensure effective transition when the consumer was eventually released. Access to the consumer helped maintain a therapeutic alliance. In addition clinicians wanted to be able to inform Justice Health about current medications, and liaise with Justice Health staff about any changes in medication made while the consumer was in custody.

If there's a current client, then of course you're going to continue to engage...or if they're going to be released within a reasonable time frame, there's no purpose to discharging them from your service, because you then lose access and they lose care. (s5)

Poor communication from Justice Health about the whereabouts of existing clients within the corrections system meant that community staff lost contact and this was detrimental to their ongoing treatment:

Often people are also moved around, where we lose contact where they are, and they don't call us to say look, they've gone from Redfern over to Silverwater. Or from Surry Hills to Silverwater, from holding to incarceration, or anything like that. We're not always sure of where people are. But usually the nature of our clients are that we're the only people that have anything to do with them. They've usually got no families, no other mental health services, not many friends or other community engagements. We're usually the only ones that know about them full-stop. Once we lose sight of them, they're really gone, and given the nature of the risky people we try and keep track of them as much as we can. (s4).

Failure to be kept informed about a consumer's progress while in correctional facilities could have significant detrimental impacts on their ongoing care once they were discharged, particularly if treatment, medication and current mental state were not communicated:

...given the fact that you're the case worker and that you've been working with this person for years, you'll be responsible in a direct physical way for their mental health follow up when they get discharged. [they] should inform you of these things. Like we ceased medication or the client became agitated and suicidal or the client... (s6)

One Sydney LHD participant also reported being given time frames or limits on the number of visits with existing consumers who the participant was keen to maintain a relationship, and that Justice Health staff did not understand why Sydney LHD would want to continue to see the consumer while in custody (s4). This participant reported an instance in which they were discouraged from continuing to see a consumer after the first couple of visits. The consumer was subsequently released outside the Sydney LHD, lost to care, and eventually re-appeared in Sydney LHD showing deterioration in mental health.

SLHD staff also reported that Justice Health staff were unwilling to discuss treatments with them, or even notify them of changes in medication (s4, s6). One staff member indicated that they had been told that they were over-stepping their boundaries by asking about treatment, and the participant perceived that Justice Health staff believed they were questioning their authority (s4). Another participant indicated that they had only found out that a consumer had been taken off his anti-psychotic medication while in custody after ringing up and asking:

So they took a unilateral decision to cease his medication while he was in prison. So they told me - I mean this is what annoyed me. I spoke to them, like the mental health carers, when he went in. Faxed them over paperwork. They said yeah, yeah, we'll give him his depo while he's in here. They did but the one after that they decided not to..... But you get this kind of worry. Like you start thinking oh, what's going on? So I rang them up again and asked them - like I found out - I think he was off for a week. Ten days he was without any kind of - and for him that matters because then they were going to discharge him I think it was about another fortnight after that. So he'd have been unmedicated for three weeks or four weeks by the time he was back in the community. (S6)

In summary the participants relayed significant difficulties in providing in-reach and through-care to consumers. This was as a result of difficulties related to the physical access restrictions of correctional facilities, issues around poor communication within Justice Health and changing identification requirements. As these examples show this could have serious implications for transition back to the community.

Information and referral pathways

In order to provide effective follow up, PIR and community mental health staff reported that they needed to know when a consumer was incarcerated (this was especially important where the consumer was already part of the service), their treatment and when they might be expected to be released (s3, s4). They also needed to know what had been set up for the consumer leaving custody, how to contact them and which services the consumer was working with (s6, s4). Many of the barriers to successful transition reported by participants related to these issues. Justice Health also reported this to be a barrier to their own work (s11) and resulted from a lack of communication from Parole or correctional facilities. People could also be released through the court system but Justice Health was not informed for 24 hours, which meant that they could not communicate the release details in a timely fashion to services in the community (s10, s11).

Participants reported specific barriers to successful transfer of information or referral between organisations. These included not being routinely informed about information important for continuity of care or transfer of care and failure to respond to requests for information, including those already discussed. Participants also described having very good experiences with other agencies or individuals in other agencies. In addition to poor information flow, systemic barriers existed. Justice Health staff reported not having easy access to information required by other organisations due to the structure of the organisation, constraints imposed by working within a security environment, and lack of access to online systems in which information was housed. Systemic barriers were especially apparent in relation to release dates. In addition, consent imposed barriers on information flow and effective transfer of care.

Communication gaps:

Several staff reported instances in which they had worked well with other agencies. One staff member from PIR reported a good information flow with staff from corrections and another having excellent communication with PIR. However staff also reported lapses in communication which could be very detrimental to progress and could result in the consumer being lost to care unless the consumer themselves notifies the service.

Oh you'd hear but it's all about the gap. It's all about the delay. Like what happens for some people is that you get paperwork and, you know, any large service is only as strong as the least effective point the information is transferred. So if people are not followed up they might be in the community and it's not known. (S6)

If we find out that they've been released outside of our area, the clients won't necessarily call us and tell us. So if we don't get the information from the justice system then it's unlikely we'll know that they've been released somewhere else. But if we do find out then we would start the process of engaging with the local community mental health service and providing hand-over and providing discharge summaries and documents around the person. (s4)

Others described having no response to their requests for information whether this be from Justice Health, community mental health teams and Parole (s1, s2, s3, s7). Participants complained that no one answered their calls or returned their messages:

Biggest barrier would be getting in contact with these people and for these people to return our calls and answer our inquiries. ...Whilst they're outside, to be honest with you, one of the problems we have is getting some form of collaboration responses from some officers of parole and probation. I might ring someone 10 times and I have no response. I might send an email and I have no response. This will impact upon helping the person that I need to help because to access all those services we might need a supporting letter from parole and probation, for example. (s1)

...with a lot of community health centres within the Sydney LHD or within Justice Health and things like that, when you do follow up, and it's not just once, it's following up a couple of times either by email or via phone call and things like that, I think it is - there's just low priority or they just don't have time. (s2)

First of all, they hardly ever call you back. (s7)

This data shows that poor communication is not just defined to one part of the system. The poor communication appeared to result from high workloads, low prioritisation of work not central to their 'core business' and inadequate systems of information management.

Confusion about release:

Confusion related to release dates posed a major barrier for effective transition of care. Release dates could change unexpectedly, or consumers who were held on remand might go to court and be released.

...one of the things that has become very evident is that people's release dates change constantly and people aren't informed and people don't know. That could be family, that could be support providers, it could be - even parole don't know a lot of the time. So if something like that could actually be properly - what's the right word? You know, probably found out and their release date was going to be set, you know, that would be really good. (s2)

Staff in the community were keen to be informed about release dates but, as discussed above, so were the staff from Justice Health (s10, s11):

Somebody has a release date, they're released by corrective services and we don't always get to know about it. So that's one of the difficulties for us. If somebody has an unknown release date, i.e. they go to court and suddenly get bail, or they get sentenced with time served, and they're suddenly released and the nurses find out about it, they do the same process but in retrospect. Find out where the person has gone to and transfer their information. (s10)

Systemic barriers to communication:

Justice Health participants identified a number of barriers to forwarding information to the community. This related to the structure and constraints of working within the justice system alongside corrections. One Justice Health participant commented that if they were allowed to access the Offender Integrated Management System (OIMS) they could help keep community mental health teams informed about charges or the potential for a consumer to be released (s11). They indicated that currently it was unusual for clinical staff to have access to OIMS and that without it they had to ask an officer which could be overly time-consuming and hampered their ability to provide information in a timely fashion. This participant also indicated that information required by community mental health teams was often only found on a paper file, which might not be in their possession. This made finding this information time consuming:

We have like a main clinic where we have the files. Now it could be a GP that they're being seen by, the file might be with a number of other clinicians.... So [for example, the files] get taken over to Long Bay, so all we get left with is a piece of paper that says the files there have been taken over and all we get is a photocopy of the treatment sheet. I don't think community mental health teams understand all that.... we don't have that on line. (s11)

In addition to Justice Health and corrections systems barriers, participants also mentioned problems with transfer of care or information flow associated with restrictions relating to multiple levels of consent to access files (s2, s3, s4, s9, s11).

The patient is deteriorating and we're still waiting for a release of the information [authority] to come back and with everyone being very sensitive about - not documentation, about previous access to information because information is gold and it's power. Then it makes it very difficult, you'll have to wait for [a Release of Information authority] to come back and this patient has become unwell but they can't tell me exactly what they've been on, what allergies they've got, then it makes it very difficult to prescribe a medication. (s11)

I think maybe accepting other organisations consent forms. Some do and some don't. So once you've got - say Inner West Partners in Recovery you have a consent signed so I could actually send that as proof to communicate with that service. Say Housing New South Wales for instance. Whereas Housing New South Wales also then require their own consent form signed to actually communicate with you. ...So other organisations actually accepting the consent form signed. (s2)

That's what the hospital staff advised us when we called up to ask for information. They said, yeah, they didn't have her permission to give it to us. So yeah, they wouldn't provide it. Yeah. (s9)

In summary the issues relating to information sharing arise from the reliance on paper forms, restrictions around consent to access files and speak, unknown release dates and unresponsive staff.

Engaging consumers in the community

Participants indicated that engaging consumers in the community was difficult. A number of consumer variables impacted on successful engagement with services including substance use, cognitive impairment, relationships, lack of basic necessities, and problems negotiating new technologies and systems. All of these increased the risk of re-offending and reduced the likelihood of engagement with services. In addition, issues surrounding accommodation were a major barrier for consumers. These are dealt with in a separate category below.

Accessing consumers in the community is difficult:

Participants described problems with engaging consumers in the community even when they knew where the consumer was living. Consumers did not turn up to appointments or were otherwise hard to contact (s1, s3, s6). One participant mentioned that consumers could be aggressive and that this risk could impact on successful brokerage of services (s1):

Although there is no aggression to me, their aggression represents a risk for them, for us and for others when we refer them to a service for example when they go to an assessment, they go to an assessment, or we support them to go, for example to apply for photo ID. They want it immediately; they will not be given it immediately.... they don't get aggressive at us ... they go off at the other person behind the counter, which hurts them a lot, causes them to call security, and you can see the chain reaction after that. Either the client goes oh, just leave me alone, okay I see now go, or why are you handling me or why are you doing this and it just escalates, and we're in the middle. (s1)

Several participants mentioned working in with the consumer's medication schedule in order to make contact with them. They met at the clinic when the client was scheduled for their depo or methadone medication (s3, s6).

Building relationships with consumers:

Participants emphasised that working with consumers involved persistence, out-reach (seeing consumers at various locations in the community rather than expecting them to turn up for appointments) and understanding the individual's situation so that they could mitigate risk.

Like this person is slow. Like the outcomes are slow. You need to build a relationship before you get outcomes. You need to find a point of entry too. (s6)

Sometimes it puts us at risk, so we just come again tomorrow. If we go to see them today and they're kicking off and they don't want to see us then we'll just come back tomorrow. We just keep showing up that way and try and maintain a safe arrangement for us, but it doesn't stop us from seeing them. We just try to figure out how we can do it in a safe way. (s4)

Several participants recognised that although it might take a long time to establish trust with a consumer, there were limits to persistence and they had to know when to limit their contact.

I mean you could knock on the door and you could do a lot of this - [knocks] - but you end up harassing the family too much. In my case they're just a bunch of young kids. There are teenage kids, younger kids and they just kept on saying to me I'll let mum know. How many times can you say that to a child before you think I need to leave this kid alone? I'm starting to distress them. (s6)

The ability to persist with a hard to engage consumer depended on organisational jurisdiction. One participant suggested that while for the community mental health team long term persistence was possible, that for PIR it might be less feasible (s4):

The way that we work with our consumers is persistence, and they might not talk to us for 12 months but we just keep showing up. You don't always get that with NGOs. It might get to three months, or six months, when they'll just keep showing up and the person still doesn't want to talk to them. They might think that is a point at which they terminate that contact. For us it's a point at which we just keep persevering, and it might be after the 12 months or the 18 months that they start inviting us in. It's about building trust, and showing up for people who've often been left behind by family, by public services. (s4)

A staff member from Justice Health stated that it might be less desirable for services to engage with consumers who were exiting the criminal justice system (s10).

Generally they're clients that nobody is very keen on treating in the community. That's because they often are chaotic, itinerant, move around. They have a combination of serious mental illness, severe personality disorders, and/or drug and alcohol disorders. So they're difficult to engage and treat. They are perceived as very difficult.... they could be at risk of harm to themselves, to the workers. So they often have appointments and they don't turn up. They tend to be chaotic clients with multiple needs. (s10)

Part of building relationships is therefore about educating the system about effectively working in this field.

Substance use and cognitive impairments:

Substance use was seen as a major barrier to successful engagement with services in the community (s1, s2, s3, s8). It was associated with risk, impaired decision-making and contributed to a lack of engagement with services. Participant s1 from PIR also indicated that they thought that this need was not being adequately addressed in custody and that encouraging people to enter residential treatment for substance use immediately after release from custody was very difficult.

Then there are the other ones that all they want is partying on as soon as they come out, and there's nothing that we can do because people will be - I have had experiences where I never - with a couple of consumers, they were never sober. If they weren't drunk they were on pills; if they weren't on pills they were on something else. (s1)

Sure, I think one of the hardest things is when they have an active drug and alcohol and they don't - they don't want to address it. ... because of the shame and embarrassment they won't even answer my phone calls, which I understand (s3)

In addition to cognitive problems related to substance use, several participants mentioned intellectual disability as an independent factor associated with lack of engagement with services (s2, s8). Participant s8 from PIR was unclear if their consumer had actually understood what they were consenting to when discussing PIR and was fixated on getting out rather than on what services might be available once they were released. Cognitive impairments could also lead to poor decision-making once released:

But then I think it also comes back to whether or not a person is living with addiction or an [Acquired Brain Injury] or cognitive functioning issues, intellectual disability, and things like that. Because then their comprehension and their understanding of the situation is going to be very different. You know, whether or not they've actually got the skills to really comprehend that and understand that and think about the steps that they've got to take. (s2).

I was introduced as the person that would work with her when she got out and she seemed fine with that, but whether she had - because she actually does have a cognitive disability as well, so whether she really understood what that entailed - she was so focused on getting out. (s8)

Relationships and friendships post release:

Participants indicated that the people that the consumer engaged with after release – families of origin (s2, s3, s6), partner (s3) or friends (s1, s2) - could either facilitate or be a barrier to successful re-entry and engagement with services.

I think we were sort of talking about it before, for people that are recently released, they might start interacting with old friends or old family and reengage in either criminal activity or be impacted by drugs or alcohol addiction. (s2)

...we understand that relationships are very important, and that in a lot of the cases the only relationships these people have are not the most helpful towards recovery (s1).

One participant also mentioned that it was important to see consumers in the context of their family structure, especially for consumers from culturally and linguistically diverse (CALD) backgrounds.

...my take on this was that you've really got to form a lot of relationship with the family. This is the CALD bit, the culturally and linguistically diverse bit, is that she doesn't really function independently. (s6)

With this knowledge transition support could be best designed to meet the context of the individual's unique life experiences.

Consumer attitude to recovery and services:

Participants indicated that attitudes towards service providers and the consumer's recovery orientation were also important factors in engagement after release. Participants also mentioned that in their experience consumers might agree to services while in custody because they think it "looks good" and will help their chances of obtaining parole (s1, s2).

What you can see then is two things. One is who really accepted this program because they want to take steps towards recovery and they work with us in collaboration, and they will remain until we achieve things and they feel stronger. There are the others that don't do that because they're frustrated that things are not going their way, and then it starts to become apparent that they have accepted to be in the program because it looks good for them. (s1)

...they think it's going to impact their parole so they go yep, I want to work with Partners in Recovery. But when they actually are released they [unclear] different. (s2)

In-reach was viewed as important because it helped clarify with consumers what services are on offer post-discharge and what their real intentions are for accepting support (s1).

Concerns of everyday life preventing engagement around mental health:

Participants described how engaging with services might be difficult or a low priority for consumers who lacked basic necessities or access to or understanding of new technologies and systems. The anxiety caused by simply living an everyday life could easily be enough to prevent engagement with services.

So while it's definitely not going to be a priority for somebody to meet up when they've got no place to live, they've got no food, they've got no clothes....no access to a phone. No access to money. No ID. I think that's where the really important things of Connections. So I think it's a six week program or a four week program. They help people link in with a GP and they help people link in to get ID and get their bank accounts and get some clothes and all of that kind of stuff. Really meeting a lot of those basic needs. That without them, they can't really move on to do those other things. But yeah, whether or not people have got a phone, whether or not they've got credit. (s2)

Yeah, the biggest factor and the biggest learning experience for me as well as the work of having that - especially if they've been there for a long, long time, massive anxiety. Anxiety of - it's - they've told me it's like it's a brand new world for me. They - I went in 10 years ago. What kind of a phone is that? It has no buttons. ... anxiety is the biggest factor, their anxiety level and that causes them to retract and not engage. (s3)

... when you have been in gaol you have no sense of empowerment or control over your life - or very little. Coming out, your expectations - it's very scary, knowing that you haven't got - probably the skills and - or the prejudice against you, to getting a job, and having a life, and to earning money. All this plays into this, and where you can live, and how you can afford to live there. How you're going to deal with your mental health without the support of prison. Just dealing with that whole anxiety of stigma and the practicalities of life ... (s8)

The preoccupation with these necessities of life and re-acculturation to life outside jail meant that consumers deprioritised their mental health in the face of what they considered to be more immediate concerns. Better supporting these issues would therefore facilitate more effective transition.

Accommodation stability is key:

Accommodation was also a key facet of life outside of which needed to be arranged in order for consumers to prioritise their mental health. Lack of stable accommodation made it much harder to make contact with and engage with consumers in the community. Finding stable accommodation was not always easy, and was compounded by the fact that consumers had often "burned their bridges" through previous engagements with housing options in the area (s1, s3, s4).

Some of these people have had a previous tenancy history and are not perhaps in the best of the pages in housing providers. (s1)

Every relationship has difficulties and barriers to it, so obviously with Housing many of our clients have been through lots of services and we're the last bastion of hope, if that makes sense. You know, they've burned their bridges with housing, they've burned their bridges with private rental

places, and so as much as possible we try to get them into support arrangements that would facilitate them being able to stay in the community. (s4)

In addition, consumer decision-making about where they wanted to live could lead to problems with accessing services. Lack of accommodation at release also created problems for transfer of care and referral because consumers could not be tracked down (s3, s4).

...when they get discharged if they don't have a mobile phone I'm like - well how do I contact them, and we don't know where they're going to be going because there was no housing arranged. They're going to be - they are released homeless. So it's - do I - I just have to call around. I call different refuges and see if they are there. (s3)

One Justice Health participant commented that in their experience community mental health teams would not accept referrals until the consumer had an address:

...community health teams want to know - will ring me up and say, well we're not taking them because we don't have an address. Sometimes we say, well we don't know until the patient gets out (s11)

Having access to stable accommodation was central to successful engagement with services. Consumers could be released into homelessness which made engagement difficult as it was often hard to locate the consumer in the community. In addition, unexpected release meant that participants were under pressure to find some sort of accommodation at the last minute. Participants reported that helping consumers find or keep accommodation was a means to foster engagement with them.

We've had numerous occasions where people have been released from custody into homelessness or situations like that... people being held in remand, for example, for long periods of time [where the] case has gone back to court, they've heard the issue again and they've released people back into the community without any sort of stable accommodation or follow-up arrangements. (s4)

One of the problems can be that they move out of catchment and then can't access services. This is often due to unstable housing at the time of release and may be permanent or temporary.

Then we have to think about how do we - because we want to keep the client engaged with our service, because they're likely to, like I say, fall through the cracks if they go outside of the Sydney local health district and they're our client. So trying to just make sure that we're setting up something that creates as stable an environment as possible when they leave would be great. (s4)

Another problem resulting from unstable or unsuitable accommodation at the time of release is that they become homeless and this makes them hard to make contact with (s3, s4).

Responsibility for housing is not well understood:

Several participants discussed whose responsibility it was to organise housing. One participant from PIR felt that consumers were being released with only temporary housing, which put PIR in the position of having to find longer term housing. Due to a lack of available housing and problems with previous tenancies, this was often very difficult (s1). They also felt that consumers needed to be better prepared about the realities of accessing housing in the community, about their own responsibilities in relation to this task. This should be part of an effective in-reach program.

I think the hardest bit is that no one before these people are being released works with them on a one-to-one basis, encouraging them to understand that once they're released they're on their own very much. They will have the support but the supports don't guarantee that they're going to go into public or community housing. One of the things that I practise very strongly is as soon as I

meet someone is to start talking about what it's going to be like out there, and to be prepared to access private rental, which will come from their income whichever it is, whether it's wages or whether it is benefits. (s1)

One Justice Health participant indicated that although they emphasised accommodation as part of discharge planning, it was often very difficult to organise accommodation while the consumer was still in custody (s7).

...accommodation is one of the biggest issues and then problems in referring people into the community. We can help with the referrals to Housing Commission, Housing New South Wales, we can help with the referrals but no one gets housing accommodation straight from gaol. You have to be outside the gaol. You have to be released and then they have to go to the office and ask for emergency accommodation and then follow the process, whatever the process is. Sometimes I call them just to confirm that the accommodation is still available. (s7)

In addition to questions about responsibility and organisation of accommodation, staff also indicated that accommodation was linked to referrals made by Justice Health staff. One participant indicated that Justice Health staff nurses responsible for transfer of care may not refer to PIR because organising accommodation fell within the responsibility of corrections staff (s10). However participant s12 also from Justice Health indicated that they did initiate PIR referrals in cases where there was no accommodation.

Consumer decision-making and catchments:

Consumer decision-making about where they wanted to live could cause problems for linking them with services. Several participants described situations in which consumers made last minute decisions to move into another area not serviced by their organisation. This involved considerable scrambling around trying to refer them to services in the new area, and could lead to disengagement with services if there were waiting lists in the new area.

I had just one last month, since mid-April to last month, trying to engage with someone that wasn't - never clear, I'm going to live in the Inner West, I'm going to live in Newcastle, I'm going to live in Liverpool, I'm going to live in here, and he was referred to us. So here I am trying to make all these efforts to okay, what am I going to do to support this person. Just a couple of days of being released - and this is a lot of credit from the person at Justice that did as much as this person could to help the consumer to be - he said no. Had agreed to come to the Inner West and then a couple of days before being released said no, I'm going to go and live in the North Coast. (s1)

I think as it is across the sector and so many other places and organisation wait lists are really a huge barrier as well. Especially if you've just started working with somebody and they're eligible. They've signed a consent form but they've moved to family in the western suburbs or southern suburbs but their wait list is going to be a couple of months. So anything can happen. Yeah, so there might be, not on purpose, but disengagement from support services because we can't continue to work with them. But if they're not picked up straight away, that rapport established, that connection established, it very easily happens unfortunately. (s2)

As these accounts showed while it is important that the consumer lives somewhere in which they are comfortable and supported, consumers moving out of catchment is a serious problem because the relationships that effective support needs to be built on need to be developed all over again. It meant that services that had been tailored to an individual's need were not utilised and that there would likely be a gap in support which would be very detrimental to the individual's ongoing stability in the community.

Concluding thoughts and recommendations

While this study is small in scale the findings that it makes shine a light on significant problems impacting on transition support for individuals with mental ill-health exiting correctional facilities. We have identified six key recommendations which should be prioritised in order to move forward action in this area. These recommendations have been derived from the qualitative data, the data on C2C participants and the academic literature in this field.

Recommendations.

1. Development of a shared information system.

A common theme running through all interviews was poor information sharing – within organisations, between organisations in the same sector (e.g. jails and courts) and between organisations across different sectors who have a shared interest in the same individuals. The interview participants suggested that this could be addressed through the development of shared information systems. This is obviously a high-level recommendation which would involve commitment and significant funding and reorganisation. However the need for such a system is strong with evidence showing that a lack of key information at transition leads to poor outcomes including lack of engagement with services, recidivism and even death (as represented in Coroner data).

2. Development of a shared state-wide forensic care community.

Poor information systems was one aspect of poor communication. The other aspect was the lack of a shared community or network connecting people in these sectors. The development of a shared community of practice would help workers to identify that they actually have a role in thinking about all those areas involved in transition to community, not just the ones they have direct responsibility for. Noting this problem other jurisdictions internationally have developed a shared community of workers which extends beyond those working directly with forensic patients in a clinical role to all those working within the mental health, the courts and criminal justice systems. A good example of such a network is the Scottish Forensic Mental Health Services Managed Care Network (Forensic Network)<http://www.forensicnetwork.scot.nhs.uk/> The Forensic Network was developed in order to establish an educated and connected workforce to manage forensic mental health care and treatment, including transition support. It provides networking, training and has established care pathways and other administrative reforms. It works at both a state level and develops local projects to reform practice where needed.

3. Active development of local communities of practice.

Interagency forums or working groups are an easy way of establishing communities of practice at a local area and have been effective as part of the Partners in Recovery program more generally (Smith-Merry et al 2015). The main stumbling blocks to the operation of these forums are 1) the time commitment involved and 2) self-identification by staff or agencies of their association with a particular forum. The first block should be dealt with by ring fencing time within roles for networking. The second

should be dealt with through organisations pro-actively identifying staff with tangential roles and asking them to attend. Both of these blocks will only be dealt with if there is significant buy-in from senior administrators within all organisations involved (e.g. Justice Health, courts, parole, community mental health, PIR and NGOs working in the sector).

4. Development of an accommodation strategy for former inmates with mental ill-health.

Apart from the communication difficulties inherent in the system the biggest factor in poor transition related to accommodation. This was evident in both the qualitative interviews and the data on C2C clients. Transition-specific accommodation such as that provided by Rainbow Lodge is difficult to get in to but can provide important stability while individuals adjust to community living. More of these accommodation supports are necessary and should be better integrated with community mental health supports. The interviews showed that there was a lack of responsibility for accommodation and confusion about just whose responsibility accommodation was. There should be a named responsibility for overseeing accommodation for this group and targets for accommodation stability assessed. This will allow the extent of need to be determined and new services developed where need is identified.

5. In-reach and through-care as standard practice.

Our qualitative findings reported that both in-reach and through-care were viewed as being of significant benefit in maintaining stability for clients at release. In-reach is also established as a significant predictor in academic literature related both to transition from forensic care and from standard secure treatment. However for the C2C study in-reach only occurred for a small number of participants, indicating that this rarely takes place even when it is considered to be essential (as it was for the C2C group). As the qualitative data shows the reasons for this lack of in-reach are complex and result from poor information systems and poor inter-organisational and cross-organisational communication. There needs to be a commitment made to in-reach by all those involved in forensic care. This will only really happen if this group of inmates is prioritised at a policy level and their needs championed by key players such as the NSW Mental Health Commission.

6. Court hand-over to mental health when an individual released directly from a court hearing.

A significant gap in the system was identified in relation to individuals who have mental health needs being released without handover by courts. Courts do not routinely contact community mental health services or Justice Health to enable sufficient supports to be set up in the community for an individual exiting the criminal justice system by these means. The primary responsibility for this needs to be with the court system as it is not feasible for Justice Health or community mental health services to monitor information around court dates and release. This should also be considered in the development of the shared information systems recommended above.

Responsibility for action:

Apart from the recommendation relating to the establishment of local interagency working groups on forensic mental health these are all high-level recommendations and must therefore be committed to at a policy level. The kind of coordination needed to transform the system to make it work at even a basic level

to meet the needs of this group must be driven by a high level actor such as the NSW Mental Health Commission and action taken by the NSW State Government.

However local-area lobbying will be an important part of taking this forward. People with mental ill-health engaging with the criminal justice system are a group that are disempowered and marginalised within our community. They are left facing poor support because they have no voice – being doubly disadvantaged and stigmatised due to mental ill-health and association with the criminal justice system (and sometimes also drug and alcohol problems, intellectual disability and homelessness). They need others to take up their cause and hopefully C2C and this report will be taken seriously as the next step to doing that.

Appendix 1: Data collection sheet C2C client data

At referral	
1. Numbers from each referrer	
2. Numbers in each diagnostic category	
3. Numbers in each legal status category at release (eg. Community Treatment Order)	
4. Numbers referred to each Mental Health team	
5. Numbers in each accommodation type at time of release (eg. boarding house)	
6. Contact with family, friends, carer:	
7. Transfer of information was: good, average, poor. Details of information provided.	
8. Numbers who were seen by Partners In Recovery or Mental Health.	
9. Numbers who accepted Partners In Recovery	
10. Numbers who accepted Mental Health intervention	
11. Numbers who completed Honos.	
12. Numbers who completed K10.	

After week 1	
1. Numbers in each accommodation type	
2. Numbers with changes in accommodation.	
3. Numbers moved out of area.	
4. Numbers moved out of area for whom referral to out of area services was made.	
5. Numbers seen within 7 days by Mental Health team	
6. Numbers involved in other services (parole, PHAMS, drug and alcohol services, employment services, accommodation services)?	
7. Numbers who have made contact with each service	
8. Numbers with a GP?	

After 28 days	
1. Numbers in each accommodation type	

2. Numbers with changes in accommodation	.
3. Numbers moved out of area.	
4. Numbers moved out of area for whom referral to out of area services was made.	
5. Average number of face to face contacts for Mental Health team since release	
6. Numbers involved in other services (parole, PHAMS, drug and alcohol services, employment services, accommodation services)?	
7. Numbers who have made contact with each service.	
8. Numbers with a GP	
9. Any other comments about GP	
10. Numbers completed Honos.	
11. Numbers completed K10.	
12. Numbers who completed Yes survey	

Appendix 2: Interview questions qualitative interviews

1. Did you experience any barriers to getting the information you needed to effectively provide transition support for clients within the intervention?

If yes can you please describe these?

2. What sorts of client information might benefit you in providing transfer of care for your clients?

If you received such information, did you receive it in time to make effective use of it?

3. Do you have any suggestions about ways in which the transfer of information to your organisation could be improved?

4. What was your experience of referring individuals on to other services?

5. Do you have any suggestions about ways in which the transfer of information from your organisation to another service provider might be improved?

6. Did you experience any client related barriers to providing transition support (eg. client did not turn up to appointment, or was resistant to making contact with the services on offer, or had moved out of area).

7. [If relevant] Did you experience any institutional barriers to providing in-reach to clients prior to release?

If so, what were these barriers (ie insufficient time to establish a time for in-reach prior to release)?

8. [If relevant] If in-reach was established, were there any aspects of in-reach that made clients more or less likely to engage with the process?

9. [If relevant] If in-reach was established, did you experience any barriers to successfully establishing follow-up with these clients? (eg. client moved out of area, failed to show up to an appointment, information about release was not provided in a timely manner).

10. If the client moved out of Sydney Local Health District, what was your experience of passing on information to service providers in the new area?

11. Were there any aspects of your experience within this intervention that enhanced your ability to provide quality transfer of care services?

12. Do you have any suggestions for ways in which the care pathway from custody to the community for individual with a mental illness could be improved?

13. Did the experience of providing transfer of care within this intervention have any negative aspects for you such as increased workload or confusion over roles or responsibilities?

14. Did the experience of providing transfer of care within this intervention have any positive aspects for you such improved flow or relevant information between agencies?

15. Do you have anything else to add about your experience of providing transfer of care services within this intervention?

References.

- Angell, B., Matthews, E., Barringer, S., Watson, A., & Draine, J. (2014). Engagement processes in model programs for community reentry from prison for people with serious mental illness. *International Journal of Law and Psychiatry*, 37(4), 490-500.
- Anthony, W., Rogers, E., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39(2), 101-114.
- Ashcraft, L., & Anthony, W. (2011). Prisoners thrive with peer support training. *Behavioral Healthcare*, 31(8), 20-23.
- Australian Bureau of Statistics. (2016a). *4517.0 - Prisoners in Australia*. Retrieved from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0>
- Australian Bureau of Statistics. (2016b). *4517.0 - Prisoners in Australia*. Retrieved from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics~5>
- Baillargeon, J., Hoge, S., & Penn, J. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology*, 46(3-4), 361-375.
- Baldry, E. (2010). Women in transition: From prison to... *Current Issues in Criminal Justice*, 22(2), 253-267.
- Baldry, E. (2011). Navigating complex pathways: people with mental health disorders and cognitive disability in the criminal justice system in NSW. *HIV Australia*, 9(1), 35,44.
- Baldry, E., McDonnell, D., Maplestone, P., & Peeters, M. (2006). Ex-Prisoners, Homelessness and the State in Australia. *The Australian and New Zealand Journal of Criminology*, 39(1), 20-33.
- Bartlett, A. & McGauley, F. (2010) *Forensic Mental Health: Concepts, Systems and Practice*. Oxford: Oxford University Press.
- Binswanger, I., Stern, M., Deyo, R., Heagerty, P., Cheadle, A., Elmore, J., & Koepsell, T. (2007). Release from prison: A high risk of death for former inmates. *The New England Journal of Medicine*, 356, 157-165.
- Binswanger, I., Nowels, C., Corsi, K., Long, J., Booth, R., Kutner, J., & Steiner, J. (2011). "From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry*, 34, 249-255
- Buck, D., Brown, C., & Hickey, J. (2011). The jail inreach project: Linking homeless inmates who have mental illness with community health services *Psychiatric Services*, 62(2), 120-122.
- California Board of Corrections (2005). *Mentally Ill Offender Crime Reduction Grant Program: Overview of Findings*. Retrieved from: <http://sd15.senate.ca.gov/sites/sd15.senate.ca.gov/files/7b.pdf>
- California Department of Corrections and Rehabilitation (2016) *Division of Adult Parole Operations Mental Health Services Continuum Program Transitional Case Management Program*, California Department of Corrections and Rehabilitation. Retrieved from: <http://www.cdcr.ca.gov/Parole/Mental-Health-Services-Continuum-Program.html>
- Centre for Addiction and Mental Health (2013) *Mental Health and Criminal Justice Policy Framework*. PAHO/WHO Collaborating Centre. Retrieved online: https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/MH_Criminal_Justice_Policy_Framework.pdf

Colbert, A., Sekula, K., Zoucha, R., & Cohen, S. (2013). Health care needs of women immediately post-incarceration: a mixed methods study. *Public Health Nursing*, 30(5), 409-419.

State of Victoria (2016) *Transition Programs* State of Victoria Justice and Regulation Retrieved from: <http://www.corrections.vic.gov.au/home/release/transition+programs/>

Cuellar, A., & Cheema, J. (2012). As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws. *Health Affairs*, 31(5), 931-938.

Dennis, D., Lassiter, M., Connelly, W., & Lupfer, K. (2011). Helping adults who are homeless gain disability benefits: the SSI/SSDI Outreach, Access, and Recovery (SOAR) program. *Psychiatric Services*, 62(11), 1373-1376.

Dennis, D., Ware, D., & Steadman, H. (2014). Best practices for increasing access to SSI and SSDI on exit from criminal justice settings. *Psychiatric Services*, 65(9), 1081-1083.

Draine, J., & Herman, D. (2007). Critical time intervention for reentry from prison for people with mental illness. *Psychiatric Services*, 58(12), 1577-1581.

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33588 prisoners worldwide: systematic review and meta-regression analysis. *British Journal of Psychiatry*, 200, 364-373.

Giblin, Y., Kelly, A., Kelly, E., Kennedy, H., & Mohan, D. (2012). Reducing the use of seclusion for mental disorder in a prison: Implementing a high support unit in a prison using participant action research. *International Journal of Mental Health Systems*, 6(1).

Glowa-Kollisch, S., Andrade, K., Stazesky, T., Teixeira, P., Kaba, F., Macdonald, R., Rosner, Z., Selling, D., Parsons, A., & Venters, H. (2014). Data-driven human rights: Using the electronic health record to promote human rights in Jail. *Health and Human Rights Journal*, 16(1), 157-165.

Goldstein, E., Warner-Robbins, C., McClean, C., Macatula, L., & Conklin, R. (2009). A peer-driven mentoring case management community reentry model: an application for jails and prisons. *Family and Community Health*, 32(4), 309-13.

Hancock, N. Scanlan, J, Gillespie, J. Smith-Merry J. (2017, forthcoming) Partners in Recovery program evaluation: changes in unmet needs and recovery. *Australian Health Review*, In press, accepted April 2017.

Hartwell, S., Fisher, W., & Deng, X. (2009). The impact of regionalization on reentry service outcomes for individuals with severe mental illness. *Psychiatric Services*, 60(3), 394-397.

Held, M., Brown, C., Frost, L., Hickey, J., & Buck, D. (2012). Integrated primary and behavioral health care in patient-centered medical homes for jail releasees with mental illness. *Criminal Justice and Behavior*, 39(4), 533-551.

Howie, S. (2016) Mental health nurse in the police custody suite 24/7. Paper presented at the 4th World Congress on Integrated Care, 23rd to 25th November, 2016, Wellington New Zealand.

Iqbal, N., Rees, M., & Backer, C. (2014). Decision making, responsibility and accountability in community mental health teams. *Mental Health Practice*, 17(7), 26-28.

Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., Huckle, S., Parrott, J., Dunn, G., & Shaw, J. (2012). Continuity of care for recently released prisoners with mental illness: a pilot randomised controlled trial testing the feasibility of a Critical Time Intervention. *Epidemiology and Psychiatric Sciences*, 21(2), 187-193.

- Johnson, J., Schonbrun, Y., Peabody, M., Shefner, R., Fernandes, K., Rosen, R., & Zlotnick, C. (2014). Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges. *Journal of Behavioural Health Services and Research*, 42(4), 417-436.
- Jones, D., & Maynard, A. (2013). Suicide in recently released prisoners: a systematic review. *Mental Health Practice*, 17(3), 20-27
- Kariminia, A., Law, M., Butler, T., Levy, M., Corben, S., Kaldor J., Grant, L. (2007). Suicide risk among recently released prisoners in New South Wales, Australia. *Medical Journal of Australia*, 187(7), 387-390.
- Keers, R., Ullrich, S., DeStavola, B., & Coid, J. (2014). Association of Violence With Emergence of Persecutory Delusions in Untreated Schizophrenia. *American Journal of Psychiatry*, 171, 332-339.
- Kesten, K., Leavitt-Smith, E., Rau, D., Shelton, D., Zhang, W., Wagner, J., & Trestman, R. (2012). Recidivism rates among mentally ill inmates: Impact of the Connecticut offender reentry program. *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care*, 18(1), 20-28.
- Knoll, J. (2006). A tale of two crises: Mental health treatment in corrections. *Journal of Dual Diagnosis*, 3(1), 7-21.
- Kuehn, B. (2014). Criminal justice becomes front line for mental health care. *Journal of the American Medical Association*, 311(19), 1953-1954.
- Lee, C., Connolly, P. & Dietz, E. (2005). Forensic nurses' views regarding medications for inmates. *Journal of Psychosocial Nursing*, 43(6), 32-39.
- Lennox, C., Senior, J., King, C., Hassan, L., Clayton, R., Thornicroft, G., & Shaw, J. (2012). The management of released prisoners with severe and enduring mental illness. *Journal of Forensic Psychiatry and Psychology*, 23(1), 67-75.
- Lincoln, T., Kennedy, S., Tuthill, R., Roberts, C., Conklin, T., & Hammett, T. (2006). Facilitators and barriers to continuing healthcare after jail: A community-integrated program. *The Journal of Ambulatory Care Management*, 29(1), 2-16.
- Mallik-Kane, K., & Visher, C. (2008). *Health and Prisoner Reentry: How Physical, Mental and Substance Abuse Conditions Shape the Process of Reintegration*. Washington DC: Urban Institute.
- McKenna, B., Skipworth, J., Tapsell, R., Madell, D., Pillai, K., Simpson, A., Cavney, J., & Rouse, P. (2015). A prison mental health in-reach model informed by assertive community treatment principles: evaluation of its impact on planning during the pre-release period, community mental health service engagement and reoffending. *Criminal Behaviour and Mental Health*, 25, 429-439.
- NAAJA (2012) *Throughcare Project* North Australian Aboriginal Justice Agency Retrieved from: <http://www.naaaja.org.au/our-services/indigenous-throughcare-project/>
- Norton, E., Yoon, J., Domino, M., & Morrissey, P. (2006). Transitions between the public mental health system and jail for people with severe mental illness: A Markov analysis. *Health Economics*, 15(7), 719-733.
- Ogloff, J., Davis, M., Rivers, G. & Ross, S. (2006) *The Identification of Mental Disorders in the Criminal Justice System*. Centre for Forensic Behavioural Science: Monash University. Retrieved from: www.crg.aic.gov.au/reports/2006-ogloff.pdf
- Olley, M., Nicholls, T., & Brink, J. (2009). Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behavioral Sciences and the Law*, 27(5), 811-831.

Olson, H., & Schon, H. (2016). Reducing violence in forensic care – how does it resemble the domains of a recovery-oriented care? *Journal of Mental Health, early online*: <http://dx.doi.org/10.3109/09638237.2016.1139075>

Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw J. (2006). Suicide in recently released prisoners: A population-based cohort study. *Lancet*, 368(9530),119-23.

Prins, S. (2014). Prevalence of mental illnesses in U.S. state prisons: A systematic review. *Psychiatric Services*, 65(7), 862-872.

Sen, P., Exworthy T., & Forrester, A. (2014). Mental health care for foreign national prisoners in England and Wales. *Journal of Mental Health*, 23(6), 333-339.

Sirdifield, C. (2012). The prevalence of mental health disorders amongst offenders on probation: A literature review. *Journal of Mental Health*, 25(5): 485-498.

Smith-Merry, J., J. Gillespie, N. Hancock and I. Yen (2015) Doing mental health care integration: a qualitative study of a new work role, *International Journal of Mental Health Systems*. 9(32).

White, P. & Chant, D. (2006). The psychometric properties of a psychosis screen in a correctional setting. *International Journal of Law and Psychiatry*, 29(2), 137-144.

WHO (2013) *Mental Health Action Plan (2013-2020)* World Health Organization. Retrieved from: http://www.who.int/mental_health/action_plan_2013/en/

Wilson, A. (2013). How People with Serious Mental Illness Seek Help After Leaving Jail. *Qualitative Health Research*, 23(12), 1575-1590.

White, P. & Whiteford, H. (2006) Prisons: mental health institutions of the 21st century? *Medical Journal of Australia*, 185(6), 302-303.

Wolff, N. (2005). Community reintegration of prisoners with mental illness: A social investment perspective. *International Journal of Law and Psychiatry*, 28(1). 43-58.

Young, J., Arnold-Reed,D., Preen, D., Bulsara, M.,Lennox, N., & Kinner, S. (2015). Early primary care physician contact and health service utilisation in a large sample of recently released ex-prisoners in Australia: Prospective cohort study. *BMJ Open*, 5(6).