The International Journal of Psychosocial Rehabilitation
Volume 18, Number 2
July 2013– June 2014

Mind the Gap: Improving Transitions for Mentally Disordered Offenders Leaving Custodial Environments

Alison Pearsall (1,2)
Dr Dawn Edge (1)
Dr Mike Doyle (1,3)
Professor Jenny Shaw (1,2)

1-The University of Manchester - Manchester Academic Health Science Centre
Institute of Brain, Behaviour and Mental Health

2- Lancashire Care NHS Foundation Trust

3-Greater Manchester West Mental Health NHS Foundation Trust

Citation:
Pearsall A, Edge D, Doyle M & Shaw J(2014) Mind the Gap: Improving Transitions for Mentally Disordered Offenders Leaving Custodial Environments. ***International Journal of Psychosocial Rehabilitation. Vol 18(2)101-112***

Correspondence:
Alison Pearsall
Offender Health Research Network
Institute of Brain, Behaviour and Mental Health
Room 2.309, Jean McFarlane Building
Oxford Road
Manchester, M13 9PL UK
Email: alison.pearsall@postgrad.manchester.ac.uk

Funding Source: This research was supported by a NIHR clinical academic fellowship

Abstract

Topic:
Review of transitional care programmes in various health settings to determine the relevance of transitional case management for individuals with severe enduring mental illness released from custodial environments.

Purpose:
Transitions, such as discharge or transfer from one service to another or between levels of care can be problematic. In some health and social care sectors such as obstetrics, cardiology, and older age services; transitional care programmes have been introduced to improve continuity of care. Examination of the various forms of transitional care, availability of programmes and associated outcomes in a range of health contexts, could provide important lessons for improving services for mental health service users leaving custodial settings.
Sources Used:
Published health, social care and criminal justice literature
Conclusion and Implications for Practice:
Poor transitional care is evident across health sectors and service domains. The consequences for service users can be far reaching such as interrupted, duplicated or omitted interventions, which may have a detrimental or damaging impact on their health and wellbeing. The resultant effects include increased use of emergency care, readmission to hospital and in extreme cases, death. Recent health policies have substantiated the importance of transitional care programmes. However, these are yet to be fully realised within mental health settings. Transitional case management may optimise offenders' engagement with mental health services and provide more effective and sustainable strategies for managing their complex health and social care needs in the community.
Keywords - 'Transitions', 'offenders', 'custody', 'community', 'release', 'continuity of care'

Introduction

Recent healthcare policy recommended integrated working between health and social services to ensure the safe transfer of service users within and between services (DH 2009). The benefits of effective transitional care are improvements to individuals' health, care and support alongside efficient use of resources (Humphries & Curry, 2011). However, despite movement between care providers being customary, limited transitional care programmes exist. Consequently, transfer remains the most vulnerable part of the service user care pathway (Royal Pharmaceutical Society, 2010).

This paper introduces the concept of transitional care, before highlighting the availability and the consequences of its absence, particularly for those with complex needs. The relevance for individuals leaving custodial environments who require continued mental health support is discussed. Finally, a case management programme designed to improve transitional care is described along with its implications for national health policy.

The nature of the problem

Individuals requiring health and social care frequently receive care in diverse locations and from a variety of health professionals within primary, secondary and tertiary services. Each service user has unique personal circumstances, specific symptoms and care objectives. Therefore effective communication between health professionals in each setting is essential to meet care expectations. Each health professional, service or care provider represents a unit of care and a boundary or barrier for the service user to gain access. Without effective information exchange between professionals, the flow and overall quality of care can be interrupted or jeopardised.

Defining transitional care

Kralik et al (2005) highlighted the lack of consensus about definition, nature and components of transitional care. They described widespread disagreement about whether transitional care was linear or cyclical and whether there was an obvious beginning and end point. Chick and Meleis (1986) seminal work defined care transitions as; 'passage from one life phase, condition, or status to another'. Concurring with this, Currie and Watterson said transitions were 'the purposeful planned movement of patients with chronic physical or medical conditions from one health service to another, or from hospital to residential care', (Currie & Watterson, 2008, p.8).

Transitional care involves a set of actions or services designed to promote safe, timely and co-ordinated transfer from one level of care to another (in the same location) or to more than one location involving continuity and coordination (Honsleman, 2008, p.13). Coleman contends transitional care is complicated involving several key stages including hospital care, discharge, follow up and support services (Coleman, 2003). Coleman proposed transitional care should

cover admission, transfer and discharge procedures (Coleman & Boult, 2003).

Despite the availability of professionals at different stages of transitional care, gaps remain that adversely affect the health and safety of service users. Naylor suggests gaps are due to incomplete information transfer, poor communication and limited access to appropriate aftercare (Naylor, 2003).

Consequences of gaps in transitional care

The consequences of poor transitional care can be extreme. Lafasco reported one in ten seriously ill service users die as a result of inadequate transitional care (Lafasco, 2013). During transitions, service users are at increased risk of medical error, with nearly one quarter experiencing adverse events, most commonly medication related, half of which are preventable (Kripalani, 2007).

Honsleman (2008) found poor transitional care led to serious complications for service users including re-admission and increased emergency treatment. Poor outcomes may be attributable to duplicated, omitted or incomplete care provision (Honsleman, 2008, p.53). Similarly, Fulmer articulated increased physical, psychological and functional problems for service users as a result of inadequate transitional care (Fulmer et al, 2007, p. 207).

Despite these risks, health care policy does not promote practitioners to provide care to individuals throughout the care pathway. A conventional approach is favoured where practitioners remain situated in clinical areas and people attend for pre-arranged appointments. Arguably, this facilitates the development of specialist knowledge but expertise is department rather than pathway based. Consequently information does not follow the person leading to multiple and disparate case note recordings within various clinical settings.

Improved transitional care

Progress in transitional care is evident in health services but more limited within mental health settings (Reynolds et al, 2004). In other clinical areas, enhanced service user outcomes have been reported. For example, in pain management, rehabilitative programmes eased transitions between hospital and community which generated improved outcomes (Brook et al, 2011). Similarly, Naylor et al (2004) revealed positive health outcomes in cardiac care with reduced hospitalisation occurring in those receiving transitional care (Naylor et al, 2004). In cancer care, transitional care programmes increased the support provided to care givers improving relationships and family functioning (Pinquart et al, 2003, p. 112).

Advanced communication and information sharing is the foundation of transitional care programmes. Effective information sharing in paediatric diabetes services during transitions positively impacted on individuals' glycaemic control (Orr et al, 1996). Similarly, in orthopaedic care the introduction of a checklist for transitional care planning improved communication between service users and staff (Hadjistavropoulos et al, 2009, p. 183).

Checklists may be beneficial in some specialties but for service users with complex needs like older adults, a 'transitional manager' or dedicated discharge planner may be required to prevent re-admission and excessive use of emergency services (Rich et al, 1995). The extent and consequences of poor transitions for older people are some of the most extreme (Naylor & Keating, 2008) including temporary disability, psychological stress, and sometimes death (The National Transitions of Care Coalition, 2008). Crotty (2005) emphasised the importance of effective discharge planning (Crotty et al, 2005, p 1110) and continuity of care in the community (Thraen et al, 2011).

People with mental illness released from custodial environments have similar issues to older people leaving hospital, in terms of the complexity of health and social care needs limiting successful community resettlement. To improve care transitions, a shift in emphasis from provider to service user centred care is required. Often service users, families and informal care-givers are the only link between providers and care settings indicating that transitional care planning must centre on the individual (Gibson et al, 2012).

Transitional care within mental health settings

In spite of continuity of care being defined as essential (Crawford et al, 2004) transitional care is inadequate following discharge from inpatient treatment (Dorwat et al, 1994) elevating service users' vulnerability to relapse, suicide and violence (Appleby et al, 2006; DH, 2009; Doyle et al, 2012; Goldacre, 1993). Many individuals struggle to cope with reduced levels of support, isolation and resumed self-care (Miguel et al, 2011). Rose found discontinuity of care on discharge led to unmet service user needs in the community (Rose et al, 2007).

Developing awareness of the consequences of poor transitional care has improved discharge management, for example, through assertive outreach or case management (Burns et al, 2007). Assertive outreach was established to promote engagement in people with mental illness (Marshall & Lockwood, 2004) and was found to reduce the likelihood of relapse and rehospitalisation (Marshall & Lockwood, 1998). Similarly, other studies have demonstrated benefits by case management (Burns et al, 2001; Mueser et al, 1998; Rosen et al, 2007), particularly for people with complex mental health problems and significant health and social needs.

The New Horizons mental health strategy document outlined effective discharge planning to facilitate safe and timely discharge. In the UK, Crisis Resolution Home Treatment (CRHT) services support people following discharge from acute inpatient care by providing rapid follow up in the community. The remit also provides home support, alternatives to hospital and assessment for inpatient treatment (Sainsbury Centre for Mental Health, 2006). Thus, support during transitions to and from hospital is available for individuals eligible for CRHT.

Transitional care for people with mental health problems in the criminal justice system

Offenders with mental health problems are socially disadvantaged with complex needs (Durcan & Corner, 2012; Farrell & Marsden, 2005). Factors related to offending including poor education, unemployment, housing, debts, substance misuse and limited family networks (Social Exclusion Unit, 2002) are also synonymous with mental ill-health (Bonta, et al, 1998; Murali & Oyebode, 2004). Despite recognition of health and social needs, critical information is often not conveyed to community mental health teams prior to prison release (Miguel et al, 2011), limiting effective community care (Caldas, 2011, p. 5).

Mental illness is prevalent throughout the offender care pathway including at arrest, court, remand, during sentence and on release from prison (Ogloff et al, 2007). McKinnon and Grubin (2010) reported high levels of morbidity among arrestees in police custody with systematic failures in detection of mental health problems, substance misuse and social problems. Other studies have similarly reported high prevalence and low detection of mental illness (Gudjonsson et al, 1993; Phillips & Brown, 1998; Steadman et al, 2000). Significant levels of mental illness exists among defendants at court (Joseph & Potter, 1993; Shaw, 1999), but limited identification means limited opportunities for early engagement into services, increasing relapse and likelihood of imprisonment or hospital admission (Durcan, 2008).

Studies report higher rates of mental illness in prisoners compared to the general public (Birmingham et al, 1996; Singleton et al 1998; Fazel & Danesh, 2002) especially among remand prisoners (Birmingham, 1996; Brooke et al, 1996; Gavin et al, 2003; Prins, 1995). Nurse et al (2003) hypothesised that higher rates in remand prisoners could be due to anxiety about facing the future (for example, appearing in court, being found guilty), the effect of imprisonment (such as, first experience of prison), and stresses on the family (including fear of reprisals, financial pressures).

Communication of mental illness between police, court and prison settings is hindered by separate systems and procedures (The Sentencing Project, 2002). National Association of Care and Resettlement of Offenders (NACRO, 2007) and Revolving Doors (2006) raised concern about poor continuity of care for individuals with mental health problems leaving prison. Programmes to link released prisoners with appropriate health and social care are impeded

by limited integrated working, widespread geographical locations and absences of inter-agency policy directives (Gaes et al, 2002; Raynor, 2007). Repper (2008) argues for the provision of appropriate transitional care (Repper, 2008, p.110) that is comprehensive and commences prior to release (Petersilla, 2003, p.173). Similarly, Lord Bradley proposed “wherever discharge or release occurs, it is important to ensure that responsibility for care is passed on to the relevant services, and that they are engaged well in advance of discharge (Bradley, 2009, p.114).
The implications of inadequate transition planning are significant including increased risk of suicide, relapse, hospitalisation, re-arrest and imprisonment (Draine & Solomon, 1994; Keil et al, 2008). Many individuals come from disadvantaged communities and similarly return (Lynch, 2006) with multiple problems including mental health, substance misuse, poor educational attainment and limited employment skills making resettlement more difficult. High numbers of people with mental health problems ‘fall through the gaps’ in the community and become neither the responsibility of mental health or criminal justice services (Harris, 1999) resulting in inconsistent interventions, poor communication and limited clinical outcomes. Consequently, many resort to using health services in a crisis-driven way, with high use of emergency services (McGilloway 2004; Jackson, 2005). Such contact is uneconomic, provides poorer long term outcomes, limited health promotion and inadequate community support (Singleton, 1998). Osher proposed an integrated framework may reduce duplication, maximise resource availability, information sharing, care co-ordination and opportunities for therapeutic or restorative community work (Osher et al, 2003). They highlight the need for intensive, time-limited interventions that take account of specific vulnerabilities during initial release, provide consistent support which is reduced as the person forges links in the community (Pickup, 2011, p. 2). However, most support programmes focus on reducing reoffending without incorporation of social support such as housing, finance, employment, education and training and improved links with families. Yet each of these factors can have a significant impact on re-offending (SEU, 2002). Blackburn (2004) highlighted the dichotomy of ‘offence focused’ versus ‘offender focused’ support and suggested amalgamation of both approaches was most effective in treating offenders with mental illness (SEU, 2002).

A range of re-entry programmes exist around drug rehabilitation (Friedmann, 2009; Knight et al, 1999), education and employment (Adams et al, 1994; Turner and Petersilia, 1996), specialized housing (Lowencamp & Latessa 2004), mentoring schemes (Jucovy, 2006) and building family ties (Shanahan & Villalobo Agundelo, 2011). Theurer highlighted the importance of support programmes combining mental health and substance misuse treatment, crisis support, housing and active case management with frequent contact in home settings (Theurer and Lovell, 2008). One such programme which incorporates all these elements is Critical Time Intervention (CTI).

Critical Time Intervention (CTI) is a variant of Assertive Community Treatment emphasising time-limited, intensive case management at critical points, such as release from prison or hospital. The purpose of CTI is to establish a stable support network in the community, forging effective links with local services including housing and health intentions for people who are additionally vulnerable due to limited informal networks. CTI was developed collaboratively by mental health clinicians and researchers to support homeless people with severe mental illness (SMI) released from hospital. CTI promotes continuity of care during transitions, by effectively linking service users to community services. The aim is to expand supportive networks in the community, including family, friends and services (Draine & Herman, 2007).

There are similarities between the original study population and offenders with mental health problems in respect of levels of disengagement with services (Susser et al, 1997; Durcan & Knowles, 2006). In 2007, CTI was adapted for mentally ill prisoners due to be released (Lennox et al, 2012). The feasibility study aimed to see if CTI effectively connected prisoners with social, clinical, housing and welfare services in the first few weeks after leaving prison. The pilot randomised controlled trial was conducted at three prison sites. Sixty prisoners were randomised to either CTI or treatment as usual (TAU) and 23 were followed up. At follow up, a higher proportion of the CTI group were involved with services in comparison to the TAU group. CTI prisoners were significantly more likely to be receiving medication, and be registered with a GP than those receiving TAU. Results suggest continuity of care for prisoners with SMI can be improved through identification of needs prior to release, and by assisting effective engagement with appropriate community agencies.

Effective transitional care is needed to facilitate service users moving in and between services to avoid discontinuity of care and adverse events. Transitional care is needed particularly for individuals with complex health problems requiring co-ordinated input from one or more service providers to ensure consistent delivery of care. CTI has demonstrated improved engagement, reduction in psychotic symptoms (Herman et al, 2000) and high levels of service user and staff satisfaction (Lennox et al, 2012) and may have potential to improve transitional care for client groups with complex needs. CTI is not designed to be a permanent support system, therefore discouraging the formation of service dependency. Significantly, CTI supports the principles of recovery as the intensity of support reduces gradually (to exit) as the person regains independence, generating considerable longer term cost savings (Jones et al, 2003). The development of evidence based interventions such as CTI for offenders should have a significant public health impact, directly influencing service use and possibly reducing re-offending rates (NACRO, 2007; Citizens Advice Bureau, 2007).

Conclusion

Transitional care has become an important focus for health policy with calls for generic, cross-specialty developments, since discontinuity of care represents common challenges in all services and specialities (McDonagh & Viner, 2006). Transitional care is particularly important for people experiencing serious or chronic illness including mental illness; however, useful initiatives such as CTI have not been integrated within routine care systems.

People in the criminal justice system with mental health problems need transitional care before release to ensure receipt of a range of health and social support to optimise resettlement. Offenders with mental health problems may be vulnerable to many issues including recidivism, instability, poor health and well-being outcomes, without intensive intervention (Loveland & Boyle, 2007). Yet many have difficulty accessing and maintaining engagement with mental health and criminal justice agencies (McGilloway et al, 2004).

Critical time intervention (CTI) has generated positive results when applied to pre-release prisoners (Lennox et al, 2012), and homeless populations with SMI (Susser et al, 1997), demonstrating its potential transferability among complex service user groups. This paper has illuminated various aspects of discontinuity of care and emphasised the need for better transitional services for people released from custodial care. Future research should consider the benefits in terms of financial and societal costs, as CTI could be beneficial by engaging people at an earlier stage to reduce risk of relapse and recidivism, while preventing unnecessary waste in health, police and prison resources.

References

Adams, K, Bennet, KJ, Flanagan, TJ, Marquart, JW, Cuvelier, SJ, Fritsch, E, Gerber, J, Longmire, D.R, Burton, VS. Jr. (1994), Large-scale multidimensional test of the effect of prison education programs on offenders' behaviour. The Prison Journal, 74 (4), p.433-449

Appleby L, Shaw J, Kapur, N, Windfuhr, K. et al. (2006) Avoidable Deaths: Five Year Report by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. University of Manchester, published online 2006 (http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths full_report.pdf)

Birmingham, L., Mason, D. & Grubin, D. (1996), Prevalence of mental disorder in remand prisoners: consecutive case study. BMJ, 313, 1521-1524.

Blackburn, R. (2004). 'What works' with mentally disordered offenders. Psychology, Crime and Law, 10(3), p.297-308.
Bonta, J, Law, M, Hanson, K, (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. Psychological Bulletin, 128, p.123-142.

Brabbins, C.J, Travers, R.F, (1994). Mental disorder amongst defendants in Liverpool magistrates' court. Medicine, Science, and Law, 34, p.279-283.

Bradley K, (2009), Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: DoH.

Brinded, P.M.J, Simpson, A.I.F, Laidlaw, T.M, Fairley, N, Malcolm, F, (2001). Prevalence of psychiatric disorders in New Zealand prisons: A national study. Australian and New Zealand Journal of Psychiatry, 35, p.166-173.
Brook P, Connell J, Pickering T, (2011), Oxford Handbook of Pain Management

Brooke D, Taylor C, Gunn J, Maden A (1996), Point prevalence of mental disorder in unconvicted male prisoners in England and Wales. British Medical Journal, Vol.313, pp.1524-1527

Brown, D, Ellis, T, Larcombe, K, (1992),Changing the code:police detention under the Revised PACE Codes of Practice. HO Research Study 129. London:HMSO

Bruton L, Keil J, (2006), Islington Neighbourhood Link-Worker Scheme:Assessing the need. London: Revolving Doors Agency

Burns T, Fioritt A, Holloway, F, Malm U, Rossler W, (2001), Case Management and Assertive Community Treatment in Europe Psychiatric Services, Vol. 52 No. 5, pp.631-636

Caldas J, Killaspy L, (2011), Long term mental healthcare for people with severe mental disorder, European Union Publication, p. 5.
Chick, N, & Meleis, AI, (1986) Transitions: a nursing concern. In P.L. Chinn (Ed.), Nursing research methodology, (p. 237-257).

Coleman, EA, (2003), Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs, Journal of the American Geriatrics Society, 51, p. 549-55.

Coleman, E A, Boult C, et al. (2003), Improving the quality of transitional care for persons with complex care needs, Journal of the American Geriatrics Society 51, p.556-7.

Crawford M, De Jonge E, Freeman GK, Weaver, (2004), Providing continuity of care for people with severe mental illnesses, Social Psychiatry Psychiatric Epidemiology, 39, p.265-272.

Crawley S (2005), Surviving prison experience: imprisonment and elderly men, Prison Service Journal.
Crotty M, Whitehead HC, Wundke R, Giles L, Tovim D, Phillps P, (2005), Transitional care facility for patients in hospitals awaiting a long term care bed, BMJ, 331, p.1110.

Currie VL, Watterson L, (2008), Improving the safe transfer of care: a quality improvement initiative: Final Report, Royal College of Nursing

Department of Health, (2009), New Horizons: Towards a Shared Vision for Mental Health. Consultation, Department of Health: London

Department of Health, (2009), Transforming community services: enabling new patterns of provision. Gateway reference 10850, London: DH.

Department of Health, (2011), No health without mental health: A cross government mental health outcomes strategy for people of all ages. London: Department of Health.

Department of health and aging, (2011), flexible aged care: transitional care program, Government of Australia: retrieved online from: www.health.gov.au/internet/main/publishing.nsf/Content/ageing-policy-transition.htm

Dorwat RA, Howard CW. (1994). A national study of transitional health services in mental health, 84(8). American journal of public health, (84) 8, p. 1229-1244

Dowell, D A, Klein, C, Krichmar, C. (1985). Evaluation of a halfway house, Journal of Criminal Justice, 13, p.217-226.

Doyle, M. and Dolan, M. (2006), Predicting community violence from patients discharged frommental health services. British Journal of Psychiatry, 189, p.520-526.

Doyle, M, Carter, S, Shaw, J. and Dolan, M. (2012) Predicting community violence from patients discharged from acute mental health units in England. Social Psychiatry Psychiatric Epidemiology, 47, p.627–637.

Draine, J, Solomon, P, Meyerson, A (1994), Predictors of re-incarceration among patients who received psychiatric services in jail. Hospital and Community Psychiatry, 45(2), p.163-167.
Draine J, Herman D, (2007), Critical Time Intervention for reentry from prison for persons with mental illness. Psychiatric Services, 58:1577-1581

Durcan G, Knowles K, (2006) Policy Paper 5: London's Prison Mental Health Services: A review. London: The Sainsbury Centre for Mental Health

Durcan, G. (2008) From the Inside: Experiences of prison mental health care. London: Sainsbury Centre for Mental Health.
Durcan M, Corner J, (2012), Severe and Multiple Disadvantage: A Review of Key Facts, Lankelly Chase Foundation
Edgar K, Rickford D, (2009), Too Little Too Late: an independent review of unmet mental health need in prison, Prison Reform Trust

Farrell M, Marsden J, (2005), Drug-related mortality among newly-released offenders 1998-2000. London:HO 40/05
Fazel S, Danesh J, (2002), Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. Lancet Vol.359, (9306), pp.545-550

Friedmann PD, Rhodes AG, Taxman FS, (2009), Collaborative behavioural management: Integration and intensification of parole and outpatient addiction treatment services in the Step'n Out Study, Journal of Experimental Criminology, 5(3), p.227-244.
Fulmer T, Foreman M, Walker M, (2007), Critical care nursing of the elderly, Springer Publishing Company, p. 207.
Fulmer, T, Mezey, M, Bottrell, M, (2008), "Geriatric Resource Nurse (GRN) Model"

Gaes G, Kendig, N (2002), The Skill Sets and Health Care Needs of Released Offenders, Federal Bureau of Prisons
Gavin, N, Parsons, S, Grubin, D, (2003). Reception screening and mental health needs assessment in a male remand prison. Psychiatric Bulletin, 27, p.251-253

Gibson MJ, Kelly KA, Kaplan AK, (2012), Family Care Giving and Transitional Care: A Critical Review, Family Care Giver Alliance, National Centre on Care Giving

Goldacre M, Seagroatt V, Hawton K, (1993), Suicide after discharge from psychiatric inpatient care, Lancet, 342; 8866, p.283-286
Gudjonsson G, Clare I, Rutter S, Pearse J, Pearse J, (1993), Persons at risk during interviews in police custody:the identification of vulnerabilities. Royal Commission of Criminal Justice, Research Study 12. London: HMSO
Gunn J, Maden A, Swinton M, (1991), Mentally Disordered Prisoners, London, Home Office

Hadjistavropoulos H, Garratt, S, Janzen JA, Bourgaault-Fagnou MD, Spice K, (2009), Development and evaluation of a Continuity of Care Checklist for improving orthopaedic patient discharge from hospital, Journal of Orthopaedic Nursing 13, 183–193

Haines, (1990), After-care services for released prisoners, a review of literature: University of Cambridge: Institute of Criminology
Halasyamani L, Kripalani S, Coleman E, Schnniper J, Walraven C, Torcson P, Bookwalter P, Budnitz T, Mannig D, (2006), Transitional care for hospital elderly patients: development of a discharge checklist for hospitals, Journal of Hospital Medicines: 1, p. 354-60.

Harris R, (1999), Mental disorder and social order: underlying themes in crime management, in D. Webb and R. Harris (eds) Mentally Disordered Offenders: Managing People who Nobody Knows. London: Routledge

Herman, D., Opler, L., Felix, A, Valencia, E., Wyatt, R & Susser, E. (2000), Critical time intervention: Impact on psychiatric symptoms. Journal of Nervous and Mental Disease, 188(3), 135–140

Herman D, Conover S, Felix A, Nakagawa A, Mills D, (2007), Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups, Journal of Primary Prevention, 28:295–312

Hiller, ML, Knight, K, Simpson, DD, (1999) Prison-based substance abuse treatment, residential aftercare and recidivism, Addiction, 94 (6), p.833-842

Honsleman SC, (2008), Access and utilization of transitional care services by the elderly according to payer source, ProQuest, p. 13-53.

Humphries R, Curry N, (2011) Integrating health and social care. Where next? London: The Kings Fund

Jackson, C, (2005), Forgotten, not gone, Mental Health Today, June 2005, p.12-13

Jones K, Colson P, Holter M, Lin S, Valencia E., Susser E, et al., (2003), Cost-effectiveness of critical time intervention to reduce homelessness among persons with mental illness, Psychiatric Services, Vol.54, (6), pp.884–890

Joseph P, Potter M, (1993a), Diversion from custody: Psychiatric assessment at the magistrates' court. British Journal of Psychiatry, 162: 325-330

Joseph P, Potter M, (1993b), Diversion from custody: Effect on hospital and prison recourses. British Journal of Psychiatry, 162: 330-334

Jucovy L, (2006), Just Out: Early Lessons from the Ready4Work Prisoner Re-entry Initiative, Office of Justice Programmes
Kasprow W, Rosenheck R, (2007), Outcomes of critical time intervention case management of homeless veterans after psychiatric hospitalization. Psychiatric Services 58:929–935

Keil J, Bruton L, Thomas S, Samele, (2008), On the Outside: continuity of care for people leaving prison, Sainsbury Centre for Mental Health
Knight, K, Simpson, DD, Hiller, M.L, (1999), Three-year re-incarceration outcomes for in-prison therapeutic community treatment in Texas. The Prison Journal, 79, p.337-351.

Kralik D, Visentin K, Loon A, (2005), Integrative Literature Reviews and Meta-Analyses: Transition: a literature review, The Authors, Journal compilation, Blackwell publishing.

Kripalani, S, Jackson AT, Schnipper JL, Coleman EA, (2007), Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists, Society of Hospital Medicine, p.314-323

Lamb HR, Weinberger LE, Gross BH, (1999), Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review. Psychiatric Services, 50, p.907–913.

Lafasco V, (2010), An introduction of transitional care, east side council on the aging: retrieved online from: http://www.escota.info/articles/full_article/an-introduction-to-transitional-care/
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

Loveland D, Boyle M (2007), Intensive Case Management as a Jail Diversion Program for People with a Serious Mental Illness: A Review of the Literature, International Journal of Offender Therapy and Comparative Criminology 51, Number 2:130-146

Lovell D, Gagliardi G, Peterson P, (2002), Recidivism and use of services among persons with mental illness after release from prison. Psychiatric Services, Oct; 53 (10), pp.1290-6

Lowerkamp C, Latessa E, (2004), Increasing the effectiveness of Correctional Programming through the Risk Principle: Identifying Offenders for Residential Placement, Correctional Programming and Risk, 4 (1), p. 501-528. Accessed 12/12/2013 http://www.uc.edu/content/dam/uc/ccjr/docs/articles/RiskPrinciple.pdf

Lynch JP, Sabol WJ, (2001), Prisoner Reentry in Perspective, Crime Policy Report; vol. 3. Washington, DC: Urban Institute Justice Policy Centre

McDonagh JE, Viner R. (2006). Lost in transition? Between paediatric and adult services, British Medical Journal 332: p.435-436.

McGilloway S, Donnelly M, (2004), Mental illness in the UK Criminal Justice System: A police liaison scheme for MDO's in Belfast. J Mental Health;13,263-275

McKinnon I, Grubin D, (2010), Health screening in police custody, Journal of Forensic Legal Medicine, 17(4):209-12

Marshall M, Gray A, Lockwood A, et al (1996), Case management for people with severe mental disorders. In Schizophrenia Module of the Cochrane Database of Systematic Reviews (eds C. Adams, C. Anderson & J. De Jesus Mari). London: The Cochrane Library, BMJ Publishing Group

Marshall M, Gray A, Lockwood A, Green R, (1998), Case Management for People With Severe Mental Disorders (a Cochrane review). Oxford, England

Marshall, M, Lockwood, A, (2004) Early intervention for psychosis, Cochrane Library, Issue 2. Chichester: John Wiley & Sons.

Meehan J, Kapur N, Hunt IM, Turnbull P, Robinson J, Bickley H, Parsons R, Flynn S, Burns J, Amos T, Shaw J and Appleby L, (2006), Suicide in mental health inpatients and within three months of discharge: National Clinical Survey, British Journal of Psychiatry, 188, p.129-134

Miguel J, de Almeida S, Killapsy H, (2011), Long term mental health care for people with severe mental disorder, European Union.

Mueser K, Bond G, Drake R, Resnick S, (1998), Models of community care for severe mental illness: A review of research on case management. Schizophrenia Bulletin, 24, p.37-74.

Murali V, Oyebode F, (2004), Poverty, social inequality and mental health, Advances in Psychiatric Treatment, 10, p.216-224

NACRO (2006),Liaison and diversion for Mentally Disordered Offender's. London: NACRO

NACRO (2007), Effective mental healthcare for offenders:the need for a fresh approach London: NACRO
National Transitions of Care Coalition, (2008), Improving Transitions of Care: The Vision of the National Transitions of Care Coalition, Policy Paper, May 2008.

Naylor M, (2000) A Decade of Transitional Care Research with Vulnerable Elders, Journal of Cardiovascular Nursing: 14; 3, p.1-14

Naylor MD, (2003), Nursing intervention research and quality of care: influencing the future of healthcare, Nursing Research, 52(60). p.380-385.

Naylor MD, Brooten DA, Campbell RL, Schwartz JS, (2004), Transitional care of older adults hospitalised with heart failure: a randomized controlled trial, (52)5, p.675-84.

Naylor M, Keating SA, (2008), Transitional care: moving patients from one care setting to another, American Journal of Nursing, 108 (9), p.58-63

Nelson, G, Aubry,T, Lafrance, A, (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless, American Journal of Orthopsychiatry, 77 (3), p.350-361.
Nurse J, Woodcock P, Ormsby J, (2003), Influence of environmental factors on mental health within prisons: focus group study. BMJ, 327, p.480-485

Ogloff JRP, Rivers G, Ross S, (2007), Identification of Mental Disorders in the Criminal Justice System: Criminology Research Council Consultancy, Centre for Forensic Behavioural Science, Monash University

Orr DP, Fineberg NS, Gray DL, (1996), Glycemic control and transfer of health care among adolescents with insulin dependent diabetes mellitus, Journal of Adolescent Health, 18, p.44-47

Osher F, Steadman HJ, Barr, H (2003), A Best Practice Approach to Community Reentry From Jails for Inmates With Co-Occurring Disorders: The APIC Model, Crime & Delinquency, Vol. 49 No. 1, January 2003.

Petersilla J, (2003), When prisoners come home: payroll and prisoner's re-entry, Oxford University Press, p.173.

Phillips C, Brown D, (1998), Entry into the CJS:survey of police arrests & their outcomes. HO Research Study 185. London: HMSO

Pickup S, (2011), Making the difference: the role of adult social care services in supporting vulnerable offenders, Prison Reform Trust, p. 2-12.

Pinquart M, Suransen S, (2003), Association of stresses and uplift of care-giving of caregiver burden with depressed moods, Journal of Gerontology, 58, p.112-128.

Prins, H, (1995), Offenders, Deviants or Patients?, 2nd edition, London: Routledge.

Prison Reform Trust, (2012), Bromley Briefings Prison Fact file

Raynor P, Mclvor G, (2007), Developments in social work with offenders, Jessica Kingsley publisher, p. 92.

Reynolds W, Lauder W, Sharkey S, Maciver S, Veitch T, Cameron D, (2004), The effects of a transitional discharge model for psychiatric patients, Journal of Psychiatric Mental Health Nursing, 11(1): p.82-8.

Repper J, Brooker C, (2008), Mental Health: from policy to practice, Elsevier health Science

Revolving Doors, (2002), Where Do They Go? Mental Health, Housing and Leaving Prison, London: Revolving Doors Agency

Revolving Doors Agency (2006), Development programme for extending offender healthcare support, London:Revolving Doors Agency

Rich MW, (1995), A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. New England Journal of Medicine, 333(18), p.1190–5

Robertson G, Pearson R, Gibb R, (1996) The entry of mentally disordered people to the Criminal Justice System, British Journal of Psychiatry, 169, p.172-80

Rose LE, Gerson L, Carbo C, (2007), Transitional care for seriously mentally ill patients, John Hopkins University, 21, p.297-308.

Rose, D, Knight, M, Fleischmann, P, et al (2007) Scoping Study: Public and Media Perceptions of Risk to General Public Posed by Individuals with Mental Ill Health, Service User Research Enterprise (SURE), King's College London.

Rosen A, Mueser KT, Teesson M (2007), Assertive community treatment-issues from scientific and clinical literature with implications for practice. Journal of Rehabilitation Research and Development, 47, p.813-825

Royal Pharmaceutical Society, (2010), Keeping patients safe when they transfer between care providers – getting the medicines right: Good practice guidance for healthcare professions.

Sainsbury Centre for Mental Health (2006), Crisis Resolution and Home Treatment: A Practical Guide, Sainsbury Centre for Mental Health

Shanahan R, Villalobos Agundelo S, (2011), Close to Home: Building Family Support for People Leaving Jail, Vera Institute of Justice

Shaw J, Creed F, Price J, Huxley P, Tomenson B, (1999), Prevalence & detection of serious psychiatric disorder in defendants attending court. Lancet, 353 (9158), p.1053-6

Singleton N, Meltzer H, Gatward R, (1998) Psychiatric Morbidity Amongst Prisoners in England and Wales. London: Office for National Statistics: Stationery Office.

Social Exclusion Unit, (2002), Reducing re-offending by ex-prisoners, London: Cabinet Office.

Steadman H,, Deane M, Borum R, Morrissey J, (2000), Comparing outcomes of major models of police responses to mental health emergencies, Psychiatric Services, Vol.51 (5), pp.645-649

Susser E, Valencia, E, Conover S, Felix A, Wei-Yann T, Wyatt R, (1997), Preventing recurrent homelessness among mentally ill men: A "critical time" intervention after discharge from shelter. American Journal of Public Health, 87, p.256-262

The Sentencing Project, (2002), Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription, The Sentencing Project.

Thraen I, Bair B, Mullin S, Weir CR, (2011), Characterizing information transfer by using a joint cognitive systems model to improve continuity of care in the aged, International Journal of Medical Informatics, 81, p.435-441

Theurer, G, & Lovell, D, (2008). Recidivism of offenders with mental illness released from prison to an intensive community treatment program. Journal of Offender Rehabilitation, *47*(4), 385-406.

Turner, S, Petersilia, J. (1996).Work release in Washington: Effects on recidivism and corrections costs. The Prison Journal, 76 (2), p.138-164.

Ventura L, Cassel C, Jacoby J, Huang B, (1998), Case management and recidivism of mentally ill persons released from jail. Psychiatric Services, Oct;49(10), p.1330-7.