

# Centra & Nacro

## Through-the-Gate Service



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# Who are Centra & Nacro?

**Centra** is part of Clarion Housing Group. We aim is to enhance the Life chances of those we support, predominantly Circle Housing residents. We offer a range of care and support services from supported accommodation, floating support, telecare and so much more.

**Nacro** is a social justice charity aiming to address social exclusion, inequality and deprivation. Our mission is to strengthen communities, enhance social inclusion, reduce crime and prevent offending behaviour.

**Together** we are working within Greenwich Prisons Healthcare Teams to assist vulnerable individuals with mental health needs in their resettlement upon release from custody.



# Project plan



## Purpose:

- Bridging the gap between support in prison and support in the community
- Enable offenders with mental health needs to access community services
- Enable offenders with gang affiliations alongside mental health needs to access holistic support
- Provide a client-led service enabling individuals to live well in the community.

## Aims:

- Secure an appropriate and safe accommodation
- Maintain mental wellbeing & establish links with community health services
- Maximise income
- Engage with all necessary services upon release to reduce the likelihood of reoffending
- Re-establish positive social and family networks
- Reduce re-offending



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# Referrals

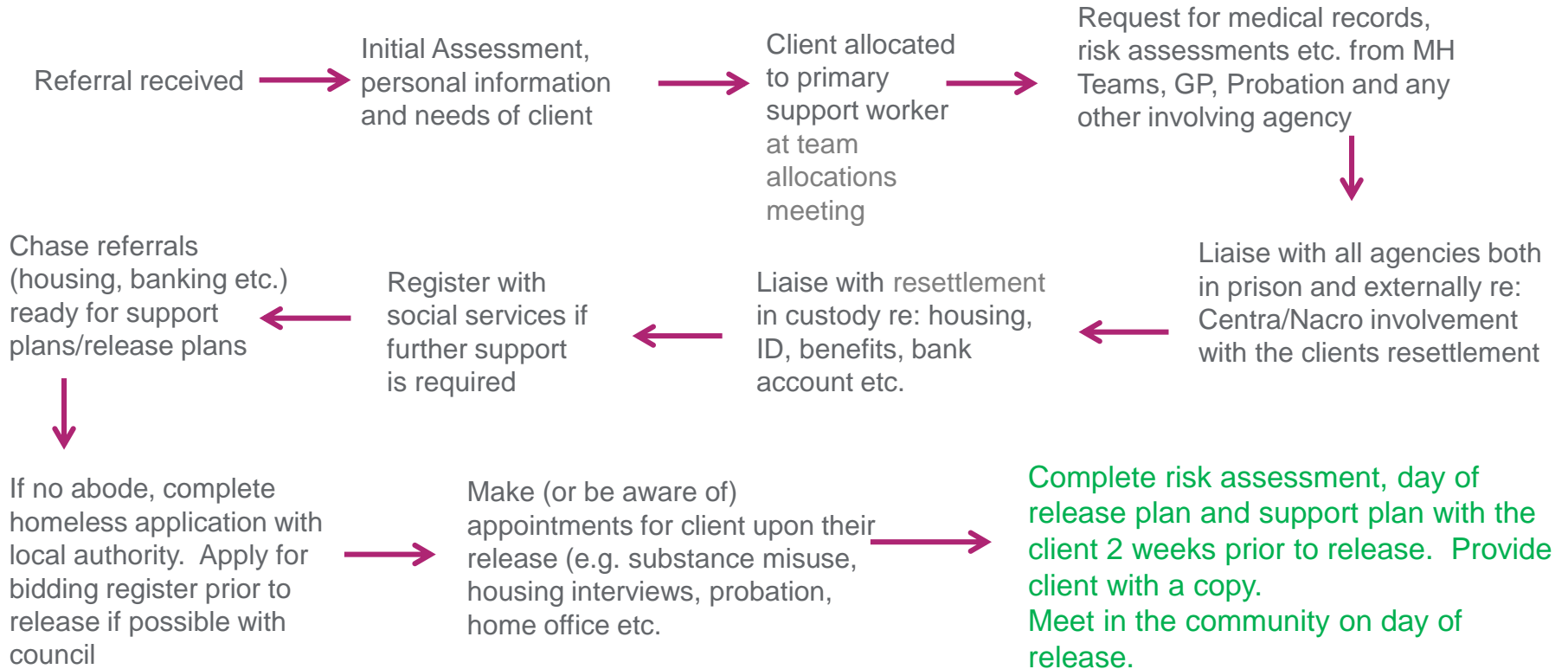
Referrals are received from Healthcare in each establishment and individuals can be referred at any point in their sentence however the sooner they are referred, the more work we can do to support them for release (ideally 12 weeks pre-release).

## Target group

- Prisoners on a Step 3+ on the Oxleas NHS stepped-care model (those with a mental health need and who are engaging with their GP or the In-Reach team)
- Prisoners who are sentenced
- Prisoners with resettlement or community support needs
- Prisoners who are at risk of homelessness or losing their tenancies
- Prisoners with high rates of reoffending/gang involvement



# Pre-release Support



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# Community Support

Day of release  
Meet client at the gate or at a chosen location (council, housing placement, probation etc.)

Support Client on the day of their release at probation and with all housing needs

Register client with benefits (ESA + DLA) this can take 3 weeks

Supply client with food bank vouchers/ sign post to local food banks/ day centres

Support client with all appointments in the community (substance misuse, probation, MHT etc.)

Register Client with GP, complete forms with client and book first appointment

Apply for or obtain forms of ID from probation / housing placement proof of address. Support in setting up bank account etc.

Complete any grants for food, clothing and/or furniture

First GP appointment: GP to refer client to community mental health team, get sick note for benefit (backdated), medication review and repeat prescriptions, referrals for health etc.

Send all medical information to benefit office to support claim(s)

Refer client to other agencies e.g. social services, Learning disability team, IAPt, MIND, Library, Gym, ETE, college etc.

Support for 6-8 weeks, client informed of closure date 2 weeks in advance, all agencies involved contacted and informed of service closure

Ongoing support to ensure reintegration back into the community and to prevent re-offending. Budget planning, meaningful use of time etc.



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# Success stories



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## Case study 1

**Conviction - arson with intent after a failed suicide attempt where he set fire to his housing association flat.**

**Mental Health concerns – ongoing concerns for 30+ years – high suicide risk**

**Other issues - estranged from his family, was in debt, and is illiterate.**

- On release G was unable to move straight back in to his flat as it was not ready to be handed back to him.
- I worked with G to contact his family to mediate and see if he was able to stay with them temporarily, one of his daughters said yes. He also met his grandson for the first time. This relationship is still good.
- He then spent over a week with his daughter after the housing association kept postponing his return to the flat. I negotiated on G's behalf to get the keys and set a move back date.
- I worked with G to make claims for ESA and DLA.
- I took G to Citizens Advice to get debt management support – which is still ongoing.
- G was physically assaulted by 2 neighbours on return to his flat. He suffered a panic attack that night. And the following night suffered nightmares and wet the bed. He spent subsequent nights travelling the night bus so he didn't have to return to his flat. G hadn't wanted to ask his daughter again, but I helped him and he went back to stay with her for a while. We also registered G with a food bank.
- G's Oxleas care coordinator contacted me 2 weeks after his release , and so after all the above had happened – he had not received any other support up to this point. G asked me to accompany him to the first 4 meetings with his care coordinator until he felt comfortable to go alone.
- G remained compliant with meds and had not been drinking.
- I worked with G's care coordinator, housing association and daughter to secure alternative temporary accommodation (following the above safeguarding issue), and look at options for long term accommodation.
- G's brother then committed suicide and I have worked with him on coping strategies. He refused bereavement counselling.
- I have worked with G to now secure permanent housing, he is in receipt of benefits, is still in contact with his daughters and their families, remains meds compliant and sober, and we are currently negotiating with debt collectors to manage the debt issues. We also applied for and secured a freedom pass (TfL). Once settled he is going to get a help dog from Battersea dogs home.

# Success stories

- IH is a 24 year old young man from South Africa. He grew up in a religious and supportive family household with his mother, father and 2 brothers. He and his family moved to London when IH was 7 years old. He did well throughout his school life and went on to attend college to start his A levels. It was also around this time that IH stopped attending church and started to spend weeks away from the family home off drinking alcohol and smoking Cannabis with his new friends. This would usually end in IH getting arrested for committing petty crimes and doing short stints in prison.
- Contact with mental health services: IH first came into contact with the mental health services in October 2012 when he was transferred to hospital following the end of his custodial sentence at HMP Highdown. There had been a significant deterioration in his mental state and he was diagnosed with psychosis due to multiple drug use and use of other psychoactive substances. He was now under the care of Bexley Early Intervention Programme and was put on a community treatment order. Once his CTO expired IH was non-adherent with his medication and his psychotic symptoms worsened.
- IH fell into a cycle of using drugs, not engaging with the CMHT, offending, going to prison, being homeless on release and sleeping on the streets then again using drugs and continuing the cycle.
- Referral to Centra Care & Support and Nacro Prison Resettlement Service: IH's chaotic lifestyle caused a major strain on his relationship with his parents. In 2015 he was arrested and charged with criminal damage for an incident at his parents' home. While he was in custody at HMP/YOI Isis IH was referred to the Centra Care & Support and Nacro Prison Resettlement Service for support through the gates.
- I met with IH while he was still in custody to assess his needs and put together a support plan. IH identified homelessness as the root cause of his non engagement with the CMHT, offending and drug use. He said that he wanted to break the cycle and make a fresh start this time. He said that he had disengaged from services in the past and wanted support with remembering and attending appointments. We agreed that when we meet in the community I would text him the day before our sessions to remind him.
- When he was released he was supported to attend Bexley council to make a homeless persons application and was placed in temporary accommodation. IH was released on license and had to meet with his probation officer weekly. I assisted him with reengaging with Bexley EIP and he was allocated a care coordinator. IH sometimes forgot to take his medication and decided that he did not want to risk becoming unwell so he opted to go on the depo.
- IH was adamant that he did not want to do drugs or abuse alcohol anymore and agreed to engage with Nexus drug and alcohol service. IH found that having numerous appointments to go to each week kept him busy but he also wanted to do something else meaningful with his time. He knew that he wanted to get back into education but wasn't sure if it was too late to start again. We explored different careers options and IH said that he had always had an interest in cooking and wanted to be a chef. We searched online for courses at his local college and found a 1 year fulltime course starting this September. I supported IH through the application and assessment process and he managed to secure a place on the course.
- IH felt that he had regained power over his life and became more confident in making decisions on his own and voicing his opinions.
- Outcomes: By the end of his 6 weeks post release IH had achieved all of the goals he had set for himself while in custody and was engaging well with all agencies involved. He was settled in his temporary accommodation and maintained his tenancy with no issues. He was managing all of his appointments and decided to next focus on joining a gym as he had gained weight since being on the depo. IH was making positive changes to his life and this was mostly due to his engagement with services and my reassurance that he could achieve the goals he set.
- IH was very happy with the service received and this was reflected in his feedback form.



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# Closure of support

Community support is designed to be delivered over a period of 6 - 8 weeks however this can vary depending on individual needs.

## Approaching closure:

- Clients are informed about the service provision and service duration from the point of our initial assessment meeting.
- Once we've complete the community resettlement work, we refer to other floating support agencies if necessary & inform all agencies involved of closure of support
- We always send a Closure pack to client and closure interview during last support session
- Telephone support/advice after closure if client is in need

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# Challenges?!

## Prison access

- Gaining access – Vetting, key access, biometrics etc
- Computer systems – a large number of log ins / password for systems (4 for computer systems in the prison alone) – communication misdirected at times and prison ICT hard to pin down
- Current prison climate – lock downs, security incidents etc. which reduce access to service users

## Getting noticed

- The prisons within the Greenwich cluster are both private (Serco) and HMP (government). It is important to recognise that every single prison operates differently and so we have different ways of working across all 3. There are also a number of different agencies delivering a wide range of provision in each prison and so often ensuring that people are aware of your project can be a challenge.
- We ensure that we attend all relevant meetings in each establishment, not only within healthcare but also resettlement and wider policy meetings.
- Staff – there tends to be a high turnover of staff in custody and a high turnover of agency staff within healthcare, this can often prove frustrating for our teams who rely on staff knowing what we do in order to refer to us.

## Working in custody and in the community

- Getting your service noticed in prison is only half the job. Once you've managed to get noticed, you've got to keep it fresh in everyone's minds. Staff are busy and new projects can fall by the wayside
- Working pan-London and in 3 prisons means you are often needed to be in 4 places at one time. Time and workload management is absolutely key.



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# Research

**Our intervention is being researched by a team at Canterbury Christchurch University to establish the extent to which it provides long lasting change in the behaviour of our service users and in turn, a reduction in reoffending.**

The study is tracking individuals from the Kent prisons (where Oxleas have also commissioned this project as part of their healthcare delivery) and the Greenwich prisons.

The study will evaluate outcomes over a period of 9 months post-release and will work with all relevant agencies to gather data for the cohort who receive our intervention and then a control group of individuals who may have been eligible for our service but for a variety of reasons have not engaged (e.g. not released to project area/refused to engage etc.)

Findings will hopefully allow for us to expand delivery share best practise in terms of supporting individuals with mental health needs through their resettlement journey.



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# Are you struggling with preparing for release?

## Perhaps we can help

We work within the Healthcare team to offer a floating support service. We can help with housing, appointments, benefits, finances, training and employment as well as much more.

## We work with individuals who:

- Are returning to a London borough
- Have limited or no support on release
- Are willing to work towards their resettlement plans
- Have a primary mental health need

Our programme allows us to support you for up to three months in custody and continue this support for your initial 6-8 weeks in the community.

If you feel you could benefit from our help please liaise with someone in healthcare to make a referral to us, or any other professional within the prison who should be able to pass your details onto us.



# Who to contact about this service

If you wish to contact a member of the team please email [inreachresettlement@circle.org.uk](mailto:inreachresettlement@circle.org.uk) to reach all front line staff.

## Front line staff are;

- Steven Burbidge (Nacro)
- Rob Elias (Nacro)
- Carla Thompson (Centra)
- Isabel Loftus (Centra)

## If you wish to speak to management of the project please contact;

Radka Bailey (Centra): [radka.bailey@circle.org.uk](mailto:radka.bailey@circle.org.uk)

Helen Dyson (Nacro): [helen.dyson@nacro.org.uk](mailto:helen.dyson@nacro.org.uk)