



SUPPORTING PEOPLE WITH EXPERIENCE OF THE CRIMINAL JUSTICE SYSTEM

Workshop Date: 6 June 2025

Location: The Ilfracombe Centre, 44 High Street, Ilfracombe, EX34 9QB

FACILITATORS:

Andrea Beacham, Senior Programme Manager for Health Inequalities, James Lander, Community Partnership Manager, Kirsty Smith, Project Officer, Royal Devon University Healthcare Trust

ATTENDEES

- Jamie White – Support Time and Recovery Worker, DPT
- Richard Merrifield – Public Health
- Kate Morne – North Devon Council
- David Richardson – DPT
- Nina Lake – North Devon Council
- Jeanette Courtman – Royal Devon (Lead Nurse – vaccine outreach)
- Glenda Jones – (Senior Nurse) Royal Devon
- Sue Marnham – Clean Sheet
- Lisa Woodward – Stop 4 Life
- Josh Stunell – BetheChange
- Ana Paulino – DPT (Reconnect)
- Tony George – DWP
- Emma – MAPPA – DWP
- Libby Smith – Health Innovation South West
- Carol Parkin – Belle’s Place
- Claire Fishleigh – Together Drug & Alcohol Services
- Terry Hodgson – Devon & Cornwall Police
- Sarah Williams – GP

APOLOGIES

- Mark D’Arcy – Support Time and Recovery Worker, DPT
- Catherine Wevill – ICB
- Richard Blackwell – Health Innovation South West
- Sally Heaman – Accommodation Probation Services Officer Devon & Torbay
- Katerina Benkanoun – Probation Practitioner
- Rich Preston – Devon & Cornwall Police
- Sara Jones – Probation Manager

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1. EXECUTIVE SUMMARY

On 6 June 2025, a multi-agency workshop was held in Ilfracombe to explore how public services can better support people in contact with the criminal justice system. Professionals from health, justice, housing, and the voluntary sector came together to build a shared understanding of current challenges and map out existing support processes. The workshop identified common characteristics and needs among this population—such as early trauma, housing instability, addiction, and isolation—and discussed ambitions for improving support. These included improving access to services, earlier intervention, stronger interagency coordination, and ensuring voices with lived experience are heard. Participants also highlighted major barriers, including stigma, fragmented systems, poor-quality housing, digital exclusion, and limited service accountability. Service process mapping started to discrepancies between the service as intended and what happens in reality highlighting missed opportunities for joined-up care. Agreed actions included: forming a working group involving people with lived experience, gathering case examples to highlight critical system gaps and preparing an improvement plan ahead of the NHS England visit in September.

2. INTRODUCTION

The workshop brought together partners from health, justice, housing, and the voluntary and community sector to explore how support for people with experience of the criminal justice system can be improved.

The session aimed to build a shared understanding of current challenges from multiple perspectives and to map service processes in order to create a collective picture of the current ('as is') system. This foundation will support future sessions that delve into where breakdowns occur and what improvements are needed. It will help us distinguish whether issues arise from flaws in existing processes or from processes not being followed as intended. This is the first phase of the 'double diamond' design approach which starts with building a shared understanding of the situation together with existing opportunities and constraints.

3. FOCUS ON THE INDIVIDUALS THIS WORK IS INTENDED TO SUPPORT

Participants had been advised in advance that we had not directly invited individuals with lived experience of the criminal justice system to this first session.

It was felt that attending a large, multi-agency workshop could be overwhelming for individuals with lived experience without appropriate preparation and support and that the focus on understanding how the current system operates might not feel accessible.

However, it was made clear that people with experience of the criminal justice system were very welcome to attend if any partner had an established relationship with someone and they felt it appropriate to bring them along.

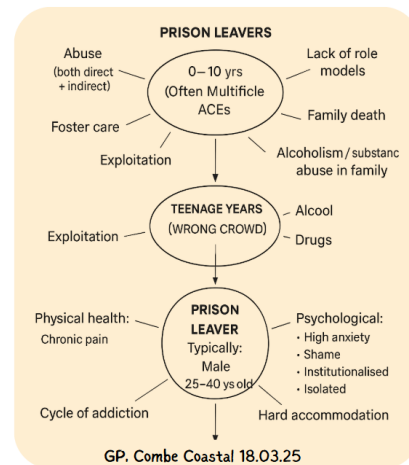
As no one with lived experience was present on the day, we began the workshop by centering our discussion on the people this work is intended to support.

We began by considering some key characteristics of this population as identified by stakeholders in prior interviews.

- Barnstaple highest number released with substance misuse issues, Bideford the 2nd
 - Predominantly male
 - 25 - 55 years of age.
 - Most carry a form of trauma from their childhood &/or
 - Significant mental health issues of which they attempt to mask with substance misuse.
 - Whilst using, unable to get support for their mental health leading to cycle of additional trauma and induces a pattern of more self medicating.
 - Rarely married, quite often have volatile relationships, resulting in a pattern of Domestic Abuse behaviours (women tend to utilise themselves for sex work to fund their addictions).
 - Housing proves difficult as often not seen as priority need, their risk may be too high or may have exhausted their options locally in the past so often living on street or sofa surfing at inappropriate venues
 - No employment
 - Limited education
 - This tends to lead to a repeat pattern of: Prison release --> Homeless ----> Substance misuse----> Offending (inextricably linked to substance misuse)----> Prison.
 - Many have health conditions, i.e. Deep vein thrombosis (from intravenous misuse), liver/kidney problems (from alcohol misuse), Chronic Obstructive Pulmonary Disorder, Hepatitis C.
 - Health conditions tend to be poorly managed when individuals are using substances.
- They do not:
- Eat a balanced diet.
 - Get regular exercise.
 - Have an established sleep routine.
 - Take medications as directed, i.e. blood thinners for Deep vein thrombosis.
 - Attend GP/Hospital/Consultant appointments.
 - Complete treatment, i.e. Hepatitis C treatment.
- Criminal Justice Worker,
Together Drug & Alcohol - 08.04.25

- History of childhood abuse
 - Low educational attainment
 - Can't function well in society & make bad choices
 - Brutalised in prison
- Charity Mentor 03/04/25

- Men
 - Late 20's - 40s
 - Sometimes homeless.
 - Struggle to reintegrate back into society
 - Eventually stop engaging with our service
- Primary Care Wellbeing Lead
03/04/25

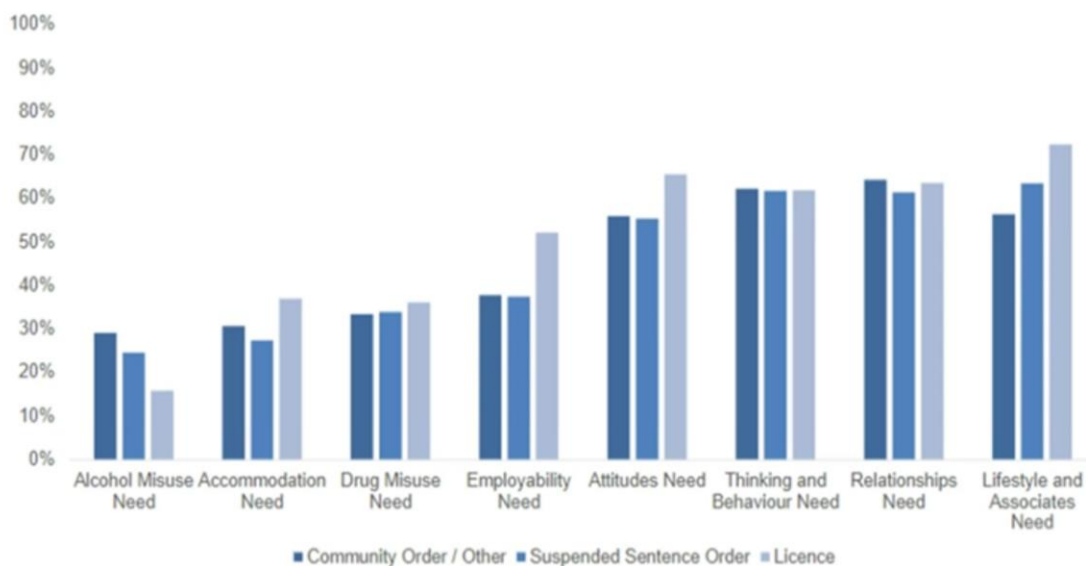


1 Common characteristics amongst prison leaver population identified by those providing support

Participants discussed the key characteristics and predictable needs of people in contact with the criminal justice system. These include early life trauma, substance misuse, housing instability, and high levels of anxiety and shame. Common patterns were noted around poor role models, foster care history, and reinforcing loops.

Carol from Belle's Place provided a recent case study of a man released from prison facing addiction, mental health needs, and transport barriers, highlighting gaps in follow-up care and housing.

The following slides were presented showing the link between reoffending and people's needs not being met and the Health & Justice Case for Change.



2 Criminogenic needs in community in England are closely linked to offending and reoffending behaviours

Public Health approach to Probation: Population is three times that in prison and will be increasing

Key health challenges facing probation populations	Poor health outcomes	Data visibility	Lack of integration	Reducing reoffending
Key health challenges facing probation populations	<ul style="list-style-type: none"> Living shorter lives, in poor health, experiencing early onset multimorbidity, high prevalence of major conditions. Higher prevalence of unhealthy behaviours (smoking, substance misuse, addiction). Unstable housing, finances and employment compound health issues; driving dependence on drugs, alcohol and reoffending. 	<ul style="list-style-type: none"> Data on probation populations is poor quality, often self-reported or unverified. Commonly not registered with a GP, ICBs and local authority public health commissioning is in turn not informed by needs creating regional disparity in services. Lack of data creates fragmented service provision, exacerbates siloed working and drives poor outcomes. 	<ul style="list-style-type: none"> Probation practitioners have limited time during appointments and lack access to information about local health offer or referral routes. Lack of integration and system join-up between community health and probation front line services leads to poor identification, driving poor care coordination, symptom management and support. 	<ul style="list-style-type: none"> Currently 8.5 million offences costing £59 billion for crime £2.9 billion for violence to the NHS Economic and social cost of reoffending is £18.1 billion Currently lower uptake of preventative services and higher uptake of costly emergency care. This is putting pressure on services across both justice and health
	Addressing healthcare inequality: Improving access, experience and outcomes for Core20PLUS5 populations.			
	Driving a neighbourhood model: Delivering focus for 25/26 on supporting individuals with complex health and social care needs who require support from multiple services and organisations			
	Health, work and prevention: Mitigating health-related labour market inactivity to operationalise the shift to prevention and tackle economic inactivity.			
Key opportunities where the NHS can play a role				

3 Case for change for NHS to take greater role in supporting probation population

4. SESSION 1: HOPES AND BARRIERS

Participants were paired to explore their individual goals for supporting this population, the extent to which they can achieve them, and the key barriers in their way.

4.1 HOPES OF PARTICIPANTS (COLLATED):

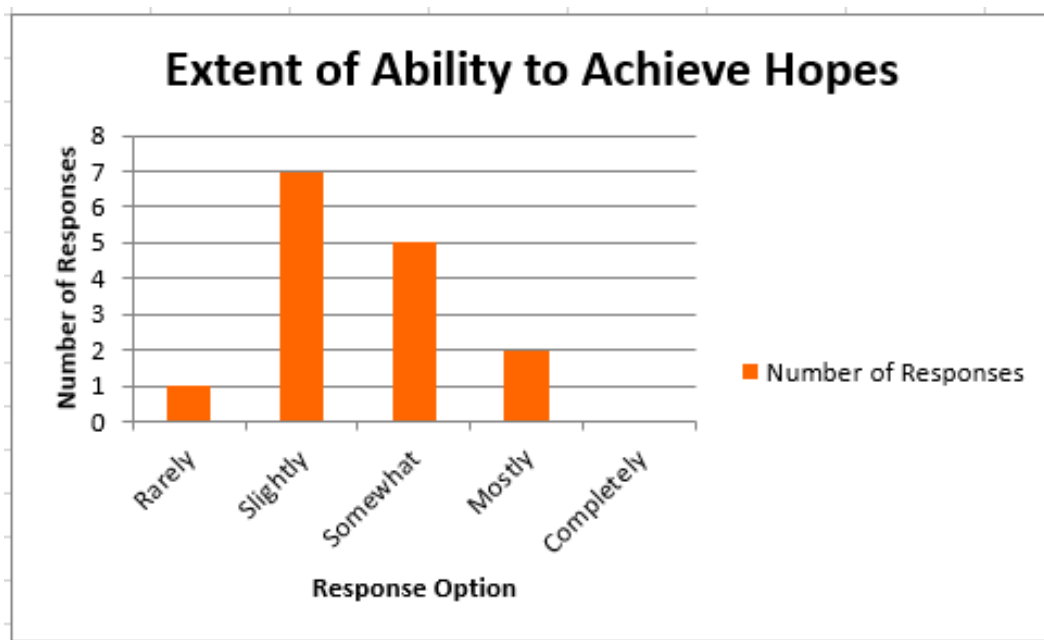
Key hopes included improving access to services, better interagency coordination, continuity of care, and listening to voices with lived experience.

- Earlier access to support, starting as soon as there is contact, with an emphasis on trust and continuity
- Improved coordination between agencies upstream, focusing on joined-up working and meeting basic needs (e.g. Maslow’s hierarchy)

- Better access to statutory services, including support for mental health, physical health, housing, and social needs
- Faster referral pathways to benefits and medical support, with improved processes before release from prison (e.g. with the DWP)
- Practical ways to identify and support people who may not speak up — the “quiet voices”
- Ensuring people are genuinely heard and listened to, with meaningful feedback following consultation
- Stronger social integration, including access to community, faith, and peer support networks
- Support for specific health behaviours, such as help to stop smoking

4.2 EXTENT TO WHICH PARTICIPANTS FELT ABLE TO ACHIEVE THEIR HOPES

Most participants (7) rated their ability to achieve these hopes as ‘Slightly’ (“I make some progress, but significant barriers prevent real progress”), with a few less (5) rating ‘Somewhat’ (I achieve certain goals, but there are noticeable limitations)



4.3 BARRIERS & ENABLERS TO SUPPORT

Barriers included a lack of housing options, poor information sharing, stigma, bureaucracy, inaccessible mental health support, and transport costs. Enablers included co-location of services, committed individual practitioners, and community-based support centres like Belle’s Place.

Access to Services

- Limited availability of support and statutory services
- Transport challenges and geographical isolation
- Digital exclusion and difficulties accessing or booking appointments
- Difficulties accessing mental health services when the person has addictions

Housing

- Shortage of willing housing providers
- Restrictions such as needing 6+ months left on a tenancy
- Poor quality accommodation, particularly in Ilfracombe

- Limited support for those not linked to probation services
- Inadequate supply of private rental options

Systemic and Structural Issues

- Bureaucratic processes within statutory bodies
- Lack of organisational awareness or ownership regarding prison leavers or people on probation
- Disjointed services with unclear accountability

Social and Cultural Barriers

- Prejudice, stigma, and shame surrounding a criminal record
- Exclusion from community spaces and decision-making forums
- Absence of lived experience representation in shaping services

Power and Politics

- Imbalance in influence between services and service users
- Political factors that affect prioritisation and resource allocation
- Fragmented decision-making across agencies

4.4 GROUP FEEDBACK SUMMARY

During feedback, participants reported shared challenges across services. These included insufficient housing provider engagement, barriers due to thresholds for adult social care, and last-minute prison release coordination. There was consensus that responsibility often falls between services, creating unacceptable gaps for people in crisis.

Agreed areas for improvement included:

- Improving coordination between service providers
- Addressing reluctance of housing providers to accept ex-offenders
- Enhancing information sharing across agencies
- Developing community initiatives to reduce stigma
- Including lived experience voices in service improvement initiatives
- Increasing flexibility and access to mental health services
- Ensuring continuity of medication post-release
- Ensuring a shared ownership, ‘no, but ...’ approach when someone is not accepted into a service

4.5 THEMED RESPONSES FROM SESSION 1

The table below contains a summary of responses from individual participants during the Appendix B: Session 1 – Group Feedback Summary

The following table summarises the group-level feedback provided after the paired interviews, including overall ratings, key barriers, and ideas for improvement.

Theme	Details
Common Barriers	<ul style="list-style-type: none"> • Housing ineligibility (e.g. income thresholds, past offending) • Poor transport access (esp. rural) • Digital exclusion and phones

	<ul style="list-style-type: none"> • Information sharing failures • Gaps between services – unclear responsibility • No clear understanding of what’s currently being offered or by whom
Group Insights	<ul style="list-style-type: none"> • Services often reluctant to take ownership unless referral thresholds met • Prevalence of short-term interventions vs. sustained support • Lack of proactive outreach, particularly pre-release
Agreed Ideas and Opportunities	<ul style="list-style-type: none"> • Hub model with colocated services where possible • Involvement of lived experience voices • Community-led support groups & peer mentors • Earlier joint planning pre-release • Shared client records with consent • ‘No. But ...’ approach that offers something else if a person isn’t eligible for a service or there is a long waiting list.

5. SESSION 2: SERVICE PROCESS MAPPING

Participants drew out the steps their organisations follow when supporting individuals in contact with the justice system. This revealed instances where the agreed process was not being followed, gaps, misaligned dependencies, and areas of duplication. Issues included:

- Delays due to disconnected services
- Lack of clarity on who holds responsibility at each point
- Constraints around data sharing and access to medication
- Missed opportunities due to poor communication between agencies

There was also acknowledgment that systemic pressures often prevent services from taking a whole-person approach, especially for individuals who don’t meet the threshold for statutory support but still face severe disadvantage.

5.1 PROCESS MAPPING BY ORGANISATION

This table summarises the service processes described by organisations during Session 2, with gaps, constraints, and dependencies noted.

Organisation/Role	Process Highlights	Key Gaps/Constraints/Dependencies
DWP	Support before and after release. In-prison work coach, contact maintained post-release.	Last-minute releases reduce prep time. Dependency on benefit system speed. Some customers disengage after first contact.
Belle’s Place	Provide hot meal, friendship access to GP, housing, addiction support,	Stigma, funding limitations, post-release care gaps.

Police	MAPPA involvement, information sharing for high-risk individuals.	Confidentiality barriers, siloed databases.
Chaplaincy	Spiritual/emotional support, signposting to community groups.	Reliance on individual initiative. Often not integrated into plans.
GP/Primary Care	Referral to support services, mental health involvement.	Difficulty accessing patients post-release. Poor communication across settings.
Together/Treatment	Substance use support, joined-up care pathways.	Fragmented data systems. Reliant on motivated referrals.
RDUH outreach	Outreach vaccinations and health checks for vulnerable populations.	Information sharing with GP services is not smooth (“not slick”) No clear understanding of what’s currently being offered in prison or by whom
DPT	Medication management for mental health and social inclusion support.	Team has limits on how long they can remain involved with an individual.

KEY PROCESS STEPS FOR EACH ORGANISATION

PROBATION SERVICE

- Start on release / community sentence → full risk & needs assessment
- Sentence plan: housing ▶ substance misuse ▶ employment/benefits
- Coordinate with housing, health, D&A, DWP, etc.
- Regular supervision & plan reviews → case closes or transfers to ongoing support

NORTH DEVON COUNCIL – HOUSING

- Duty-to-refer alert → priority & risk assessment
- AFO criteria → housing officer
- Explore private or temp options; help with viewings, ID, finances
- Rent/deposit assistance; move-in support & ongoing tenancy checks

DWP

- In-prison Work Coach meets person pre-release; open UC claim
- Day 1: advance payment, ID/photos, PES account
- Post-release Work Coach: benefit maintenance, barrier assessment
- If health needs → Disability Employment Adviser & personalised “health journey”
- Flexible Support Fund ▶ SWAPs training → sustained work or education

BELLE’S PLACE

- Outreach / drop-in → immediate needs check (housing, food, safety)
- Safe trauma-informed space; hot meal & practical help (forms, GP reg)
- Ongoing relational support; referrals to onsite housing, probation, health

POLICE

- First contact & needs check → flag vulnerabilities
- Decide pathway: no action ▶ community resolution ▶ arrest/custody
- In custody: Liaison & Diversion referral; safeguarding alerts shared
- Case assessed for MAPPA
- Information shared with partners
- Ongoing monitoring for high-risk cases

CHAPLAINCY

- In-prison or post-release contact
- Emotional/spiritual support
- Referral to voluntary/community sector

GP/PRIMARY CARE

- Health assessments post-release
- Mental health referrals
- Support for medication continuity

TOGETHER / DRUG & ALCOHOL SERVICE

- Court / probation / GP / self referral → assessment & detox plan
- Joint care-plan; psychosocial support; mental-health & housing links
- Regular reviews; relapse prevention; discharge to after-care / peer mentoring

SECONDARY-CARE MENTAL HEALTH

- Referral / presentation → screen → triage (primary vs secondary vs crisis)
- Full assessment; risk + dual diagnosis; multi-agency care plan
- Ongoing treatment & reviews

DPT HOME TREATMENT TEAM (CRISIS)

- Intake routes: A&E, police, ambulance, partner alerts
- Intensive short-term home support: meds, safety, social inclusion
- Link to community teams → step-down or stabilise

RECONNECT (NHS TRANSITION TEAM)

- Assess in-reach or remotely; take case to weekly MDR meeting
 - Accept → 7-day release plan (accomm, health, benefits, peer mentor)
 - Request more info → chase probation, return to MDR
 - Reject → referrer advised of alternatives
- Records on SystmOne; follow-ups at MDR

STOP FOR LIFE DEVON (TOBACCO)

- Self / professional referral → phone call-back
- Assess readiness; set quit date; NRT if stable address

- Flexible contact (face-to-face or phone); transport can be barrier
- Support continues up to 12 weeks → track outcome or disengagement

6. ACTIONS AND NEXT STEPS

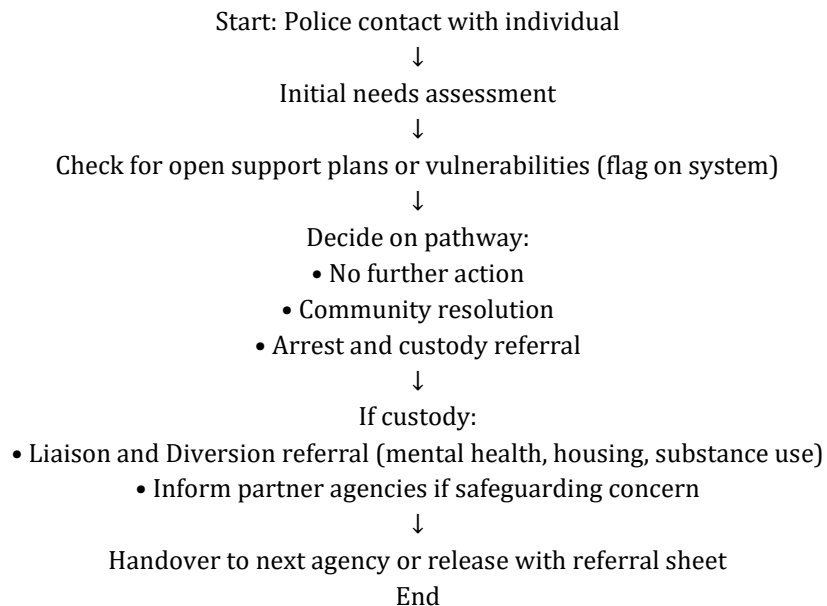
The following actions were agreed as part of the workshop wrap-up:

- Map current processes and identify constraints more clearly across services – create joint understanding/overview of the situation
- Form a working group to ensure people with experience of the criminal justice system are part of the work going forward (interviews/diary/video/in-person/virtual)
- Invite adult social care (Richard M) and Secondary Mental Health (David R)
- Gather case examples showing how gaps in housing, transport, or medication access affect individuals and what could be done now (as well as more systemic solutions)
- Share summary of the day and check accuracy of process maps with attendees
- Prepare for NHS England visit in September and develop an improvement plan

APPENDIX A: PROCESS MAPS BY ORGANISATION

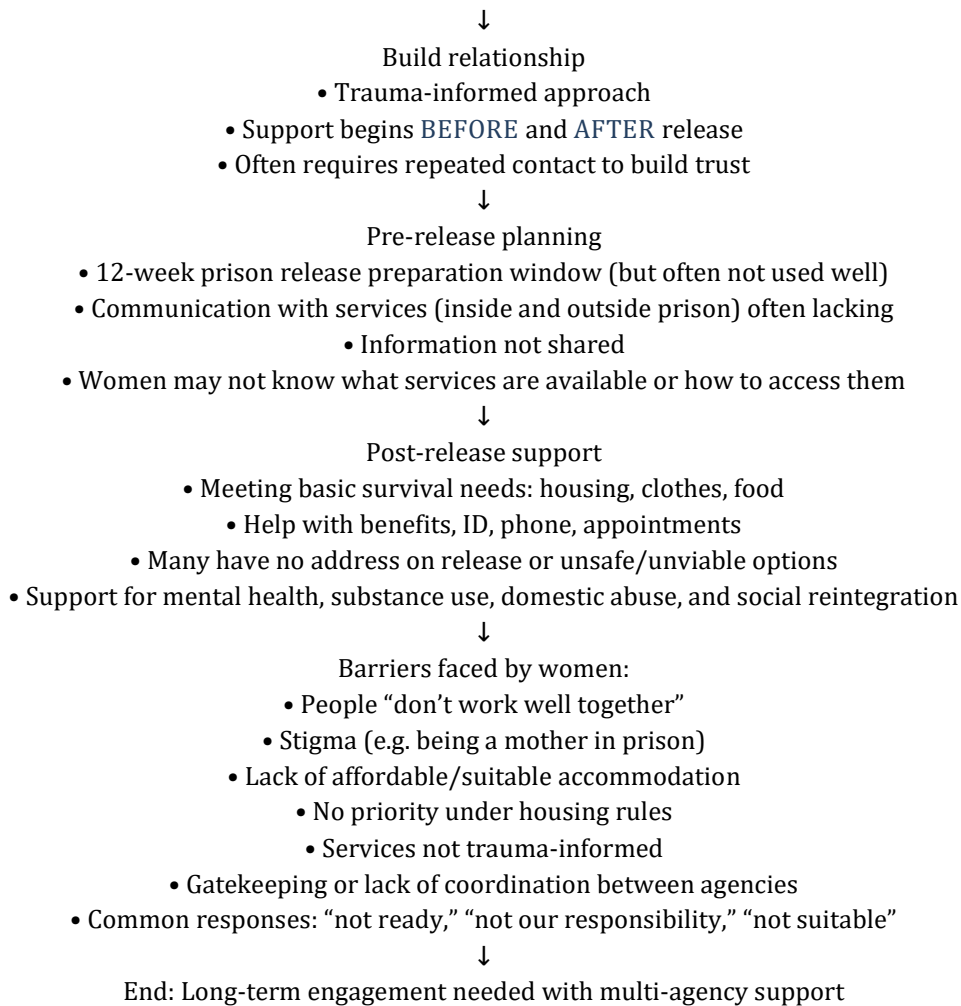
The following processes were identified by each organization in relation to working with people in the criminal justice system.

POLICE PROCESS

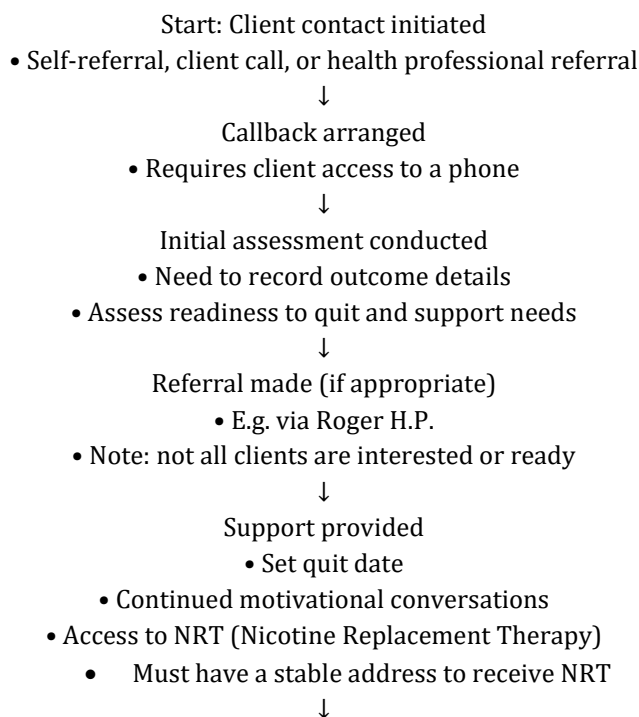


BETHECHANGE (WOMEN'S PATHWAY)

- Start: Referral to service
- Routes include: agency referral, self-referral, peer referral
 - CAC (custody assessment centre) engagement
 - Pre-release contact possible



STOP FOR LIFE DEVON – TOBACCO CESSATION PATHWAY



Mode of contact:

- Flexible options: in person (face-to-face), by phone, or at back-up venues
 - Transport access may be a barrier



End: Ongoing support until outcome achieved or disengaged

PROBATION SERVICE PROCESS

Start: Person enters probation following prison release or community sentence



Initial assessment by Probation Officer



Create sentence plan including:

- Risk assessment
- Housing needs
- Substance misuse support
- Employment and benefits support



Liaison with partner services:

- Housing providers
- Health teams (GP, mental health)
 - Drug and alcohol services
- DWP or employment advisors



Ongoing supervision & review

- Weekly or monthly check-ins
- Adjust support plan as needed



End of probation period or transition to ongoing community support

End

NORTH DEVON COUNCIL PROCESS

Start: Referral received from probation, police, or self-referral



Initial eligibility check and risk assessment



Determine housing options:

- Emergency accommodation
- Supported housing scheme
 - General needs housing



Liaise with relevant agencies:

- Probation or prison resettlement team
 - Drug and alcohol services
- Mental health or support workers



Assess ongoing support needs

- Signpost to tenancy support
- Regular wellbeing checks or support visits

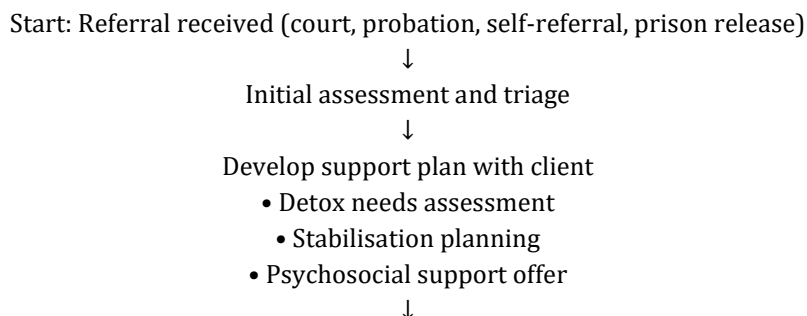


End: Person housed with ongoing support or referral to alternative agency

HOUSING SUPPORT PATHWAY – NORTH DEVON COUNCIL
(FOR EX-OFFENDERS ON RELEASE FROM PRISON)



TOGETHER DRUG & ALCOHOL SERVICES PROCESS



Engage with wider services if required:

- Mental health team
- Housing or homelessness support
- Social care or safeguarding referrals



Regular review and progress check-ins

- Risk management and relapse prevention



Discharge or transition to aftercare

- Recovery support groups
- Peer mentoring / training pathways

End

SECONDARY CARE MENTAL HEALTH SERVICES PROCESS

Start: Referral or presentation (e.g. custody, GP, court, probation)



Initial mental health screening



Triage for appropriate service level:

- Primary care (IAPT or community mental health)
- Secondary care (CMHT, psychiatry)
 - Crisis team / acute support



Comprehensive assessment

- Risk to self/others
- Substance misuse / dual diagnosis
- Social circumstances and trauma history



Create treatment and safety plan

- Multi-agency care plan (if needed)



Ongoing support, review, and joint working

End

HOME TREATMENT TEAM (MENTAL HEALTH) PATHWAY

Start: Referral or presentation due to high risk (e.g. suicide, hospital admission)



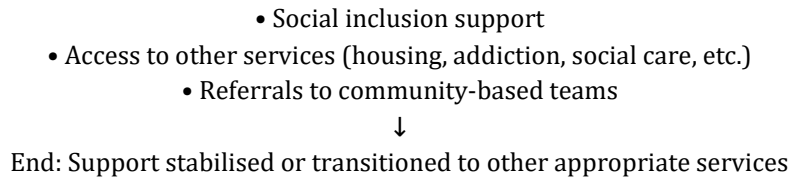
Routes into the team:

1. A&E → Referred by Mental Health Liaison
 - Assessment: Can the team work with them?
 - Do they meet mental health admission threshold?
2. People known to partners who are off-radar
3. Police referrals
4. Ambulance / First Response referrals

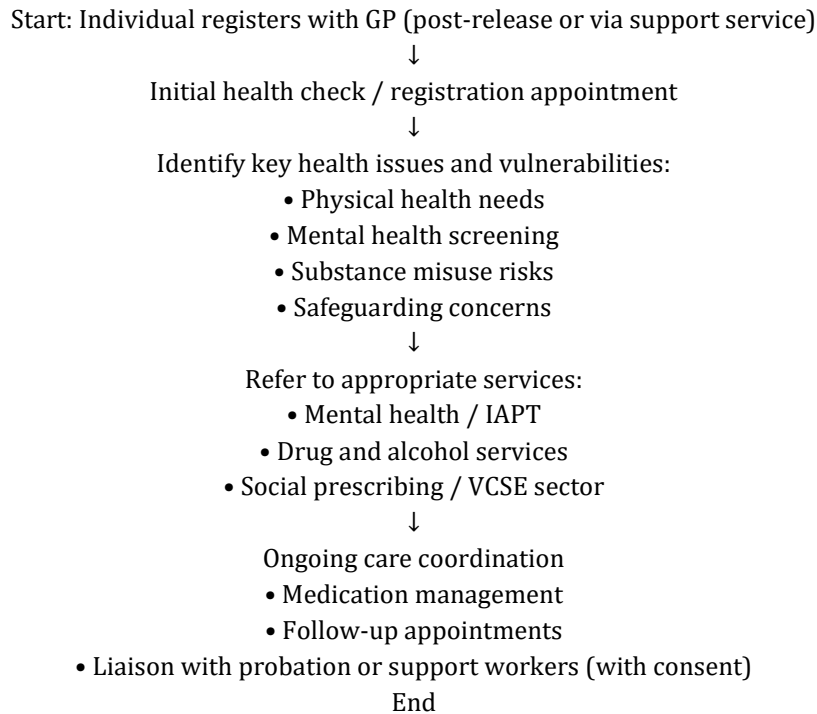


Team intervention (if accepted):

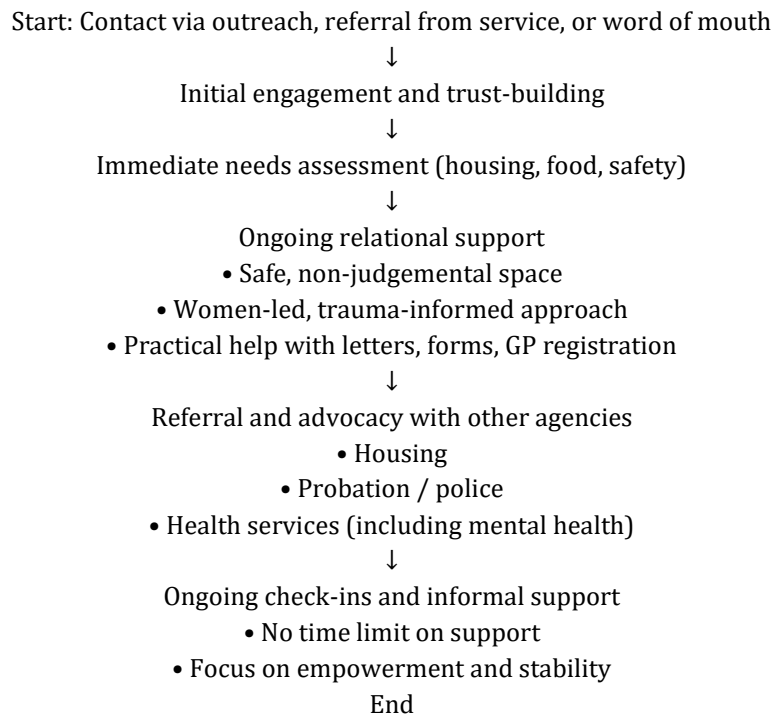
- One-to-one support with individuals
 - Medication management



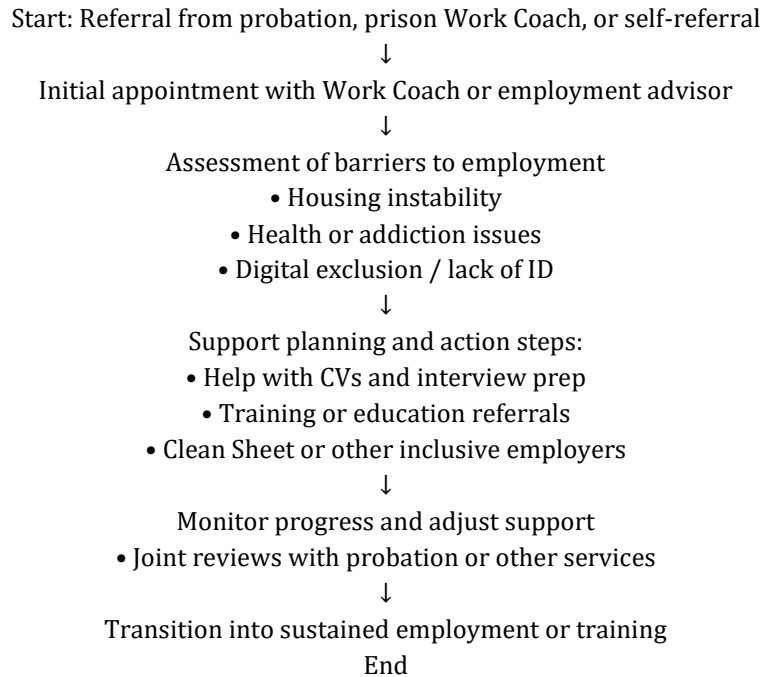
GP & PRIMARY CARE PATHWAY



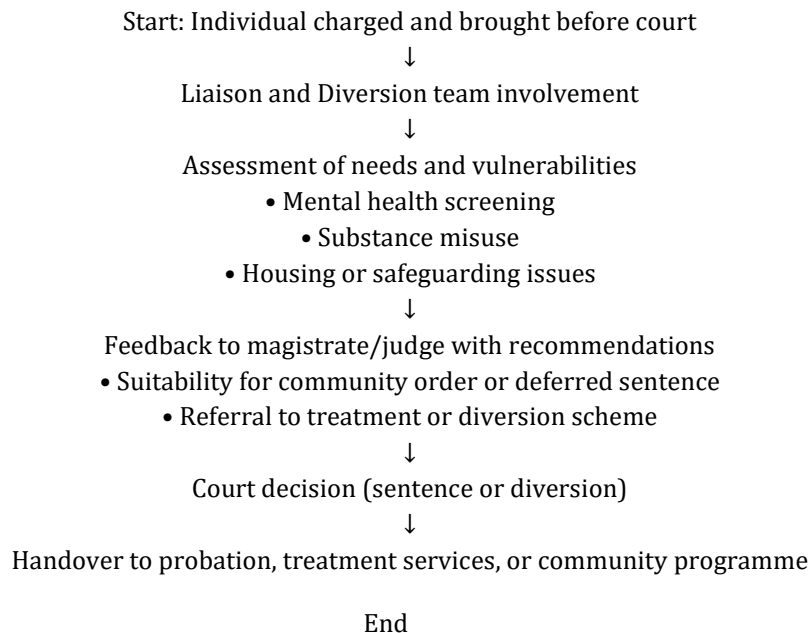
BELLE'S PLACE SUPPORT MODEL



EMPLOYMENT SUPPORT PATHWAY

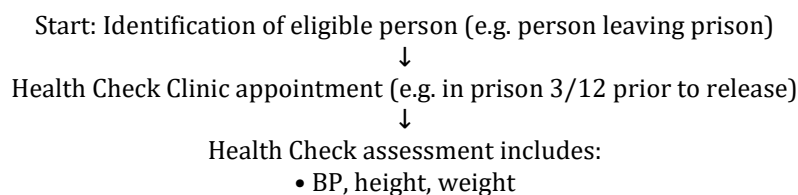


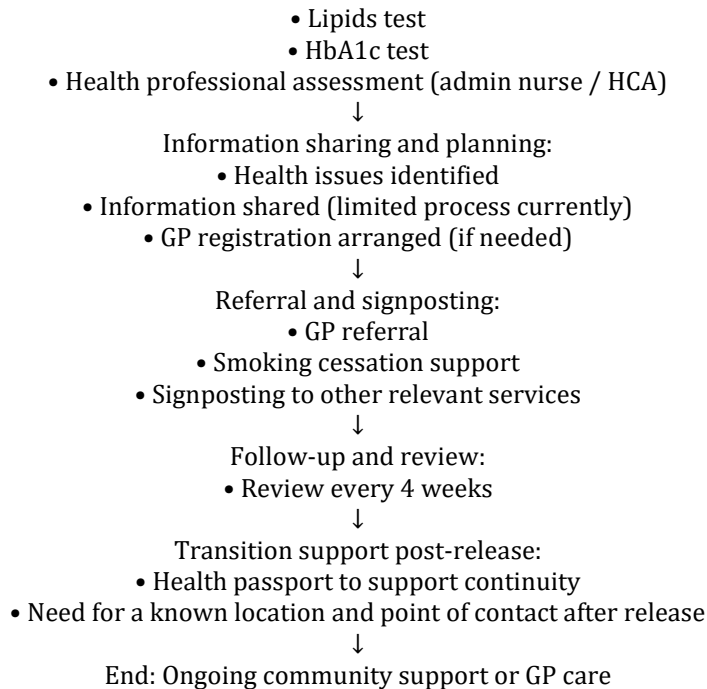
COURT DIVERSION / PRE-SENTENCE SUPPORT PROCESS



HEALTH CHECKS SERVICE PATHWAY (RDUH)

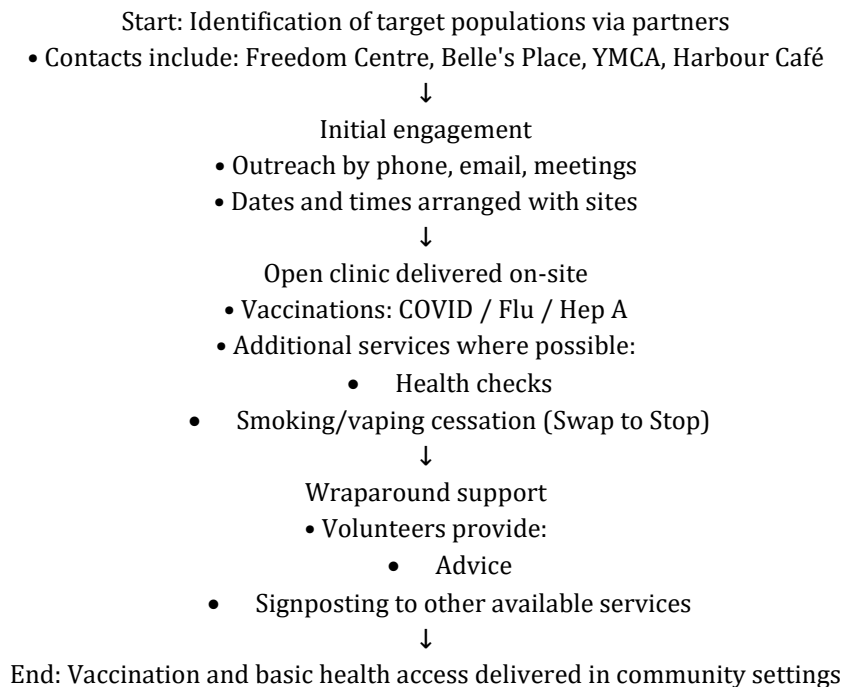
(PATHWAY NOT CURRENTLY COMMISSIONED)





SEASONAL VACCINATION OUTREACH PATHWAY NDDH

(PATHWAY NOT CURRENTLY COMMISSIONED)

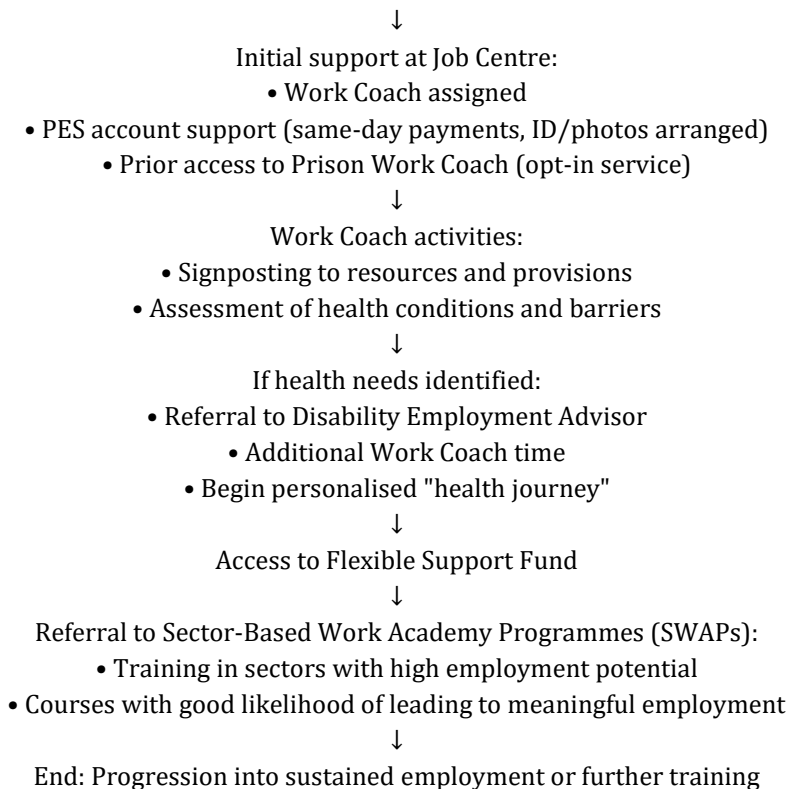


DWP POST-PRISON EMPLOYMENT SUPPORT PATHWAY

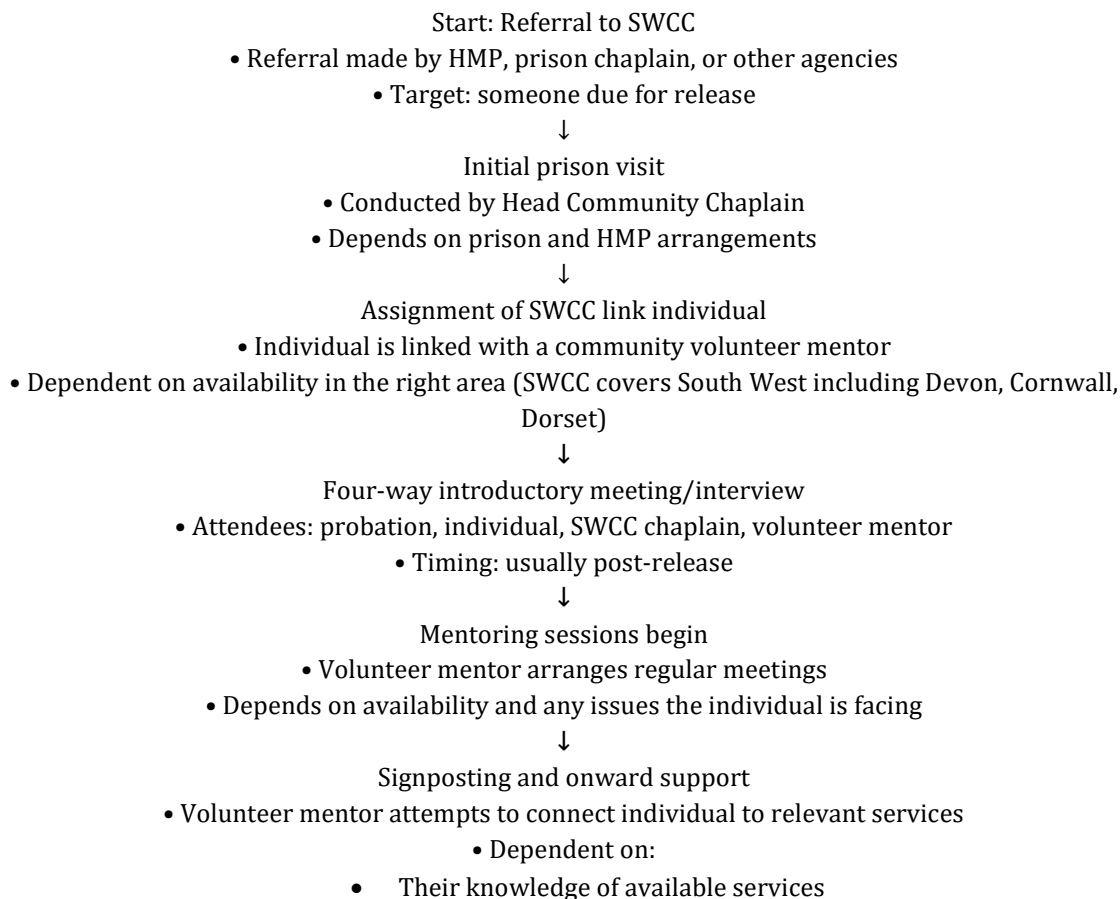
Start: Release from prison (benefits stop)



Day 1: Advance payments available



SOUTH WEST COMMUNITY CHAPLAINCY (SWCC) MENTORING PATHWAY
 (SUPPORT FOR PEOPLE DUE TO BE RELEASED FROM PRISON)



- Communication with other agencies
 - Access to accurate, up-to-date information
- End: Individual supported to engage with services and reintegrate

RECONNECT SERVICE PATHWAY (SUPPORTING PEOPLE RELEASED FROM PRISON)

Start: Prisoner identified for potential Reconnect support

↓

Assessment by Reconnect team

If in Devon prison: assessment/in-reach work begins

If in out-of-area prison: remote assessment by Reconnect team

↓

Multi-Disciplinary Reconnect (MDR) weekly meeting

Review cases

Discuss referrals and risks/concerns

↓

Three potential outcomes:

① Reconnect Accepts Referral

- Inform referrer
- Send acceptance letter
- Meet person at prison pre-release
- Develop 7-day release support plan
- Liaise with probation to attend first supervision
- Co-produce support plan including:
 - Accommodation
 - Health needs
 - Drug/alcohol services
 - Benefits
 - Peer mentor support
 - Primary care
- Update records (SystemOne and Reconnect shared drive)
 - Follow up at next MDR meeting

② Reconnect Rejects Referral

- Inform referrer
- Advise on alternative support pathways

③ Reconnect Requests More Information

- Case info is incomplete or release is not being planned in a timely way by probation
 - Actions:
 - Liaise with Probation Officer (Prison or Community)
 - Bring case back to MDR for decision once info is received

End: Referral either supported by Reconnect or redirected to alternative support

CROSS-AGENCY COORDINATION

Start: Person in contact with criminal justice system (custody, court, probation)



Multiple agencies become involved simultaneously:

- Police and probation
- Housing provider
- Mental health and drug/alcohol services
- GP and primary care
- DWP and Education Providers



Coordination challenges:

- Information sharing barriers
- Differing eligibility and access points
- Limited awareness of each other's roles



Opportunities for improvement:

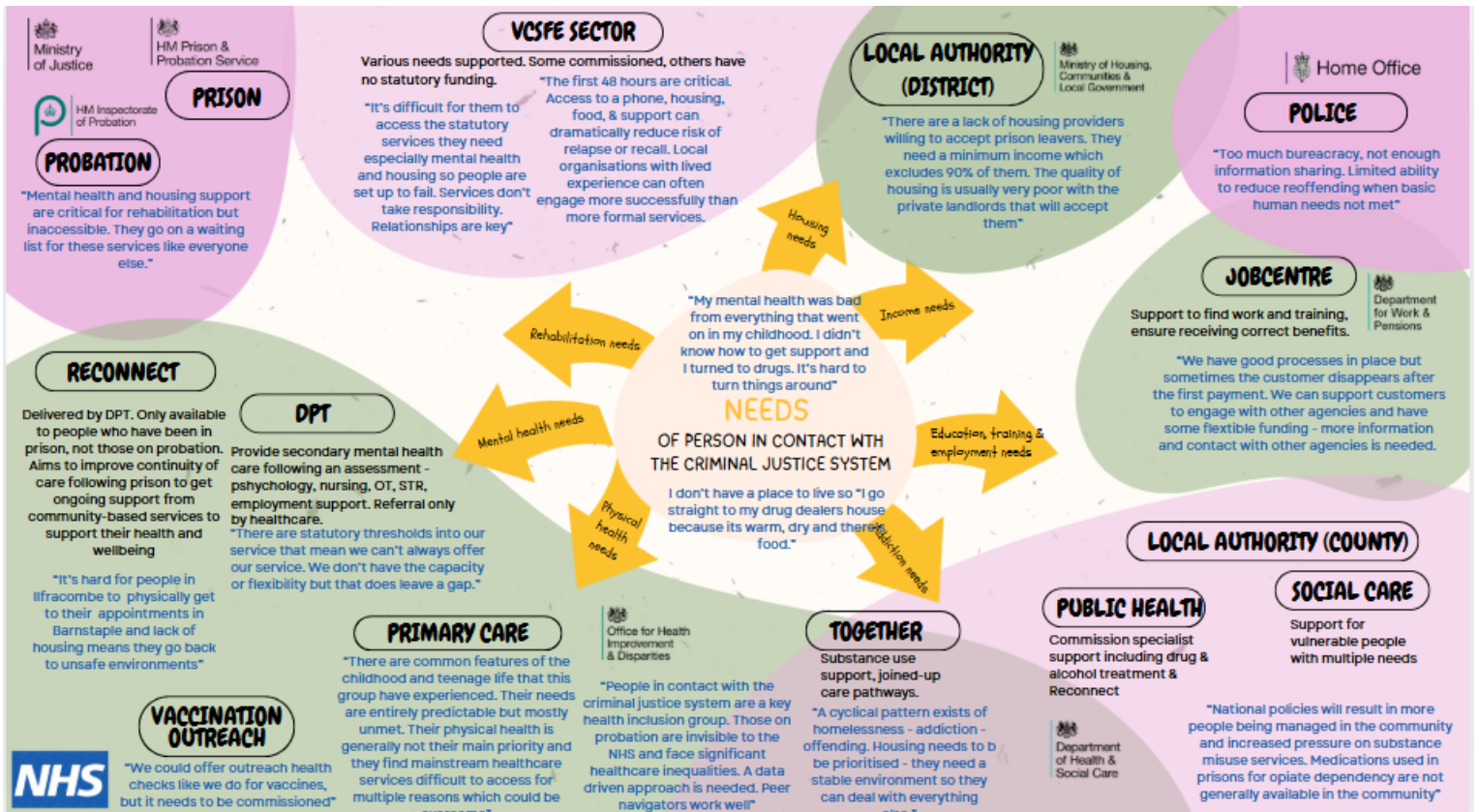
- Multi-agency case meetings
- Named contacts / referral pathways
- Shared data protocols and escalation routes



Desired outcome: Joined-up system that reduces duplication and improves outcomes

End

APPENDIX B: DRAFT RICH PICTURE OF THOSE INVOLVED



APPENDIX C: FULL LIST OF BARRIERS FROM GROUP FEEDBACK

- Co-ordination with GPs
- Support around individual
- Lack of housing providers
- Private landlords not willing to take on people with a criminal record
- Minimal income
- Quality of accommodation
- Process of benefits (too long)
- Too many handover points
- Increase in demand/lack of funding & resource
- Unable/worries about sharing data
- Lack of meaningful daily activities/community initiatives
- Bureaucracy (buy in)
- Integration (social)
- Stigma/shame
- Lived experience involvement (lack/power imbalance)
- Transportation (lack of)
- Lack of services taking responsibility ('not our area')
- Addresses required (past history)
- Integration (organisations)
- Assets for opportunity
- Supporting to take first steps
- Lack of awareness of resources available to signpost to
- Unable to access benefits/phone/housing/medication
- Inability to access basics (phone, bus passes etc)
- Access to data, case studies and funding
- Time
- Policy and lack of Government backing
- Duplication
- Appropriate referrals
- "Hard to reach" – services are hard to reach too!
- Access to IT/digital/phone/internet
- No fixed abode = DNA
- Complex life – miss appointments
- Breakdown in continuity of care after release – opiate substitution in prison not available in the community
- All feels 'last minute'
- Different categories of prison have different stay periods
- Prisoners may be homeless before/after
- No local connections
- Have not met 'threshold' – lack of power – they become a non-priority
- Need a 'No, But...' approach
- Process on paper ticks every box "but I'm hearing in reality it's failing"
- Staff often have to do 'work-arounds'
- Probation refer far too late – has a knock-on effect
- Staff end up in high risk situations