



Out of Reach: Mental Healthcare in Approved Premises and the Continuity of Care Gap in England and Wales

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Introduction

Approved Premises (APs), still commonly referred to as probation hostels, occupy an unusual position within the criminal justice system in England and Wales. There are just over 100 establishments, providing more than 2,000 beds for men and women, with most managed directly by the Probation Service and a smaller proportion operated by voluntary organisations under contract. Their principal function is to provide temporary, semi-secure accommodation for people released from prison who require additional supervision and risk management (Marston and Reeves, 2022).

Residence in an AP is normally imposed as a condition of post-release licence. Residents are therefore living in the community, but their freedom is substantially constrained. Curfews, monitoring, restrictions on movement and other licence conditions are commonplace, while serious or repeated non-compliance may result in recall to prison. APs consequently represent neither custody nor independent community living. They occupy an important intermediate position between the two.

This position is particularly significant when considering mental healthcare. People entering APs frequently have substantial and complex health needs. Many arrive directly from prison, including some who have received care from prison mental health in-reach services. Others have histories of substance misuse, self-harm, suicidal behaviour, personality difficulties, trauma and poor physical health. Yet release from prison also changes fundamentally the healthcare system upon which they depend. Prison healthcare ends and responsibility passes to community services.

This paper argues that APs expose an important weakness in this transition. Residents are located at precisely the point where continuity of care is most necessary but can be particularly difficult to achieve. The problem is therefore not simply one of a high prevalence of mental disorder. It is also one of discontinuity between systems.

The particular challenge of Approved Premises

The high level of health need among people in prison is well established. Poor mental and physical health frequently coexist with substance misuse, socioeconomic disadvantage, histories of trauma and social exclusion. Because most AP residents arrive from prison, APs inevitably accommodate a concentration of these difficulties.

However, the AP environment introduces additional challenges. Prison, notwithstanding its many harmful effects, provides a highly structured environment. Medication, appointments and contact with healthcare professionals can be

organised within an institution in which the individual is physically contained. On release, this structure disappears remarkably quickly.

Residents must negotiate the responsibilities associated with ordinary community life while simultaneously complying with the unusually intensive requirements of an AP placement. They may need to claim benefits, register with a GP, attend probation and healthcare appointments, rebuild family relationships, seek permanent accommodation and comply with licence conditions. Alcohol and illicit drugs become more readily available. For some residents, these pressures explain the apparently paradoxical observation sometimes made to AP staff that living in an Approved Premises can feel “harder than prison”.

The AP itself can also be demanding. Establishments vary considerably in size, but residents live alongside others who may themselves be experiencing addiction, mental disorder, emotional instability and substantial social problems. Some residents are deliberately placed considerable distances from their home communities because of risk-management considerations or exclusion zones. Consequently, the very placement intended to support safe resettlement may simultaneously separate an individual from family, established healthcare and other sources of social support.

These pressures matter because the period immediately following release from custody is already one of considerable vulnerability. Suicide and self-harm represent particular concerns. Deaths of people under probation supervision occur at rates substantially above those found in the general population, and the Prisons and Probation Ombudsman continues to investigate deaths occurring within Approved Premises. AP staff therefore manage a population in which psychological distress can rapidly become a crisis.

Approved Premises as a liminal environment

The concept of liminality provides a useful way of understanding this position. Originally used to describe transitional states in which an individual has left one social position but has not yet fully entered another, the concept has subsequently been applied much more broadly to institutional and social transitions.

AP residents are, in an important sense, liminal. They are no longer prisoners but are not entirely free members of the community. They sleep outside prison walls but remain subject to surveillance, curfew and the possibility of rapid return to custody. Their status is simultaneously that of citizen, patient, former prisoner and person subject to statutory supervision.

This ambiguity extends to healthcare. In prison, healthcare responsibility is relatively clearly defined. Following release, residents become eligible for mainstream NHS services in the same way as other citizens. In practice, however, simply becoming eligible for community healthcare does not guarantee meaningful access to it.

The AP consequently becomes a point at which different systems intersect: prisons, probation, primary care, community mental health services, substance misuse provision, local authorities and specialist forensic services. Each operates according to different thresholds, geographical boundaries, referral processes and organisational priorities. Residents are expected to cross these boundaries at precisely the time when they may be least equipped to do so.

The result can be a paradox. A person may receive regular psychiatric input while in prison yet experience less support immediately after release, despite encountering substantially greater environmental demands.

Continuity of care

Continuity of care should therefore be central to understanding mental healthcare in APs. Continuity involves considerably more than simply making a referral before release. It encompasses the maintenance of therapeutic relationships where possible, effective transfer of information, coordination between agencies, timely access to medication and treatment, and the avoidance of unnecessary interruptions during transitions.

For AP residents, several components of continuity may be threatened simultaneously. The prison providing treatment may be located in one area, the AP in another and the resident's eventual permanent accommodation somewhere else again. A single period of resettlement may therefore involve several geographical and organisational transitions.

The relatively short duration of many AP placements compounds the problem. Community mental health services necessarily operate assessment and eligibility procedures, and waiting times may exceed the resident's stay. A referral can therefore be administratively successful while being clinically ineffective: by the time an appointment becomes available, the person may have moved.

The consequence is a conspicuous gap between prison mental health in-reach and ordinary community mental healthcare. It is within this gap that AP staff frequently find themselves working.

AP staff as de facto providers of continuity

AP staff are not mental health professionals. Nevertheless, their contribution to maintaining residents' wellbeing is substantial and arguably under-recognised.

Staff are present throughout the day and night. They observe residents' behaviour, recognise deterioration, listen to concerns and frequently become the first people to respond when an individual becomes distressed. On arrival, residents are assessed for vulnerabilities including substance misuse, self-harm and suicide. Where significant concerns emerge, procedures provide for enhanced observation, assessment and review. Staff consequently require skills in suicide prevention, first aid, emergency responses and, increasingly, naloxone administration.

Much of this work might best be described as relational containment. Staff provide structure, reassurance and practical assistance while simultaneously exercising statutory authority. Simple actions—helping somebody register with a GP, encouraging medication adherence, arranging an appointment or noticing an abrupt change in behaviour—may prevent a deterioration from becoming a crisis.

Yet this creates an important tension. The system depends substantially upon non-clinical staff to maintain people with potentially serious mental disorders during the transition between clinical services. The more fragmented formal continuity becomes, the more responsibility implicitly shifts towards AP staff.

Access to primary and secondary care

Primary care provides the most obvious route into community healthcare. AP residents are entitled to register with and receive treatment from general practice. In many cases this works satisfactorily. Nevertheless, difficulties occur.

Residents may arrive without adequate medical information or supplies of medication. Practices may have understandable concerns about managing individuals presenting substantial risks. Residents may subsequently move to another area, disrupting referrals that have only recently been established. A person can therefore experience several changes of healthcare provider during a relatively short period.

Access to secondary mental healthcare can be still more difficult. Crisis services provide an important route for residents experiencing acute deterioration and may offer assessment, short-term intervention or onward referral. However, crisis services are designed principally to respond to acute need rather than provide long-term continuity.

For residents with severe and enduring mental disorders, Community Mental Health Teams (CMHTs) would appear to offer the most appropriate support. In practice, access can be complicated by referral thresholds, geographical eligibility and waiting times. Prison mental health teams may make referrals before release, but acceptance by a community team is not automatic.

This can produce the uncomfortable situation in which an individual who received regular specialist mental healthcare in custody moves into an AP and experiences a reduction rather than an enhancement of clinical support.

Specialist provision

There are examples of more specialised provision. The Offender Personality Disorder (OPD) pathway has developed services across prisons, probation and Approved Premises, including Psychologically Informed Planned Environments (PIPEs). These approaches recognise explicitly that the environment and relationships surrounding an individual can themselves have therapeutic significance.

A small number of APs also benefit from enhanced specialist mental health provision, including establishments developed in partnership with NHS services. Such models demonstrate what can be achieved when clinical expertise is brought directly into the AP environment. Their limited number, however, means they cannot provide a general solution to the mental health needs of the AP population.

RECONNECT represents another potentially important development. Designed to improve continuity between custody and community healthcare, the service works with people before and following release to facilitate engagement with community health services. Enhanced RECONNECT extends this approach to individuals presenting particularly complex needs or high levels of risk.

The importance of these initiatives lies partly in their recognition that merely telling somebody which service to contact is insufficient. Transition requires active coordination.

Closing the gap

The central problem facing mental healthcare in Approved Premises is therefore not simply insufficient specialist provision. It is fragmentation.

Improvement requires a clearer expectation that continuity begins before release from prison. Where somebody is receiving active mental healthcare in custody, release planning should identify who will assume clinical responsibility, how medication will be maintained and when the individual will actually be seen. A referral alone should not constitute evidence that continuity has been achieved.

APs should also have clear and rapid routes into local mental health services. Given the concentration of need within these establishments, expecting each resident to negotiate conventional pathways independently is inefficient and potentially unsafe. Greater use of named mental health liaison professionals, regular clinical sessions within larger APs or dedicated referral pathways could reduce dependence upon crisis services.

The role of AP staff also deserves greater recognition. This does not mean transforming probation staff into clinicians. Rather, staff require sufficient mental health literacy to recognise deterioration, communicate effectively with health professionals and understand how to obtain appropriate assistance. Equally important is access to professional consultation when they are uncertain about a resident's presentation.

Finally, healthcare planning must recognise the temporary nature of AP residence. A successful intervention is not one that merely connects an individual to services surrounding the hostel. It must anticipate the next transition and, where possible, ensure that care follows the person rather than repeatedly requiring the person to begin again.

Conclusion

Approved Premises perform an essential but difficult function within the resettlement system of England and Wales. They accommodate people at a moment of profound transition, often combining substantial mental and physical health needs with stringent requirements for supervision and risk management.

Viewing APs as a liminal environment helps explain why mental healthcare is particularly challenging. Residents have left the highly structured healthcare environment of prison without necessarily becoming securely connected to community provision. At the same time, they face increased freedom, greater personal responsibility and exposure to the social pressures associated with resettlement.

The resulting continuity-of-care gap places considerable demands upon AP staff and can leave residents with serious mental disorders inadequately supported at precisely the point when they are most vulnerable.

Specialist initiatives including the OPD pathway, PIPEs and RECONNECT demonstrate an increasing recognition of this problem. However, specialist programmes cannot substitute for reliable connections between prison healthcare, primary care, community mental health services and probation.

The challenge is therefore less about creating another discrete service than about making existing services join together. Approved Premises sit at the boundary between institutions. Their residents should not be expected to carry the consequences when healthcare systems fail to cross that boundary with them.

References

- Brooker, C. and Sirdifield, C. (eds.) (2022) *Probation and Mental Health: Towards Evidence-Based Practice*. London: Routledge.
- HM Government and NHS England (2023) *National Partnership Agreement for Health and Social Care for England: Improving Health Outcomes for People in Contact with the Criminal Justice System*. London: HM Government/NHS England.
- Marston, P. and Reeves, C. (2022) 'Approved Premises: Futures of Control in the Community', in Burke, L., Carr, N., Cluley, E., Collett, S. and McNeill, F. (eds) *Reimagining Probation Practice: Re-forming Rehabilitation in an Age of Penal Excess*. Abingdon: Routledge, pp. 152–173. <https://doi.org/10.4324/9781003172031-9>.
- Ministry of Justice (2025) *Deaths of Offenders in the Community*. London: Ministry of Justice.
- Moran, P., Jarrett, M., Vamvakas, G., Roberts, S., Barrett, B., Campbell, C., Khondoker, M., Trebilcock, J., Weaver, T., Walker, J., Crawford, M. and Forrester, A. (2022) *National Evaluation of the Male Offender Personality Disorder Pathway Programme*. Ministry of Justice Analytical Series. London: Ministry of Justice. National Institute for Health and Care Research (2022) *Evaluation of RECONNECT Services for Adult Prison Leavers*. London: NIHR.
- NHS England (2026) *Primary Care Services*. London: NHS England.
- NHS England (2026) *Crisis and Acute Mental Health Services*. London: NHS England.
- Office for National Statistics (2025) *Suicides in England and Wales*. Newport: ONS.
- Prisons and Probation Ombudsman (2026) *Investigations into Deaths in Approved Premises*. London: PPO.
- Reeves, C. (2015) 'Everyday life in UK probation approved premises for sex offenders', in Reeves, C. (ed.) *Experiencing Imprisonment: Research on the Experience of Living and Working in Carceral Institutions*. Abingdon: Routledge, Taylor & Francis Group Wakeling, H. et al. (2026) Research concerning Approved Premises in England and Wales.