Authors' reply: Dr Boast is quite correct to highlight the probable variation in practice across different services. Similarly, we know there are wide variations in practice across prison mental health services and post-release aftercare.[1,2] Although this is not surprising, it is important to note as any future policy in this area will need to ensure that best practice is shared, so that offenders with mental health problems have access to safe and effective care equivalent to that offered in NHS and healthcare settings.

Dr Boast suggests that we paint a negative picture of services and current practice, but we do in fact acknowledge that some discharges back to prison are entirely appropriate, especially for those patients without a serious mental illness where long-term treatment is not required. Time spent in medium secure units would generally be positive for those admitted from prison, but in some cases any benefits will be lost once the patient returns to prison. We wanted to emphasise that there is currently very little evidence to suggest that the quality of care in prison is equivalent to that in medium secure services and we know that many prisoners will, for a number of reasons, discontinue their treatment while in prison or after release.

Tragedies recently reported in the media involving mentally ill people soon after their release from prison highlight the importance of effective community care and treatment and on-going support and supervision. This is particularly true for those released with psychotic illness.[3] In response to this need, we are currently investigating what happens to patients once they return to prison from medium secure units and we hope to have preliminary findings by the summer of 2015. We are aware that the burden of providing care and treatment to released prisoners is frequently placed on already hard-pressed primary care teams and mainstream mental health services, even though more intensive and specialist interventions are often required.

We concur with the proposal for new prison hospital services and we commend the model described by Dr Boast, which is currently operating in East London. New service models and the suggestion for wider use of hybrid orders are of real interest and warrant further consideration from a policy, clinical and legal perspective.

Although the return to prison of an increasing number of patients from medium security may be inevitable to prevent bed blocking and maintain the throughput of patients in an expensive in-patient service, we currently do not know the full cost or consequences of this policy. This includes risks of further relapse and readmission and possible risk to public safety due to what is, in effect, a bed-management policy.

To conclude, we hope our article, Dr Boast's letter and our response continue to generate discussion in this important area, so that the availability, configuration and quality of services provided to mentally disordered offenders remains high on the commissioning and regulatory agenda.

1 Lennox C, Senior J, King C, Hassan L, Clayton R, Thornicroft G, et al. The management of released prisoners with severe and enduring mental illness. *J Forens Psychiatry Psychology* 2012; **23**: 67–75.

2 Shaw J, Senior J, Thornicroft G, Birmingham L, Kendall K, Brooker C. *A National Evaluation of Prison Mental Health In-Reach Services. A Report to the National Institute of Health Research.* The Offender Health Research Network, 2009 (http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf).

3 Keers R, Ullrich S, DeStavola B, Coid J. Association of violence with emergence of persecutory delusions in untreated schizophrenia. *Am J Psychiatry* 2014; **171**: 332–9.

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