IPL0003

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In summary

- It is known that many people in prison have mental health problems, but current data on actual clinical need is limited and piecemeal.
- Since the 1999 Future Organisation of Prison Healthcare report, healthcare for prisoners has been delivered as a partnership between the NHS and the Prison Service.
- For mental healthcare, the main reform was the development of Prison Mental Health In-Reach Services, created as the equivalent to community mental health services serving the wider population (henceforth “In Reach”), created following the 2001 Changing the Outlook report.
- In Reach was initially intended to focus on prisoners with severe and enduring mental illness – including schizophrenia and psychosis.
- However, a 2005 evaluation found that In Reach was instead becoming a catch-all for all mental health needs in the prison population, due to a lack of prison-based treatment services for people with common mental health problems .
- A 2012 study led by researchers at The University of Manchester found a very low rate of continued engagement with community mental health services in released prisoners.
- It is known that former prisoners have elevated rates of suicide following discharge and lack of engagement with routine healthcare services leads to excess use of expensive non-routine care, such as ambulance and accident and emergency services.
- Therefore, it was identified that a different approach was needed, with researchers trialling and evaluating the Critical Time Intervention model (CTI).
- CTI involves working with people before they leave a secure environment, to ensure they are set up with funding, accommodation, employment, education, and other services, as well as appropriate healthcare.
- In the US, this was found to significantly reduce the number of nights spent homeless by discharged psychiatric patients.
- A research team led by The University of Manchester evaluated the effectiveness of a CTI model in improving prison leavers’ engagement with community mental health services.
- Prisoners discharged following CTI were found to be significantly more likely to remain in contact with services at 6 month and 12-month intervals following release.
- A qualitative study (also led by The University of Manchester) found that CTI was approved of by staff and prison leavers, with CTI participants reporting less anxiety about release, and more support with community reintegration.
- Direct delivery of CTI is more expensive than treatment as usual in terms of costs to the NHS, but further research is needed to determine whether its use leads to overall savings to the public purse in terms of reduced use of emergency healthcare

services, reduced drug and alcohol use, potential reductions in reoffending and increased community tenure for a needy population.

In detail

Before the start of the 21st Century, prison healthcare was delivered 'in house', with the Prison Medical Service remaining distinct from the NHS. It faced criticism for being out of date, not developing at the same rate as the NHS, and having underqualified, under-trained staff.

This changed in 1999, with the Future Organisation of Prison Healthcare report, which led to the creation of a partnership between the Prison Service and the NHS in delivering healthcare. In practical terms, this meant that prison healthcare services are routinely part of competitive tendering processed resulting in contracts being awarded to local NHS services, a small number of NHS Trusts which operate super-regionally, or private providers, such as Practice Group Plus.

However, it is widely acknowledged that there has never been sufficient provision of mental health services in prisons. It is known that many people in prisons have mental health problems, but there is little current data on this. **An ONS survey in 1997 found that the prison population shows a higher incidence of psychosis, addiction disorders, and depressive disorders than the general population.**

In Reach

The 2001 Changing the Outlook report led to the creation of In Reach teams in prisons, which were the equivalent of community mental health teams. The aim of In Reach was to help prison leavers resettle into community services.

A 2005 evaluation of In Reach services, though, found that they were underfunded and understaffed. The original remit of In Reach was to focus on patients with severe and enduring mental health conditions, such as schizophrenia and psychosis. However, prison healthcare had no equivalent of multi-disciplinary primary care services, which – in the community – would deal with mild and moderate mental illness, such as depression. As a result, the objective of In Reach was broadened to cover all mental health cases in prisons, with the result that the service was overwhelmed, and unable to focus on cases of greatest need.

Prison leavers who have engaged with In Reach services are supposed to make contact with community mental health services. To help facilitate this, In Reach teams may take steps such as providing contact details of community services, or even scheduling appointments on behalf of prison leavers for them to attend upon release.

In reality, though, prison leavers often have chaotic lives, with many of them homeless or lacking a permanent address, and not registered with a GP. They often, therefore, make heavy use of emergency healthcare services to meet everyday health and care needs, with significant expense to public services in money and time and less than optimum personal and societal health outcomes.

Because of the disruption faced by prison leavers upon release, making contact with community mental health services is often a low priority.

A 2012 study led by The University of Manchester found that, of 53 prisoners who had been in touch with In Reach services, and who had severe and enduring mental health conditions, **just 4 were in contact with community mental health services six-months after**

release. The study concluded that there "*is a need for robust discharge planning and proactive through care for prisoners with mental health problems*".

In interviews with ex-prisoners, it was found that they didn't have time to make or attend their appointments, in between arranging benefits, reconnecting with family, and organising accommodation. As a result, making and keeping appointments with mental health teams did not feature highly on their list of priorities.

Critical Time Intervention

Critical Time Intervention (CTI) is an American model of care, designed for people in psychiatric hospitals who were discharged as homeless. It involves the development of holistic discharge packages, to organise all the services and needs that patients have said are a priority to them. This includes funding, accommodation, education, and employment alongside healthcare needs. CTI managers (who are clinicians, routinely nurses) work with patients both before and for a short period following their discharge, to ensure they have stable pathways and support in place.

A review of CTI in the US found that patients who received support from this model were less likely to be homeless, and spent less time using emergency care facilities, than the 'treatment as usual' group.

Researchers from The University of Manchester wanted to know if this model could be applied to prisons. They adapted the training manual for CTI managers, to cater to the needs of prison leavers. This included steps such as:

- Ensuring prisoners on remand were able to attend court dates with arrangements in place (such as medication supplies, appointment with community services) should they be released.
- Registering prison leavers with GP services in the areas they were discharged to.
- Liaising with statutory and third sector organisations, plus families and other community links, around providing accommodation, where this was possible.

One of the biggest challenges faced by prison leavers and CTI managers during the trial was finding suitable accommodation, with even temporary or hostel accommodation difficult to arrange.

Two trials were carried out to evaluate the effectiveness of CTI, with the larger trial focussing on prison leavers with severe and enduring mental health issues.

It was found that people who went through CTI were significantly more likely to remain in contact with mental health services, and to be concordant with their medication, than those who didn't. This was true at 6 and 12 months after release.

CTI means working proactively with people before they leave prison, and includes a transitional period. For instance, a CTI manager may meet a prison leaver at the gates, to take them to GP appointments, probation appointments, housing providers and so on. The handover to community mental health services is gradual, with CTI managers ensuring the necessary support is in place before disengaging.

Researchers found that, in addition to better outcomes, CTI was liked by both prison leavers and staff, with a common notion that it was the 'right thing to do', and that working in this intensive way provided 'proper' mental health care. **CTI participants were less anxious about release, and reported receiving more support with housing, access to services,**

and community reintegration, than during previous periods of incarceration, due to being closely supported by their CTI manager.

CTI has not been widely adopted to date, in part due to higher costs than the standard model of release. However, given that it showed significantly better outcomes for prison leavers with severe mental health issues, it is likely that its use could lead to net savings overall, through wider economic benefits to public services through lower use of emergency care, better community integration, and reduced rates of reoffending.

The Ministry of Justice should commission research to investigate the wider health economics of CTI.

CTI is no magic bullet – a related model, Engager, when trialled found that, for prisoners with more mild mental health conditions, the results were mixed. However, for those prisoners with the greater mental healthcare need, the evidence shows that CTI has the potential to be a powerful tool for improving community resettlement, and helping prison leavers to lead fulfilling lives outside the justice system.

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