

## Engagement with Mental Health Services on Release from Prison

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### Abstract

Engagement is seen as an important part of successful treatment in severe mental illness, however, it is often not well defined as a concept. A number of attempts have been made to clarify this definition and psychometric measures have been developed to assess engagement. This commentary discusses issues related to engagement with mental health services and its application to prisoners with severe mental illness returning to the community.

### Introduction

The periods leading up to and immediately following release from prison are highly stressful for prisoners, with uncertainty regarding their personal affairs (e.g. housing, benefits, family relationships) and legal restrictions [1] complicating arrangements for their return to the community. There is an increased frequency of severe negative health outcomes in the immediate post-release period with higher numbers of suicides in the 1st month [2] and compared to the general population, twenty nine times the rate of all-cause mortality during the first two weeks after release [3].

For prisoners with a severe mental illness, there is the added complexity of transferring or returning to the care of community mental health services [4]. A recent study indicating that lack of psychiatric treatment may be linked to violent behaviour [5] highlights the importance of treatment in preventing recidivism. However, studies have demonstrated that there are high dropout rates in this period of transition, and that even where there is communication and discharge planning between prison and community services, only a small minority of patients make contact with mental health care in the period after release [6].

### Engagement for Released Prisoners with Mental Illness

Engagement is often described as important to successful treatment and is at the centre of well-cited reviews regarding the improvement of mental health services [7], but is less often clearly defined. In an area as under-researched as the community re-entry of mental patients, assessing contact is in itself a worthwhile goal. For those with a mental illness, contact with community mental health services after release from prison is a necessary first step for engagement and has been shown to be related to health and forensic outcomes. The risk of mortality is greatly elevated in prisoners returning to the community with high levels of drug related deaths and suicide [2,3] and in other settings, follow up within seven days of discharge is recommended and has been shown to be beneficial in avoiding these outcomes [8]. Patients with a severe mental illness may also be more likely to commit further crimes after release and case management in the community can reduce this risk [9].

Contact alone, however, does not reflect the complexity of the concept of engagement. A large number of studies that discuss engagement with, or disengagement from, services record only appointment keeping or loss of contact [10]. There is a growing consensus that issues such as acceptance of help, collaboration in treatment and openness with mental health workers are also integral aspects of engagement, and measurement of a number of facets is needed to reflect the term's complexity. Contact and other elements of engagement will be related

in many cases but measuring only one part of engagement, such as contact or appointment keeping, may give misleading conclusions. In some contexts, particularly in assertive community treatment [11], the relationship between contact and engagement is complex with more contacts reflecting poor engagement and the need for a team to pursue an unwell and poorly engaged patient. Similarly, a patient with a long term but stable illness may have infrequent contact, yet be still well engaged.

In recent years, measures with well-established psychometric properties have been developed that consider a more complex definition of engagement. Some of the first comprehensive measures come from clinical psychology where mere attendance has not been seen as sufficient to indicate progress in psychological therapy [12] and psychiatry has followed with a number of groups putting their work forward [13].

Of particular interest to forensic researchers and practitioners will be the Treatment Engagement Rating scale [14] that has been developed in Dutch forensic outpatient units. This tool assesses nine components of engagement (i.e. Session Attendance, Making Sacrifices, Openness, Effort to Change Problem Behaviour, Goal Directedness, Efforts to Improve Socio-Economic Situation, Constructive Use of Therapy Session, Dealing with the Content of Therapy Between Sessions and Global Rating of Treatment Engagement) and is completed by a therapist who rates each of the 21 items on an individualised 5 point scale. The component scores can be analysed separately or combined to give a total engagement score. It is designed to be applicable to a variety of patients and treatment with varying goals and has been shown to predict treatment completion and treatment outcome [15]. Although session attendance alone was significantly associated with both outcome variables, other components in the scale were more strongly related to the outcomes. The results from this group again highlight the value of recording contact and session attendance, but also reinforce the notion that engagement is more complex and that studies using a simple method of measurement should not overstate their results.

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## Improving Engagement during the Transition from Prison to Community

There is agreement that engagement is of high importance, yet research suggests that in the period after release from prison, few patients make the contact with appropriate community mental health services [6]. In England and Wales, it is recommended that a multidisciplinary team meeting, with professionals from both prison and the community, convenes to put in place discharge plans. In many cases this is not possible due to the limited resources of services and the unpredictability of a release in remand populations leading to a lack of robust discharge planning. After release the responsibility for contact is shared by the patient and health professionals. Case management by community services may be crucial to reducing levels of recidivism [9] and whilst initiatives to improve engagement across this transition are in place across North America, empirical evidence regarding their efficacy is limited [16].

Critical Time Intervention (CTI) is a time-limited case management model that aims to improve engagement by providing additional care that bridges prison and community services. It is patient-centred and the goals of the intervention are decided jointly by the patient and therapist. The primary aim is to ensure continuity in care between prison and community services, but the therapist can also be active in addressing a number of other issues and concerns (i.e housing, benefits, employment, social support, substance problems). This model of work conforms to previous suggestions on how barriers to engagement can be addressed [17]. CTI is modifiable to the needs of the patient and aims to modify the patient with discussion of their hopes and concerns for the future and collaborative plans to solve these.

CTI has a well-established evidence base in a variety of other contexts [18] and in English prisons, Jarrett et al. [19] found that the intervention was feasible and that patients in the treatment arm of the pilot had better outcomes than controls; a randomised controlled trial is underway [20] and will recruit a larger number of participants with more comprehensive baseline and follow up data that will allow more complete analysis. Patients' own opinions and experiences of the transition from prison to the community are needed and qualitative interviews will be completed with a sub group of patients. This will allow a more comprehensive understanding of the difficulties patients face will give patients the opportunity to put forward their views about engagement with services and will allow discussions on the benefits of the CTI.

## Conclusion

There is a need to improve levels of engagement for patients who are released from prison both for those individuals and potentially for the wider community. Contact is part of engagement, is a necessary first step for this group of patients and therefore its inclusion in evaluation of interventions aimed at this period of transition is valid. However, contact alone does not sufficiently reflect the complexity of the concept and future research should consider using more comprehensive measures of engagement to ensure that contact with services is accompanied or followed by engagement, improving the likelihood of positive treatment outcomes.

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