# Supporting prisoners with mental health needs in the transition to RESETtle in the community: the RESET study

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Abstract

Background

Homelessness is linked to poor mental health and an increased likelihood of offending. People often lose accommodation when they enter prison and struggle to find accommodation upon release leading to an increased likelihood of relapse and re-offending. The RESET intervention was developed to support prisoners with mental health needs for 12 weeks after release to co-ordinate their transition into the community and obtaining secure housing.

Methods

The primary objective of the study was to assess the participants' housing situation. A prospective cohort design followed up sixty-two prisoners with mental health needs for nine-months post-release. Data was collected at three time points regarding accommodation, re-offending and contact and engagement with services. Inferential statistics using chi-squared tests and t-tests were used to examine differences in scores between the two groups at each time point.

Results

The RESET group were significantly more likely to have secure housing at all three time points being housed for approximately twice as many days than the comparison group (244 vs 129 days at nine months: p=<0.01). The RESET group also had a significantly greater level of contact with GPs and significantly more received benefits at all three time points.

Conclusion

This is the first study to focus on reducing homeless for recently released prisoners with mental health needs. The RESET intervention was successful in achieving its main objective; accommodating participants in permanent housing and reducing homelessness. There was also an association between receiving the intervention and greater engagement with other services. This supports the view that secure housing is important in ensuring a positive transition from prison to the community for prisoners with mental health needs.

Keywords

Mental health, Prison, Housing, Community, Transition

Background

The prison population in England and Wales was 83,353 in December 2019 [1]. It has been reported that over 90% of prisoners have one or more psychiatric disorders with 7% of the male prison population diagnosed with a psychotic illness [2] compared to 0.4% to 0.7% of the general population [3,4].

Prisoners, Homelessness and Mental Health

Homelessness is linked to poor mental health and an increased likelihood of offending. The proportion of homeless people with mental health problems in Great Britain is nearly double that of the general population with many also reporting drug and alcohol problems [5]. This often reduces the help available with services unable or unwilling to provide mental health support to homeless

people still using drugs or alcohol. Crisis, the charity that provides support, advice and courses for homeless people across Great Britain, reported that people often lose accommodation when they enter prison [6]. On release, they then struggle to find accommodation with a private landlord and can wait months to get housing benefit. A third of people leaving prison have nowhere to go upon release [7] representing up to 50,000 people annually [8]. A 2018 survey indicated 36% of rough sleepers in London had served time in prison [9] with 15% of prisoners homeless prior to incarceration [10]. Nearly 80% of those who were homeless before entering custody had reoffended within one year compared to less than half of those in secure housing [10]. Stable accommodation was estimated to reduce the risk of reoffending by 20 per cent [7].

Supporting prisoners with mental health needs

Many prisoners with mental health needs make active use of health and other services when in prison [11]. However, after release, community support is limited [12,13] with only a small number of released British prisoners in contact with mental health services [14]. The first month post-release is highly stressful for all prisoners due to uncertainties about legal restrictions, trying to find secure housing and accessing benefits. Prisoners with mental health needs have the added concern of transferring care teams [15]. Maintaining contact with services is important as there is an increase in severe negative health outcomes in the period after release from prison [16]. The suicide rate for prisoners with mental illness in the first year post-release is 8.3 times higher than the general population with nearly a fifth of these taking place within 28 days of release [17]. Prisoners also have twenty-nine times the rate of all-cause mortality during the first two weeks after release compared to the general population [16].

Having a safe place to live and maintaining mental and physical wellbeing are high priorities for released prisoners with mental health needs [18,19]. Housing problems negatively impact on the establishment of a stable routine outside prison [20] with 42% of prisoners having no fixed abode and 50% not registered with a General Practitioner (GP) upon release. A lack of co-ordinated service planning impacts on prisoners' abilities to access housing which leads on to an increased likelihood of substance misuse and reoffending [21]. The Bradley report, which looked at how to divert people with mental health problems and learning disabilities away from the criminal justice system, concluded that for resettlement to be successful prisoners needed to engage with community services as soon as possible once they left prison [22].

Most existing research has focused on supported release schemes from the general prison population with few interventions targeting the transition between prison and the community for prisoners with mental health needs [23,24]. One systematic review has reviewed the evidence [25]. Thirteen research studies were included; ten from the United States of America, two from England and one from Australia. The interventions lasted from six weeks to one year with most ranging between three and six months. The review found interventions improved contact between participants and support services but did not reduce reoffending. No intervention examined accommodation status.

Critical Time Intervention (CTI)

The CTI approach was developed in the USA in the 1990s as a structured, time limited intervention to prevent homelessness in individuals with severe mental illness moving from hospital into the community. Early studies showed CTI significantly reduced homelessness [26]. Shaw and colleagues designed a multisite trial (the CrISP study) utilising a CTI model for male prisoners with severe mental illness in England. The study reported significantly greater service engagement at six weeks

and a non-significant greater level of engagement at 12 months [19]. The ENGAGER pilot trial, supporting men with common mental health problems upon release from prison and based on CTI principles, also reported good levels of engagement [27].

Community Rehabilitation Companies (CRCs)

During the period of the study, prisoners sentenced to a custodial term of more than one day received at least 12 months of supervision upon release. Offenders considered to be of low or medium risk were supervised by CRCs. The CRCs were private companies contracted by the UK government to manage and deliver a resettlement service for most offenders released from custody. The CRC resettlement interventions aimed to address the seven reducing reoffending pathways [28]. These were: providing access to suitable accommodation, developing skills to help settle into employment, tackling financial problems, securing access to primary care and other health services, encouraging users to access drugs and alcohol treatment, supporting users' children and families and addressing specific offending behaviours.

Supporting Prisoners to RESETtle in the Community (RESET) Intervention

The RESET intervention aimed to enable prisoners to positively prepare for release, providing a link between healthcare and statutory resettlement providers, to ensure a smooth and coordinated transition into the community. Prisoners were eligible for the service if they had mental health needs, no current release plan, were being released to specific catchment areas in South London or South East England and were capable of giving informed consent. The caseloads of 20-30 were smaller than statutory resettlement caseloads with approximately 50% of each team member's cases in prison and the other 50% in the community at any one time. Referrals to the RESET service were made by the Prison InReach team. Pre-release work predominantly focused on building a rapport, developing an individual's motivation and engaging with statutory services. The RESET team offered to meet the prisoner on their day of release and escort them to crucial appointments planned for that day such as probation and local authority housing. The team also ensured they had their correct medication, prescriptions and planned appointments for the first few days. Support continued for 12 weeks to help the participant obtain appropriate safe and secure accommodation, to access welfare benefits, to engage with health services and strengthen links with family and community support services. The RESET teams worked closely with a wide range of statutory agencies to provide holistic, joined up support. The workers in the RESET service did not hold professional qualifications though they often had sociology, social care or criminology degrees with all having prior experience of working in support roles with vulnerable people. The workers were trained to a minimum of level 4, Information, Advice or Guidance (IAG) training; roughly equivalent to the first year of an undergraduate honours degree. The staff also received training in skills such as motivational interviewing, housing law, advocacy and dynamic risk management.

Standard Care

The standard care was provided by the CRCs. Prior to a prisoner's release, the CRC resettlement team at the prison liaised with local probation services to discuss and address any identified housing need. The care provided by the CRCs upon release included: support with accommodation referrals, referrals to the benefit agency and supervision appointments to manage the terms of their release from prison. Some interventions were also instigated (i.e. completing housing applications or job searches). However, the comparison group were not met on the day of release and, there was not the intensive support, advocacy and mentoring for 12 weeks post release to address their

accommodation, benefits and ongoing healthcare needs, as opposed to those receiving the RESET service.

Aims and Objectives

The overall aim was to examine the impact of the RESET intervention.

The primary objective: To examine the participants' accommodation status at three months post-release.

The secondary objectives: To examine at 2 weeks post-release, 3 months post-release and 9 months post-release:

- accommodation status (at 2 weeks post-release and 9 months post-release only)
- number on maintained benefits
- number in contact with mental health and GP services
- level of service engagement
- number in employment or education
- number reoffending

Method

A prospective cohort design was used. The participants were male prisoners, aged 18 and over, residing in six prisons in Kent and London and referred to the RESET service. Approximately 50% of the prisoners suitable to receive the support service became "lost" to the service due to various circumstances, such as being released unexpectedly at a remand hearing or being transferred to another prison. The intervention group were those who received the RESET service with those "lost" to the service acting as the comparison group. The comparison group received standard care planning provided by the CRCs.

Recruitment Process

A prison InReach worker met with each prisoner meeting the inclusion criteria and, if interested in participating, their names were passed on to the project researcher. Written informed consent was obtained before any data was collected. Participants were recruited from February 2017-January 2018 and followed up for nine months following release from prison. The flow diagram is detailed in the supplementary evidence.

Data Collection

Baseline data was collected in relation to participants' demographic details, previous and current mental health, forensic history, accommodation status prior to prison and the reasons for referral to the RESET service.

Data was collected regarding accommodation, re-offending and contact with services at three time points; two weeks after release from prison, three months post-release (the formal end of the RESET intervention), and nine months post-release. The data was collected by the study team with assistance from support agencies and clinical services. The level and quality of user engagement with services were also assessed using the Service Engagement Scale [29] at the three time points. This was completed by the RESET support coordinator or the link Worker involved in the participant's care. The measure has 14 items with four subscales; availability, collaboration, help seeking, and treatment adherence. A four-point Likert-type scale records the answers with lower scores indicative

of greater engagement between the participant and service. The number of participants engaging with the RESET service was also recorded at these three time-points. The frequency and number of contacts with the CRCs was not recorded.

Data Analysis

The data were entered in to IBM SPSS 24. Initially, descriptive analysis examined the results of the intervention and comparison groups. Chi-square tests were conducted on all the categorical data sets and t-tests on the continuous data sets to examine whether there were any significant differences in the baseline information collected from the intervention and comparison groups. Inferential statistics using chi-squared tests were then used to examine any differences in scores between the two groups at the time points where categorical data was collected. T-tests were used to examine differences in those data sets where continuous data was collected.

Results

Sixty-two participants were recruited to the study with thirty-one receiving the RESET intervention and thirty-one participants, assessed as eligible to receive the service but "lost" and not receiving the intervention, in the comparison group. The comparison group consisted of ten prisoners released without support, ten that did not engage with services upon release, three transferred out of the referring prison, four not supported for "other reasons" with missing data on four further prisoners. The participants' baseline demographic, clinical, and offending information are detailed in Table 1.

The characteristics of the two groups were similar. The participants were predominantly single, unemployed, white British men in their thirties with a history of substance misuse and self-harm and at least one previous prison sentence. The intervention group had been serving a slightly longer prison sentence while there were slightly more in the comparison group subject to Assessment Care in Custody and Teamwork (ACCT) supervision, to monitor their mental health and risk of self-harm, at the time of release. The primary diagnosis of the RESET group participants, as noted in their prison InReach case notes, was; mood disorder 14 (45% ), schizophrenia 9 (29%), personality disorder 6 (19%) and other 2 (6%)). Similar numbers were reported in the comparison group; mood disorder 16 (53%), schizophrenia 7 (23%), personality disorder 3 (10%) and other 4 (13%). One participant in the comparison group did not have a diagnosis recorded. The main diagnosis in the "other" category was drug and/or alcohol misuse. The principal reason for referrals to the RESET service was for help with housing.

The housing situation prior to prison is reported in Table 2. Nearly 80% of participants reported either being homeless or living with family or friends with more homeless participants in the intervention group and a greater number of participants living with friends or family in the comparison group. None of the differences were statistically significant.

Two weeks post-release, there were 30 participants (97%) engaged with the service meeting weekly or twice weekly. At the end of the formal RESET intervention period, 29 participants (94%) were still in contact with the service (mainly weekly). Five participants remained in contact with the service at nine-months post-release. No deaths were reported during the follow-up period.

Tables 3,4,5 detail the accommodation status, engagement with services and service engagement scale results for both groups at the three time points.

Table 3 shows the RESET group were significantly more likely to have secure housing at all three time points with the RESET group being housed for approximately twice as many days than the comparison group. There were also significant differences in the number homeless at the first two

time points with no-one homeless in the RESET group compared to over a quarter in the comparison group. The homeless number remained higher in the comparison group at 9 months post–release. The participants in temporary accommodation were all in the RESET group. The difference was significant at the first time point and almost the reverse of the numbers of homeless recorded in the comparison group. There were also consistently higher numbers of the RESET group in Bed and Breakfast accommodation with the difference being significant at three months post-release. The comparison group had more days in hospital throughout the nine months follow up period with this difference being significant at 14 days post release. Some of the comparison group were in prison at all three time points as opposed to no-one of the RESET group. There were also consistently more of the RESET group in independent accommodation at all three time points. The RESET group were more likely to reside with family and friends although the difference in numbers with the comparison group was small. Similar numbers of both groups were found in hostel accommodation and supported accommodation.

The RESET group had a significantly greater level of contact with GPs and significantly more were in receipt of benefits at all three time points as shown in Table 4. All had access to these services at three months with 90% of the group receiving both services at 14 days. This high level of contact was maintained at nine months post-release. Consistently more of the RESET group were in contact with mental health services. Few of either group entered in to employment or education.

Table 5 reports the SES scores. The numbers of responses for the comparison group are small so the findings should be treated with caution. The RESET group scored lower on every sub-scale and the total score at all three time points indicating greater engagement. The collaboration sub-scale scores were significantly lower at fourteen days and three months post-release suggesting the RESET group had a greater level of service engagement regarding their care and treatment. The RESET group recorded low scores on the availability and treatment adherence sub-scales.

Offending

None of the RESET group re-offended in the first 14 days post-release as opposed to four in the comparison group. This was significantly lower ( $\chi^2$ 4.42(1) p = 0.04). Although not significant, less re-offending was also reported at the following two time points (five at three months and seven at nine months) compared to the comparison group (six at three months and nine at nine months).

Discussion

The project aimed to evaluate the impact of the RESET service. Data was collected from virtually all participants at the three time points (fourteen days – 60 (97%), three months – 60 (97%), nine months – 59 (95%). The follow up rates compare favourably to other studies.

At the end of the three-month intervention, the RESET group had significantly more days in secure housing with significantly fewer of this group homeless. More of the RESET group were in independent accommodation and significantly more in B&B accommodation. This was likely to be a result of the RESET service helping participant's access temporary accommodation while applying for permanent housing. The intervention group also had significantly fewer homeless participants at two weeks post-release and significantly more days in secure housing at the other two time points. More of the comparison group were also in prison at all three time points. These findings support the view the intervention was successful in supporting participants to access secure housing and reduce homelessness. Support from the outset is important as, even if people leaving prison have somewhere to stay initially, this can often be insecure or unsuitable with most ex-prisoners sleeping rough doing so after their initial accommodation had fallen through [30]. Providing immediate

support at the prison gates to help obtain accommodation and access to services is therefore important. The benefit of this can be gauged by the fact that none of the intervention group were homeless 14 days following release.

Secure housing has been proposed as the most important factor in ensuring a positive transition from prison to the community for prisoners with mental health needs as [19,31]:

(1) it establishes a stable base from which to address other resettlement concerns;

(2) secure accommodation is key aspect of being able to access services. Without a fixed address, they become difficult to connect with;

(3) housing helps break a cycle of returning to poor previous relationships and routines thus reducing the risk of reoffending.

It can be seen that the impact of the RESET intervention was more extensive than just addressing housing needs and that this wider effect was born out in the results.

Establishing a stable base

Sustained engagement on release has been problematic for both health and criminal justice interventions [32]. Prisoners often distrust healthcare professionals with housing, relationships, and employment higher priorities upon release [33]. The main exception is when interventions are particularly valued [32]. The high levels of service engagement are likely to reflect the value placed on the service by the RESET participants in this study. However, the method of allocating participants to either the RESET or comparison group was based on whether they remained in one prison or were "lost" to the RESET service. This could have led to the RESET group containing more participants who were inclined to accept help and the comparison group containing more participants who were more likely to reject support. Five participants also required ongoing support and were still in contact with the RESET service nine-months post-release. This suggests some users would benefit from more than three months of support. The intervention group were also significantly less likely to be admitted to hospital in the first two weeks following release and fewer days in hospital at three months suggesting having secure accommodation and support reduced the likelihood of relapsing.

Accessing services.

Obtaining accommodation soon after release helped establish a secure base for participants to access other services. Significantly more of the intervention group were in contact with a GP and in receipt of state benefits at all three time points. All of the RESET group were in GP contact at three-month post-release with 90% in contact within the first two weeks of release. Williamson recorded only 50% of released prisoners were registered with a GP [20]. The GP has a central role as the co-ordinator of helping with mental and physical needs and liaising with other services. Homeless people with mental illness have problems registering with a GP and, particularly, in obtaining medication with many released without any prescribed medication [34]. The value of having GP access can be recognised by the fact that 87% of the cohort were still in contact at nine-months post-release, long after the intervention had stopped.

100% of the RESET group were also in receipt of benefits at three months post-release with over 90% receiving benefits at the other two time-points. Accessing benefits helps ex-prisoners to have resources to find accommodation with a private landlord upon release and also allows them to purchase essential day to day items [5]. Interviews for benefit payments are often arranged at inaccessible venues for people with mental health problems with sanctions applied if appointments

are missed [34]. Delivering a service that supports participants to apply for benefits shortly after release, and taking them to appointments, leads to a larger number receiving benefits.

The RESET group were also significantly more likely to be in contact with mental health services with 48.4% in contact at the end of the intervention though this reduced to 25.8% of participants at nine-months. This is higher than those recorded by other studies at three months post-release and similar to those at nine-months post-release [19, 27]. Previous experiences of accessing health services were often poor resulting in a lack of trust with mental health services. Many ex-prisoners with mental health needs report that services would not support them due to their complex needs [35]. The positive relationship between the participants and the RESET service, and the service's knowledge of community provisions, was important in helping gain access to appropriate mental health services. The importance of obtaining secure accommodation before accessing services has also been noted as, without secure accommodation, daily survival was a constant struggle meaning their mental health was not prioritised [35].

The intervention group scored lower on the total score and all sub-scales on the Service Engagement Scale at all three time points indicating a greater engagement between the RESET intervention participants and services as opposed to the comparison group. The collaboration sub-scale scores showed significantly better engagement at fourteen days and three months. The findings need to be treated with some caution due to the low numbers of respondents in the comparison group. However, there were high response rates from the RESET intervention group supervisors at the first two time-points so these scores can be examined on their own. The collaboration sub-scale questions focus on the willingness of the participant to take an active part in their care and treatment and to accept advice. The score at the end of the intervention compares favourably with the score of 3.24 from a cohort with first episode psychosis recorded when developing the measure [29]. In addition, the RESET group recorded low sub-scale scores for their accessibility and availability when liaising with services and their constructive relationship with services with regards to medication treatment. It has been proposed the true level of engagement can be judged by looking at the acceptance of help, collaboration in treatment, and openness with mental health workers [16]. These scores support the view of a positive service engagement by the RESET group and can be seen as a potential foundation for developing future relationships with other services.

Few participants were in education or employment in the nine months following release. This could be explained by the need to address ongoing mental health concerns and maintain some level of stability in the community prior to engaging in education or training.

Breaking a cycle of poor previous relationships and routines.

Significantly less of the intervention group reoffended in the first two weeks post-release with fewer re-offending at the other two time points. Although the numbers are small, the RESET group were more than 20% less likely to reoffend at nine months, similar to the figures reported by the Centre for Social Justice [7]. Prisoners with mental health problems are often released without housing and this increases the risk of reoffending [36] with 79% of those homeless before being brought into custody re-offending within one year of release [10]. In this study, at nine-months post-release, 22.6% of the RESET group had re-offended including 25% (four out of sixteen) of those who were homeless at the time of imprisonment. Having secure accommodation may have be an important feature in reducing the likelihood of re-offending.

There were some limitations to the study. The process of allocating participants to either the RESET or comparison group may have led to the RESET group containing more participants who were

inclined to accept help. Randomly assigning participants to both groups, or even recording SES scores at the time of recruitment, would have helped address this potential bias. All but eight (13%) of the participants in the study were White British. People of minority ethnicities made up 27% of the prison population in December 2019 [37] but Black Asian and Minority Ethnic (BAME) prisoners are under-represented in prison mental health caseloads [38]. This is a clear problem if it reflects a true pattern of referral and recruitment to the RESET service. It would be helpful to examine BAME prisoners' views of accessing support from RESET services to ascertain how they view (and access) the service. The RESET service currently only supports male prisoners so was unable to comment on the efficacy of the service to women with mental health needs transitioning out of prison. The number of participants was relatively small. It is recognised that the numbers recruited allowed significant findings to be reported. However, larger numbers would have given more robust information. The follow up period only lasted for six months following the cessation of the intervention. It is unclear what the impact of the intervention would be over a longer period of time. Although one of the roles of the RESET service, there was no examination of the impact of the intervention on the re-engagement or development of family contacts as this was not one of the objectives of the study.

## Conclusion

The study recruited sixty-two prisoners with mental health needs transitioning into the community and followed up for nine months following their release. The results indicate the RESET intervention was successful in achieving its main objective; accommodating participants in permanent housing and reducing the likelihood of homelessness. There is also support for the view that secure housing is important in ensuring a positive transition from prison to the community for prisoners with mental health needs with those receiving RESET services significantly more likely to be in contact with other services (for the receipt of state benefits, accessing GPs and engaging with mental health services), having a lower rate of re-offending and a greater level of service engagement. There was positivity from the participants about the RESET service with over 95% in contact with the service until the formal end of the support. It was also noticeable the RESET intervention had a significant positive impact on a range of outcomes in the first two weeks post-release indicating that being able to access the service at the time of release from prison is important. Subsequent studies would benefit from looking to recruit a greater number of prisoners with mental health needs transitioning into the community and randomly allocating participants to the intervention and comparison groups. The number of BAME prisoners accessing the service was lower than expected and it would be helpful to explore the reasons for this reduced take up.

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## Conflicts of interest

Three of the authors (AK, FH and JP) work for the Trust. However, the project was conducted independently of the funders and the views expressed in the paper are those of the author(s) and not necessarily those of Oxleas NHS Foundation Trust.

## Ethics approval

Ethical approval was obtained from the East of England – Essex Research Ethics Committee in December 2015 (reference number 15/EE/0414) and from the National Offender Management Service (NOMS) (reference number 2016-099) in August 2016.

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