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Critical Time Intervention for Severely Mentally Ill Released Prisoners

CrISP

Manual for Case Managers

[November 2015]

OFFENDER HEALTH RESEARCH NETWORK

Critical Time Intervention for
Severely Mentally Ill Released Prisoners
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About this manual

This manual has been developed to guide and support health and social care professionals using Critical Time Intervention (CTI) as a method for providing intensive, time-limited support for prisoners with severe and enduring mental illness (SMI) in their transition from prison to community living. CTI was initially developed in the United States of America specifically to support homeless people with SMI being discharged from hospital and is described in Chapter 1. This version is an adaptation of the original intervention.

Acknowledgements

Contributions were received from members of the core research team, the Steering Group formed for the randomized controlled trial that tested the adapted intervention, practitioners who worked as CTI managers during the randomised controlled trial and a Working Group established to revise the original manual comprising practitioners and public/patient representatives with mental illness who had experience of the transition from prison to community. A full list of manual contributors is included at the end of the manual.

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A. The original Critical Time Intervention (CTI) study

Originally, CTI was designed to prevent homelessness among people diagnosed with severe mental illness (SMI) as they transitioned from specialised sheltered accommodation and hospital care to accommodation in the community (Susser, E. et al., 1997). The developers of the intervention recognised that poor continuation of care and support at this vulnerable time point put successful re-entry to community living in jeopardy. Factors such as not taking medication as prescribed; difficulty managing drug and/or alcohol abuse; an inability to sort out finances; and problems re-establishing social and family networks increased the risk of independent community living arrangements breaking down and at-risk individuals becoming homeless once more. CTI aimed to redress this problem by providing a time limited, specialised intervention designed to bridge the gap between specialist services for the homeless and the mainstream community services that would provide longer term care.

The original CTI intervention was delivered by trained staff over a 9 month period and comprised 3 main phases, each of 3 months in duration: (i) transition to community, (ii) try-out, and (iii) transfer of care. During these stages, robust links between the client, service providers and social support networks were put in place; the ground rules for these relationships agreed; and practical advice and support provided for the client, service providers and friends/family as issues arose. The intervention proved successful with fewer homeless nights experienced by individuals who received the intervention than those who did not - and the positive effect persisted after the intervention period ended.

The success of CTI for those at high risk of homelessness opened up the possibility of it being suitable for other high risk groups and research started to test its efficacy in managing the transition between prison and community for people with SMI.

B. Mental illness in prison

There is considerable evidence to show that the prevalence of psychiatric morbidity among prisoners is higher than in the general population (Office for National Statistics, 1997; Birmingham et al., 1996). A recently published review confirmed that serious mental disorder is also disproportionately prevalent in prisoners, with about one in seven prisoners having a psychotic illness or major depression, (Fazel & Danesh, 2002). Thus severe mental disorders occur around 5-10 times more frequently in prisoners than people in the community, with prisons accommodating an increasing number of people with severe and enduring illnesses and complex needs. It has also been found that prisoners are less likely to have their mental health problems accurately identified (Birmingham, et al, 1996; Senior et al., 2013).

It is current English Government policy to provide mental health care of an equivalent standard in prison to care in the wider community (Bradley Report, 2009). This extends to an obligation to ensure continuity of care when the prisoner leaves prison. In reality, unpredictable release dates, particularly in the case of remand prisoners, means that often there is very limited time available for linking released mentally ill prisoners with community services. However, even where routine discharge planning has been possible, research has shown that few prisoners with severe and enduring mental illness go on to make contact with community mental health services (Lennox, et al., 2012), strengthening the argument for the implementation of more assertive through-care and discharge planning.

C. Adapting CTI for prisoners with severe mental illness (SMI)

There are clear parallels between the challenges faced by the client group of the original CTI study and prisoners with SMI re-entering community life, particularly in respect to the poor transfer of care to community mental health providers, negatively affected by co-morbid substance misuse and chaotic and unstable lifestyles. To investigate the potential utility of CTI to improve prisoners' engagement with community mental health services on leaving prison, the authors and collaborators of this manual trialed an adaptation of the original CTI model in two studies.

(1) Feasibility pilot study

In a study funded by the Medical Research Council (Ref: G0401268) participants under the care of mental health in-reach teams in three prisons, with a diagnosis of SMI and within 3 months of their release date were recruited to take part in a pilot study. In total 60 prisoners were randomly allocated to receive either the revised CTI or treatment as usual.

The findings from the pilot were encouraging. When the participants were followed up at 6 weeks from date of release, those that had received CTI were significantly more likely to be in contact with community mental health teams (CMHTs), registered with a General Practitioner (GP) and receiving medication than those who had received treatment as usual (Jarrett et al., 2012).

(2) The CrISP randomised controlled trial

Following on from the feasibility study, a much larger randomised controlled trial involving 200 male prisoners with severe and enduring mental illness was undertaken. The period of intervention and its phases mirrored those of the pilot study. Follow up took place over a longer period. Contact with the CMHT at 6 weeks following release was again the primary outcome measure however additional factors, including number of days in hospital, detention under the Mental Health Act and any subsequent convictions were also examined.

Findings: The intervention was effective in ensuring engagement with services at six weeks. Further, the difference between the intervention and Treatment as Usual group was maintained at the six, but not 12, month follow up points. Overall, staff and participants interviewed as part of the qualitative arm of the study were positive about the intervention. Analysis in regard to cost showed intervention group had higher levels of service use and costs than the control group.

Find out more about ...

Critical Time Intervention:
For information about current research using CTI follow the link below to the Centre for Advancement of Critical Time Intervention:
http://sssw.hunter.cuny.edu/cti/about-us/

2. WHAT IS CRITICAL TIME INTERVENTION?

A. Introduction

Key to the success of the original CTI intervention was ensuring continuity of mental health care at the point of transition from institution to community living. For mentally ill prisoners the transition from prison to community is a similarly vulnerable period during which the transfer of care from the prison in-reach team to community services is frequently poor. Prisoners with a mental health diagnosis may not readily engage with their local CMHT on returning to the community and of prisoners that have in place a pre-arranged appointment on release – few actually keep that appointment (Lennox et al., 2012).

Failure to engage with community services may reflect the prisoner's immediate priorities on release. Maintaining mental and physical good health are very important, particularly in respect to securing employment (Woodall et al., 2013) – however, having a place to live, sorting out a source of income (benefits, a job) and making contact with family again are likely to be the foremost concerns for the individual when walking through the prison gate and making community service contact is further down the list of priorities.

Developing a holistic plan to address both health and social care needs as part of the transition from prison to community is a central principle of CTI; when this doesn't happen the negative outcomes that may occur following release are well documented.

- Many mentally ill offenders often return to an environment of socio-economic disadvantage that puts them at increased risk of re-offending and a return to the Criminal Justice System (CJS).

Note: Currently 25% of all released prisoners in England and Wales will reoffend within 12 months (Ministry of Justice, 2013). Previous research has indicated that: 42% of released prisoners have no fixed abode, 50% are not registered with a local General Practitioner and 60% are unemployed (Williamson, 2007).

- The rate of comorbid substance abuse in the mentally ill prison population is high (Office for National Statistics, 1997). Following release, discontinuity of treatment initiated in prison to control/ reduce substance dependency, and the likelihood of returning to an environment in which drugs and alcohol are readily available puts the offender at risk of relapse and possible overdose.

Note: In the first 12 weeks following release from prison the risk of drug related death for drug using offenders is elevated, with risk in the first 2 weeks 3 to 8 times higher than in the rest of this period (Merrall et al., 2010).

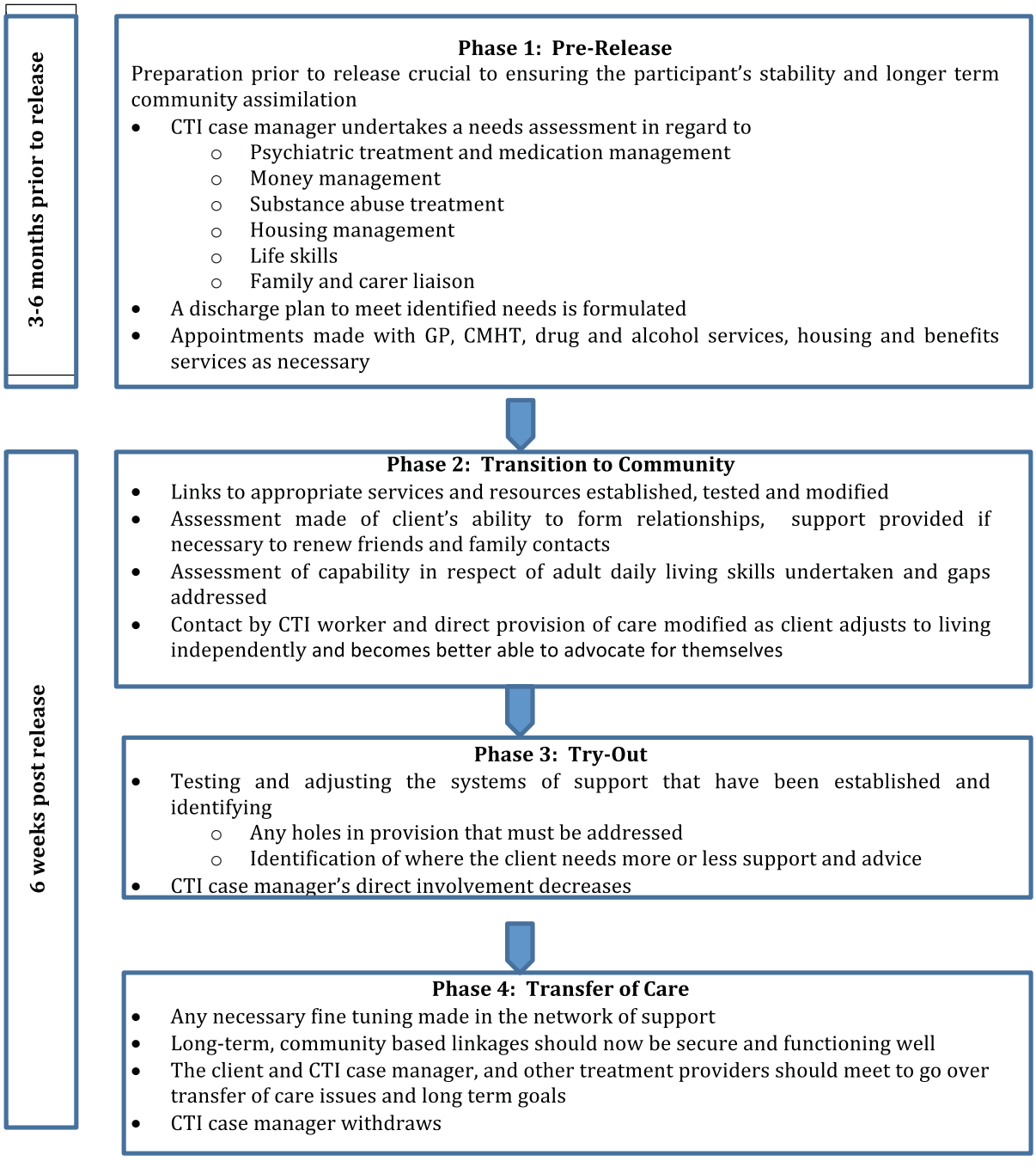
- An increased risk of suicide following release has also been reported.

Note: Of prisoners that die by suicide that were discharged within the previous 12 months: 21% die in the first 28 days and 51% in the first four months (Pratt et al., 2006).

The CTI provides a model for assertive health care delivery as well as personal and social support to ensure engagement with services on release from prison and to facilitate the offenders return to settled and stable community living.

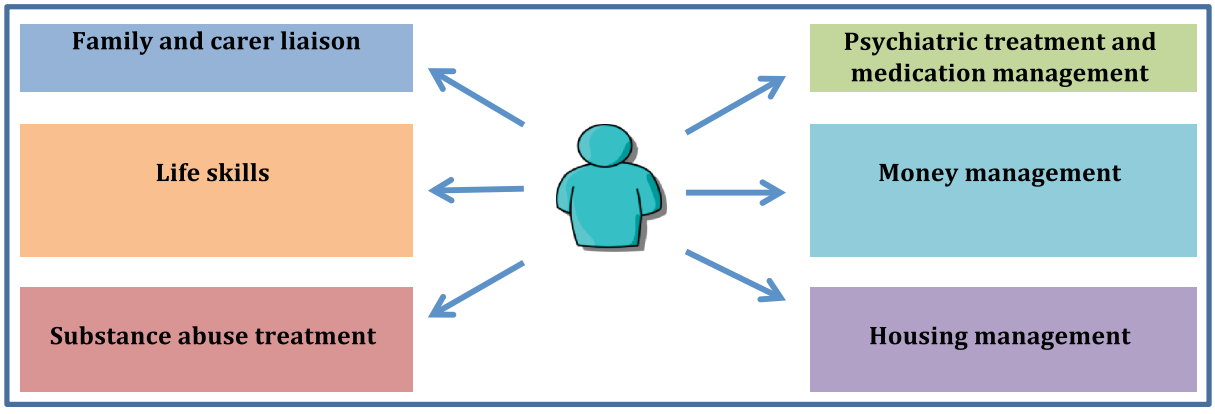
The original 3-stage CTI model was adapted to a 4-stage model for use with mentally ill prisoners to include the period in prison, pre-release, when the case manager begins the in-depth assessment of the prisoner's needs on transition to the community and the community services that will be necessary to continue the health care delivered by in-reach services during custody. The assessment also identifies other external agencies and significant individuals the prisoner must link to for practical help and psychological support. The figure below illustrates the phases of the adapted model.

Figure 1: Summary of the adapted CTI model



In Phase 1 of the intervention, Pre-Release, the following key factors have been identified as crucial in facilitating stability and successful community assimilation.

Figure 2: Key areas in which CTI is focused



These areas should be addressed and monitored in every stage of CTI. Two or 3 should become the primary focus, depending on the individual client. Some may not be applicable, e.g., not all clients have contact with family, or have substance abuse problems. The following sections describe why each area has been identified as crucial to CTI's success.

B. Psychiatric treatment and medication management

Establishing psychiatric services in the community is an integral part of a successful transition to community living (Lamb, 1992; Susser, et al., 1992). The CTI case manager facilitates this link between the client and the new psychiatric provider, and serves as a resource for both parties.

For the client:
- accompanying them to the first few appointments
- talking to them about how comfortable they feel with their new provider
- trying to make other arrangements if the provider match seems poor.

This element of the CTI case manager's role may be particularly important in the first phase of the CTI intervention, when clients may refuse treatment, or when there are delays in access to community services.

For the service provider:
- giving insight into the client's particular strengths and vulnerabilities
- supplying information about psychiatric and medical history.

(1) Linking clients to the right mode of provision of health care

This will depend upon the client's desires and the particular problems they are working on. Since all clients in the CTI target group have a mental illness:
- all will need a psychiatrist or community psychiatric nurses as one of the providers of services
- many clients will also need other services including psychotherapy
- long-term care coordinators under the Care Program Approach (CPA) must also be in place.

Since the CTI model recognises the importance of both formal and informal mental health supports:
- community providers may be enlisted in addition to traditional services, including self-help groups and family members
- specialist teams such as Assertive Community Treatment (ACT) teams, crisis teams, home treatment teams etc. might also be required to play a role.

(2) Ensuring medication compliance

Continuing to take medication as prescribed is a vital part of ongoing psychiatric treatment. The CTI case manager:

- should attempt to establish a system in which the client can easily obtain medications and be encouraged to take them
- plays a crucial role in psychoeducation, ensuring the client understands the importance of taking their medication as prescribed

Note: Discussions of the rationale for taking medication should be carried out by the CTI case manager with the client and the psychiatrist, the client's family, and residential staff, where appropriate.

- must address the possibility of side effects and other factors that might interfere with a client's medication compliance.

Note: The CTI case manager might role-play with the client ways of talking to his psychiatrist about medication issues.

(3) Setting up a medication monitoring system

Whenever possible, a medication monitoring system should also be set up, this might take the format of:

- self-monitoring by the client

Note: Options might include using a pill box, putting the week's medication into small envelopes for daily use, or using a diary.

- enlisting the help of someone else

Note: The CTI case manager might ask someone at the client's residence to monitor pill intake until the client can manage independently.

Careful medicines management is vital to ensuring the client continues to take prescribed treatment as required in order to stay well. In England, the Care Quality Commission require all care providers, regardless of care setting, to store, administer and record medicines safely. Professional bodies such as the Nursing Midwifery Council also publish standards for medicines management. The CTI manager should work follow the trust's protocol and best practice recommendations for the safe management of clients prescribed medicines.

C. Money management

Successful money management is another crucial component in a client's adaptation to community living. The CTI case manager:

- helps the client learn to budget their money
- monitors the client's success in this endeavor
- assists in identifying financial entitlement if appropriate
  - ideally, benefit entitlement will be applied for before the client moves into the community
- ensures the client learns where their local Job Centre Plus/ other benefit offices are, and that they have contact numbers for the individual case workers handling their benefits
- supports the client in their job search.

D. Substance abuse treatment

Substance abuse problems are very serious and potentially undermining of CTI's effectiveness. The original CTI study showed that the intervention was less effective for individuals with serious

substance abuse problems. Studies have also shown that clients who are dually diagnosed have poorer mental health outcomes than those with only mental illness (Drake, et al., 1989). It is therefore imperative that CTI targets this problem. Since CTI is time-limited, the most practical approach is to try to facilitate the client's commitment to change harmful addictive behaviours.

(1) CTI substance abuse intervention techniques

CTI approaches substance abuse both through a careful analysis of the client's long-term needs, and the supports this necessitates. The CTI model uses the following principles outlined in the substance abuse literature (Carey, 1996):

- treatment intensity
- stages of change
- motivational intervention
- harm reduction.

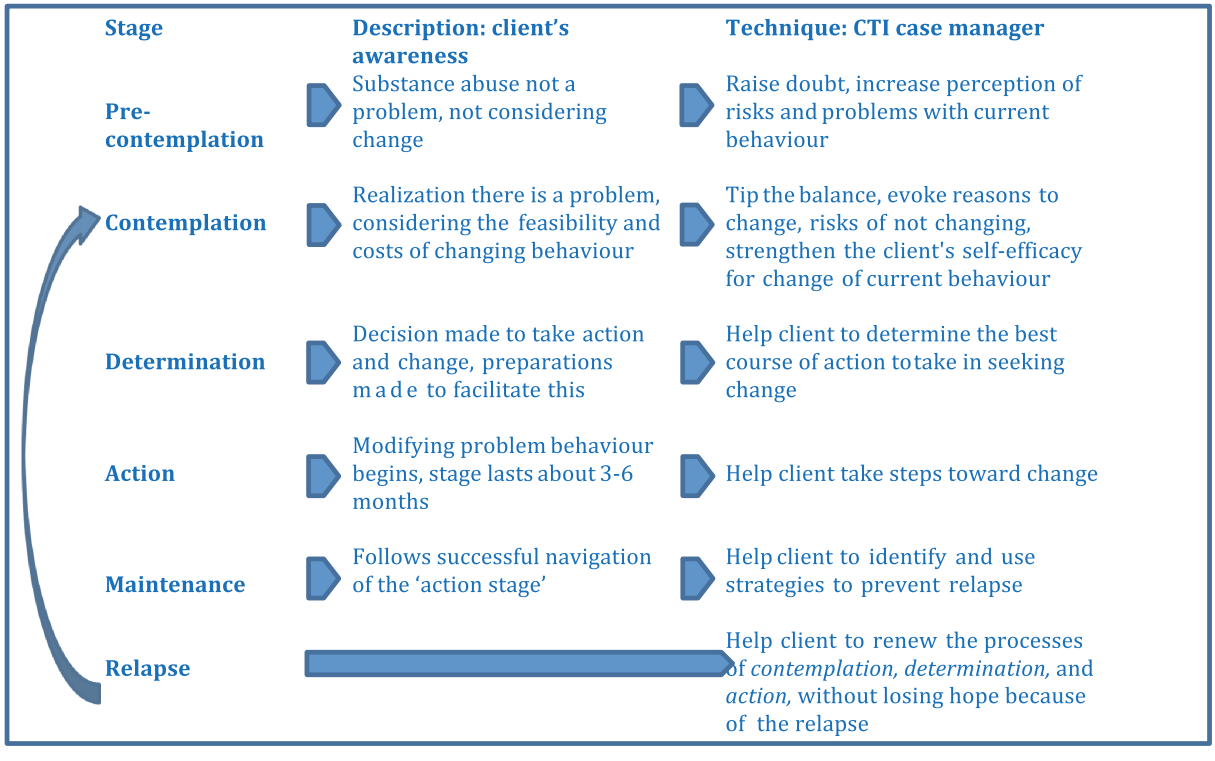
(i) Treatment intensity

The first principle stresses that since drug and alcohol problems vary in magnitude, the intensity of treatment should match the severity of the disorder (Institute of Medicine, 1990).

(ii) Stages of change

Motivational interviewing is informed by Prochaska and DiClemente's Stage Model of the Process of Change (1992) which is a trans-theoretical model of how people change addictive behaviours, with or without formal treatment.

Figure 3: The stages of change and CTI manager intervention techniques



Relapse is also recognised as a stage in this cycle. It is worth emphasising that relapse is not seen as a treatment failure, but as an inevitable part of the process of recovery.

- It is vital for the CTI case manager to identify which stage the client is in. Each stage implies a different level of awareness and readiness for change, and different intervention techniques to bring about this change.

Note: If the CTI case manager initiates a discussion of the benefits of Alcoholics Anonymous meetings to her client who is in the pre-contemplation stage, her recommendation will fall on deaf ears; her client is not yet aware that substance abuse is adversely affecting his life.

If techniques are used that do not match the client's level of awareness and commitment, they will be ineffective. If they are appropriate, however, they are an excellent spur to help the client move to the next stage in the change process.

(iii) Motivational interviewing

The substance abuse intervention carried out by the CTI case manager is based on motivational interviewing techniques (Miller & Rollnick, 2012). Motivational interviewing is designed to mobilise the client's own desire to change; its techniques are non-confrontational, and geared to minimize the defensiveness often created by traditional confrontational techniques. Motivational interviewing helps clients move through the stages of change faster and more effectively than they would without intervention. It assumes, however, that the responsibility and capability for change lie within the client.

Motivational interviewing has specific recommendations of how counsellors can work most effectively with clients, depending on their stage of change. CTI has modified the model by only using the interviewing techniques.

The CTI case manager should take a history of substance use, with a particular focus on:

- frequency
- severity
- choice of substances
- how the client views the costs and benefits of continued use
- strategies the client has used in the past, if any, to curb use.

CTI case managers should also rely on their clinical skills to monitor what the client is not willing to reveal about their substance use. CTI case managers might be on the lookout for:

- money seeking behavior
- the selling of possessions
- probation violations
- irritability
- other significant changes in the client's mental status
- physical signs, such as poor hygiene, weight loss etc.

Triggers for substance use should also be explored; if the client is not aware of any, the case manager might ask for several stories about past use episodes. Together, the client and case manager might be able to identify what feelings or circumstances lead to substance use. This inquiry will help inform the CTI case manager about the intensity of treatment needed, the stage of change the client is in, "trigger" situations, and strategies that may help the client curb his use.

(iv) Harm reduction

Harm reduction (Marlatt & Tapert, 1993) is based on the idea that substance use exists on a continuum of abstinence to abuse. If a person reduces the quantity or frequency of substance use its harm will be reduced. Although abstinence may still be the ultimate goal, any reduction in use is encouraged.

This stance is in contrast to traditional all-or-nothing approaches to substance abuse treatment, where clinicians refuse to treat anyone who has not made a commitment to abstinence.

Scenario: The CTI manager is aware her client is still using substances when he moves into housing in the community. If substance abuse might jeopardize the client's housing, the client and case manager might find a way to minimize this risk. For example, the client might agree not to get high or drink in the residence. Although this is not ideal, it is a realistic first step in helping the client preserve his housing, and move towards sobriety.

(2) Long term referrals

The CTI case manager will make referrals informed by her understanding of where the client is in the stages of change, and the intensity of the treatment needed. Forging strong links with specialist substance misuse service providers in order to match the client to the most appropriate community service provider(s) to meet their needs is key. The National Institute of Health and Care Excellence (NICE) provide a comprehensive and regularly reviewed pathway of care for individuals with severe mental illness and coexisting substance misuse. The pathway, which brings together NICE guidance and quality standards for caring for dual diagnosis service users, advocates the close involvement of substance misuse health professionals in the planning of care, in helping to train healthcare professionals and in the development of local protocols to set out responsibilities, processes for assessment, referral, treatment and shared care across the pathway. In the *determination, action,* and *maintenance* stages, 12-step groups such as Alcoholics Anonymous and Narcotics Anonymous groups are excellent resources.

In addition to making referrals, the CTI case manager should work with informal community supports, such as family members, educating them about the biology and dynamics of substance abuse, and helping them set appropriate limits and establish strategies to help clients maintain their sobriety.

E. Housing management

Client and environment congruence, conceptualized as the degree to which the client's needs, capacities, and aspirations are consistent with the resources, demands and opportunities of the community living situation, can be a deciding factor in clients' success in retaining housing (Coulton et al., 1984). Clients who are satisfied with their residences will be much more likely to make their living situations work.

Housing need varies along a continuum from accommodation with high levels of support to independent housing. The best match immediately on release from prison might need to be reviewed further into the intervention period. During the initial part of the transition, supervised accommodation or staying with family may be most appropriate as the client adjusts to community living and receipt of services settles down.

Note: Different residences offer differing levels of support, if the residence the client has chosen doesn't seem to be a good match, an alternative should be sought. However, CTI case manager may need to evaluate whether a genuine problem exists with the accommodation arrangement, or whether the client is reacting with anxiety to an unfamiliar, daunting environment.

As the Try-Out phase progresses however, the case manager may find that her client expresses a desire to move toward living independently in which case the case manager and client will work together to agree the local options that best fit the client's changing need.

Crisis situations related to housing involve a range of scenarios, such as threat of eviction, or psychiatric decompensation. The CTI case manager and client should try to foresee potential housing crises, identify ways to avoid them, help to develop coping strategies and have signposts to other resources if a crisis should occur.

Scenario: A client who is living with his family, has been acting in a bizarre manner, and has not showered in several weeks. In this situation, the CTI case manager might arrange a meeting with all parties to negotiate a new understanding about what the client must do to continue living with his family; they might agree that the client take his medication in front of someone for the next month, and showers at least once a week.

When facing housing loss, the client will almost certainly need to call on someone to help negotiate the situation with the accommodation provider. Therefore, in addition to her direct care role, the CTI case manager should help identify appropriate community resources for the client to call upon if needed.

This plan for dealing with housing crises should be one which can be implemented during and beyond the intervention period.

F. Life skills

The fundamental nature of the CTI intervention is to provide support, assessment, treatment, and life skills training in the community. The merits of social skills training have been extensively reported (Liberman et al, 1998; Test & Stein, 2000) for individuals with chronic mental illness. We prefer the more encompassing term "life skills" over social skills, since it encompasses the learning of a range of adaptive behaviors, for example: use of transportation, cooking, personal hygiene and how to behave and interact in a social situation.

G. Family and carer liaison

When appropriate, CTI works with clients' families in order to provide psychoeducation on the nature and treatment of mental illness. This education will facilitate families' abilities to respond to crises that might arise after the client's placement in the community. In the first period of CTI, the CTI case manager will cover the following areas:

- **The nature of CTI**

How the CTI model works, its aims.

- The stages of the intervention model and the role of the family in adding to its success.
- The need for support at the time of transition.
- The type of services that CTI offers, the role of the case manager and how the family may support the client.

- **The nature of mental illness**

Facilitating a better understanding of the typical symptoms of the client's mental illness, and psychiatric and psychosocial approaches to treatment.

- The symptoms the medication treats, common side effects.
- Help to alleviate possible guilt and stigma the family might feel when a relative has a mental illness.
- Clarification of misconceptions, e.g., some family members may believe that their child's drug use has caused his mental illness.

- **Providing positive and negative support**

How to most effectively and sensitively confront issues in order to support the client's residential stability, growth, and independence.

- Adopting the principles the CTI case manager employs:
  - being supportive, empathic, flexible, consistent, and encouraging of autonomy but available in times of crisis.
- Dealing with stress through better communication:
  - learning how to communicate clearly, and use problem-solving skills (Grunebaum & Friedman, 1988)
  - making positive comments in a calm, supportive tone, requests made simply and directly (McFarlane, 1991)
  - learning how to listen, and how to speak to each other without going on the attack.
- Setting clear boundaries and limits, ensuring the family understand the importance of having a clear and consistent way of interacting with the client.

Case managers can also gather valuable information from the family about how to most effectively support the client, e.g., families can provide a history about what has worked and what has failed in the past.

After these psychoeducational sessions have been completed, CTI case managers will remain available to mediate between clients and their families for the remainder of the CTI period. Common situations where the CTI intervention can be beneficial are:

- mediating substance abuse related conflicts, handling situations in which the client may demand money or resort to petty thievery, facilitating communication between family and staff at community residences

- giving general counseling, where CTI case managers can talk with families about their feelings about the client.

In general, family interventions should be increased when conflicts develop and continue, as needed, after their resolution to safeguard any new contracts the family members have agreed upon.

Find out more about ...

Motivational interviewing:
A general, online resource for more information about motivational interviewing can be found at:
www.motivationalinterviewing.org

Assertive Community Treatment:
The Royal College of Psychiatrists has published several documents on community mental health services which discuss the role of ACT. The College website may be accessed here:
www.rcpsych.ac.uk

National Institute of Health and Care Excellence

The overview for the NICE Pathway for Psychosis with coexisting substance misuse and links to associated documents may be accessed here:

http://pathways.nice.org.uk/

3. THE ADAPTED CTI 4-PHASE MODEL

A. Introduction

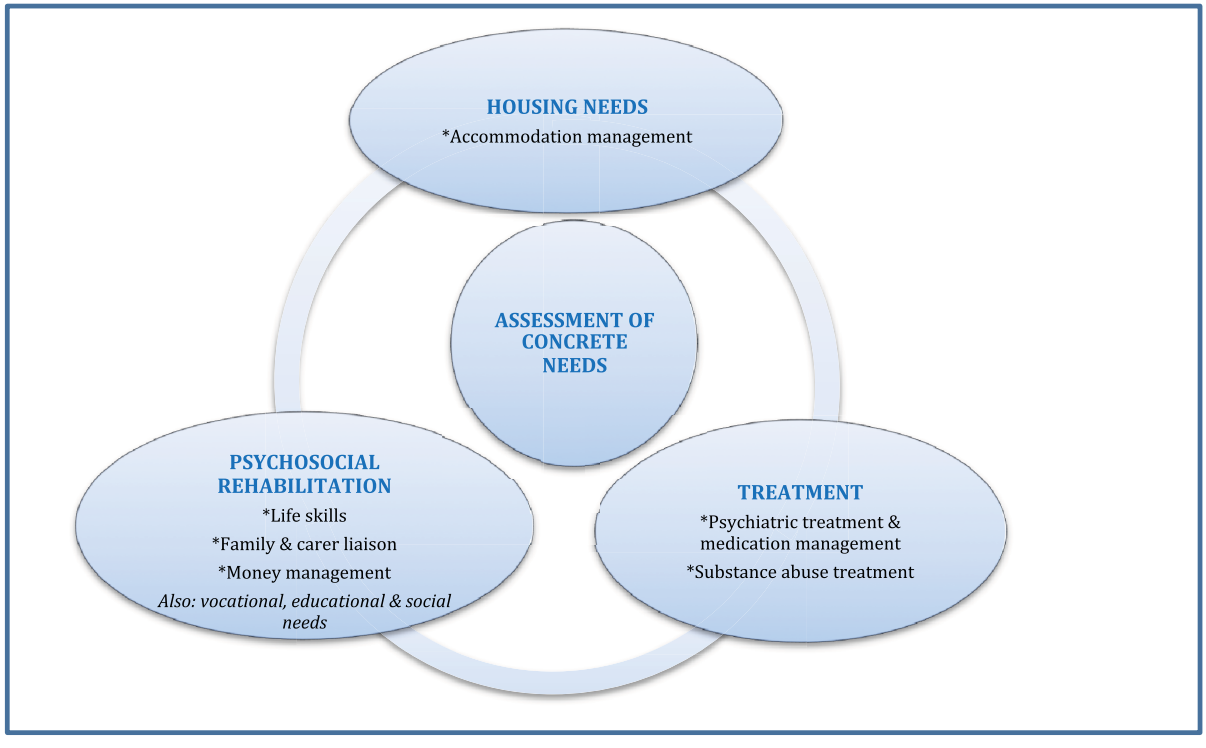
CTI is sensitive to the changing needs clients have during the transitional period from institutional to community living. At each stage of the intervention the following key component are tested and reviewed:

- assessment of concrete needs and linking,
- assessment of psychological needs
- client's strengths.

(1) Assessment of concrete needs and linking

In each of the stages of CTI, the CTI case manager will assess the client's concrete needs. During the course of recovery, the needs of a person with SMI will change. In this context, we refer to "needs" in three spheres: housing, treatment, and psychosocial rehabilitation. Careful evaluation of the needs of people with SMI is vital for successful community living (Ford et al., 1992). The needs of the client are evaluated for each area of intervention by CTI described in Chapter 2.

Figure 4: Assessment of concrete needs and areas of CTI intervention



In addition to the key areas of CTI intervention described in Chapter 2, the client and CTI case manager should explore what might give the client a sense of meaning and purpose in his life.

Note: Options to explore might include:

- employment
- vocational rehabilitation
- volunteer work.

Often, people with mental illness have talents and abilities that are unrecognised or neglected by themselves and those around them.

If the client and CTI case manager decide that these areas are of interest, but not practical or desirable at the present time, some options will have been pinpointed that may instill in the client a sense of hope for the future, and motivation for change.

Note: Since CTI is time-limited, it is particularly important to establish a long-term plan for the client prior to the conclusion of CTI. A comprehensive assessment of a client's long-term housing, treatment, and psychosocial needs is necessary during the initial phase of CTI.

(2) Assessment of psychological needs

Different psychological issues come up in each stage of CTI. These psychological issues are often overlooked by practitioners working with the mentally ill because concrete needs and psychiatric symptoms tend to dominate the clinical picture. However, the philosophy of CTI recognises that these psychological issues are crucial, and must be carefully handled if the intervention is going to be successful.

There are common, "baseline" psychological issues that might emerge and the CTI case manager may find it helpful to keep the following questions in mind:

- How much support does the client want?
- Are the CTI case manager's interventions experienced as helpful, or intrusive?

Note: CTI case managers should be aware of all these issues, and bring them to CTI team meetings, discuss them with involved community providers, or talk about them directly with the client, as the situation warrants.

- Does the client accept suggestions from the case manager, prefer to ignore them, or do the opposite?
- What is the client's cultural background?
    - How does it affect how the client is able to seek or receive help?
- Is there a cultural or racial difference between the client and CTI case manager?
    - If so, how will that affect the work they do together?
- How does the client typically deal with stress?

The CTI case manager will also want to establish what "natural" support systems are available to the client, such as family or friends?

- Does the client typically make use of them in times of trouble?
- Or, when crisis hits, does he isolate himself?
- What are typical scenarios that have led to the client experiencing difficulties in the past?

The case manager should try to evaluate all these questions from multiple viewpoints:

- from discussions with the client
- observations of the client's behaviors
- consideration of treatment history
- conversations with others involved in the client's life, e.g., family, friends, or treatment providers.

Most people struggle with opposing wishes when they seek help. On the one hand, they may wish to be dependent, taken care of, and relieved of responsibility; on the other hand, they may wish to maintain a sense of autonomy, independence, and self-esteem (Mann, J., 1973). When the CTI case manager is sensitive to this dimension of the client's experience, she is able to work more empathetically with him, and is better able to balance being supportive with leaving room for autonomy. Over time, the CTI case manager will try to find the right balance between providing structure and waiting on the sidelines for the client to find his own way. In general, CTI advocates the least coercive approach, so increased client autonomy is always the goal.

(3) Assessment of the client's strengths

All clients have a wealth of strengths and abilities they bring to their situations; these may include job skills, social skills, educational strengths, or creativity. These strengths, however, are often not recognised by clients or by those around them.

We believe that clients can be most effectively engaged when their individuality is recognised and nurtured. Our clinical philosophy also follows this model: clients are assumed to have the internal resources needed to make positive changes in their lives; however, these resources may have atrophied from disuse, or may need to be adjusted for use in new settings. The CTI case manager's role is to help discover and rehabilitate these strengths. In addition, CTI case managers can regard elements of the client's personality usually seen as bothersome – such as loudness or constant talking, as a strength, as these characteristics may help the client persevere, and get the attention he needs.

B. Phase 1: Pre-Release

Clients appropriate for CTI will be identified from the mental health in-reach team caseload. In the randomised controlled trials, participants were prisoners on remand or with short sentences and likely to be discharged within 3 months of recruitment. However, CTI could potentially be started earlier than 3 months prior to release for any longer sentenced prisoner with a known release date. Once identified, at the earliest opportunity following referral to the in-reach team, the client would be seen and a full assessment of needs undertaken.

A CTI care plan is then developed which includes work to be addressed in prison, during transition and then longer term in the community.

Note: The CTI intervention does not utilize bespoke documentation to avoid additional administrative burden for the case manager; locally used care planning documentation will be employed.

The rationale for developing a CTI discharge plan at this early stage is that remand prisoners' length of stay within the prison is unpredictable and the prisoner could be discharged from prison/court hearing at any stage. For longer term prisoners, starting the needs assessment 3 or more months before discharge ensures the maximum opportunity for a detailed exploration of all local care providers to ensure the best match for longer term care.

(1) Psychiatric treatment and medication management

(i) Psychiatric and primary care input

The CTI case manager should establish whether the client is registered with a GP and whether the client has had previous contact with the CMHT and psychiatric services in the locality they are returning to.

Note: If the client is not registered the CTI case manager should establish where the prisoner is likely to live and then make contact with local services, e.g., general practice, CMHT and drug and alcohol services, as required.

In the Pre-Release phase it is essential that the CTI case manager develops a relationship with the CMHT that will be treating the client in the community in order to facilitate the exchange of information. In the case of previously homeless prisoners, contacting primary care and psychiatric care providers will follow on from work to arrange the client's accommodation.

For remand prisoners, the CTI case managers should establish when the prisoner is next in court and for each court appearance it should be assumed that they could be discharged at that point. Preparation on the part of the CTI case manager should therefore include liaison with the following:

- **Solicitor**

Note: For remand or shorter sentence prisoners, the CTI case manager, with the client's permission, should make contact with his solicitor to establish:

- whether the client will be given bail and/or acquitted at the next hearing, and if likely
- whether it is possible for the client to be remanded in custody for a further period to ensure, e.g., housing and any other practical arrangements needed immediately on release are in place.

- **General Practitioner**

Note: The CTI case manager should make contact with the client's GP and:

- inform them of the progress of their patient
- if appropriate to the prisoner's circumstances, tell the GP the date of the next court appearance
- arrange an appointment with the GP, hopefully within 2 days of the court date (or for longer term prisoners - their expected release date) in order for the client to obtain medication.

- **Community Mental Health Teams**

Note: The CMHT members who will be caring for the prisoner will be invited into the prison and/or the CTI Manager will visit the CMHT in the community prior to discharge to outline the needs of the prisoner and any potential problems with their treatment in the community. Additionally:

- for remand or shorter sentence prisoners, the CMHT will be informed of the next date of court appearance (or for longer term prisoners - their expected release date)
- arrange an appointment with the CMHT within a week of discharge.

(ii) Medication

Using motivational interviewing techniques, the CTI case manager will work with the client in prison to address views on medication adherence and engagement with mental health services. Additionally whether self-management of medication, or help from a third party will be required. This may have implications for the client's accommodation on release.

Note: The CTI case manager:

- will speak to service providers about the client's previous engagement (if any) with services
- will encourage the client to engage with services
- might role play with the client different ways of talking to their CMHT worker about medication issues
- will assess in prison the need for supervision of medication in the community and whether the client would cope with a pill box or might need supervision of their medication.

For remand prisoners, the CTI case manager will accompany the prisoner to each court appearance.

Note: The CTI case manager will take with them a week's supply of the client's medication, or make arrangements with other appropriate personnel, e.g., Criminal Justice Liaison Team, to hold the clients medication to issue to the client if he is bailed or acquitted and will not return to prison.

If necessary the case manager will:

- accompany the client to their post-discharge address
- accompany the client to the pre-arranged GP and CMHT appointment.

(iii) Transfers

The CTI case manager will request that when an individual is receiving CTI intervention that they remain at the designated prison and are not transferred to another establishment.

(2) Money management

This is potentially a difficult area. Prisoners on remand do not receive a payment on discharge from prison, unlike sentenced prisoners. Some individuals will move quickly in to employment, others will rely on the benefits system.

Note: Whilst the prisoner is still an in-mate the CTI case manager should complete as far as possible any documentation required by the Department for Work and Pensions (DWP) for receipt of benefits to get the claim process underway prior to the client's prison release date. The CTI Manager may also explore the possibility of obtaining a crisis loan from social services to cover the interim before DWP payments begin.

(3) Substance abuse treatment

The CTI case manager will take a full history of substance and alcohol misuse and will establish what treatment the client has had prior to imprisonment.

Note: Ideally, the substance misuse team would visit the client whilst still in prison. Appointments should be made with substance misuse services as near to the court date as possible for remand prisoners, or for longer term prisoners, their expected release date. CTI case managers should establish the venue and timings of Alcoholics Anonymous, Narcotics Anonymous meetings and other self-help groups in the vicinity, of the prisoner's community residence.

The case manager will assess at what stage in the Prochaska and DiClementes (1992) Stage Model the prisoner is (see Chapter2). Prior to release, the CTI case manager will use motivational interviewing techniques to try and mobilise the clients desire to change and will simultaneously make contact if appropriate with statutory and voluntary services in the community.

(4) Housing management

The CTI case manager will establish the client's housing and accommodation history.

Scenario: The client may wish to live alone but in reality mental health and substance dependency problems may mean 24 hour staffed accommodation is more appropriate.

The case manager will also establish the client's desired location of discharge and assess whether that is appropriate to the client's needs.

Enquiries about accommodation should include discussion with colleagues in the probation service.

Note: If stable accommodation is found in the community this may improve the client's chances of being bailed. The CTI case manager should, with the client's consent, keep in touch with his solicitor about whether this outcome is likely. Additionally, if the client is to be discharged to residential accommodation, with the client's consent, the case manager should visit the residence to check it is appropriate and also share information as necessary to facilitate the client settling in successfully.

(5) Life skills

As part of the needs assessment, the CTI case manager will establish:

- the client's competency in daily living skills, their potential to develop/ improve these skills and also their wishes in terms of education, employment, hobbies etc.
- whether the client has any difficulties with social engagement or with forming relationships
- what level of support the client needs in managing their accommodation, this will of course lead into the type of accommodation best suited to the client's needs
- whether the client requires particular therapies or the specific input of e.g., an occupational therapist, counsellor, or family interventions.

(6) Family and carer liaison

In respect to liaison with the client's family and peer group network, the CTI case manager will establish:

- the identity of family and friends that the client is in contact with in the community
    - with the client's consent, they will take the phone numbers of anyone of specific importance to the client
    - make contact with family members and/or friends to gain an overview of the client's likely network
- if the client intends to live with any specific family member or with a friend, or will receive significant input from these individuals, and if so
    - the case manager will go to visit the family prior to her client's release to provide psycho-education, e.g., the nature of mental illness, providing positive and negative support and also information about the nature of CTI.

C. Phase 2: Transition to the Community

The CTI case manager formulates a treatment plan with specific attention to the five key areas of the intervention described in Chapter 2. Since the intervention is time-limited, services must be prioritized; some will need immediate attention, and others can be addressed later.

(1) Assessment of concrete needs and linking

The main task of this phase is linking clients to appropriate resources, and moving away from providing assertive, direct care. The client will need a psychiatric care provider. Some clients may want vocational training, and some may want to find work. The CTI case manager should work with the client in determining which options would be most realistic and beneficial. This process should be commenced as early on following identification by the in-reach team as possible.

Good linkages are crucial to the success of the intervention; these are the people and agencies that will gradually assume the primary role of supporting the individual in the community. It is essential that the formation of links is a gradual process that is tested and modified as indicated.

During Transition to the community, the CTI case manager has a high level of contact with the client.

Note: The CTI case manager will maintain regular phone contact, and visit the client's new residence to evaluate his adjustment to community living.

The client may not immediately feel comfortable with the treatment provider arranged in the Pre-Release phase, or the new program or agency he is attending.

Note: The CTI case manager may decide to:

- accompany clients to appointments with new agencies to help smooth this stressful experience
- work with clients to strengthen their ability to advocate for themselves.

(2) Assessment of psychological needs

When a client first leaves prison, separation issues may arise. Whilst in prison, the client will likely have achieved some level of comfort and familiarity in that environment.

Note: The CTI case manager may need to plan frequent contact with clients during this period as their need for support is perhaps at its highest. Increased peer or family contact may also be recommended.

In addition, it is likely that he will be leaving behind some important relationships. CTI, therefore, tries to provide the opportunity for a gradual, empathic separation, so as not to compound the challenges of this already difficult time.

(3) Assessment of client's strengths

A vital strength that can help the client in this period is the ability to form new relationships. Relationships in the client's residence, peers, and the range of service providers delivering care, will become the bedrock of the client's adjustment to his new living situation. It is important, therefore, for the CTI case manager to gauge how easy it is for the client to develop and maintain these links. If this strength is not present, the case manager may need to act as a bridge between the client and those with whom he will be forming new relationships.

Another strength that must be assessed in the initial phase is adult daily living (ADL) skills. The CTI case manager will gauge whether their client can cook, keep their residence clean and do their laundry, etc.

Note: The CTI case manager may:

- step in and teach or model ADL skills when necessary
- mobilise the client's own natural support network, e.g.,
    - if the client has a brother who cooks well, the brother might be enlisted to provide some lessons
    - if the client has a friend living in the community he is entering, that friend might be enlisted to show him around the area, pointing out local shops and facilities.

Perhaps most importantly, the client will need to ask for advice and support during this difficult initial transitional time. Many issues will come up in this period, and the client may not know how to deal with some of them. The CTI case manager may have to encourage the client to call her in these situations, if the client seems unlikely to do so naturally.

(4) Summary

The essential task of the Transition to the Community phase is to facilitate the clients' transition from the prison by linking them to services in their new communities. A multitude of practical and emotional issues arise during this period, including finding good service linkages, and helping the client to deal with the anxieties and challenges of moving into the community. The CTI case manager's skills in dealing with the difficulties inherent in this phase will be vital, as will be finding ways to access and nurture the strengths the client will be bringing to his new situation.

D. Phase 3: Try-Out

This stage is devoted to testing and adjusting the systems of support that have been established in the community. The role of the CTI case manager in this phase will increasingly taper off, with the expectation that the client will develop confidence in interacting with his treatment providers without the case manager's presence.

(1) Assessment of concrete needs and linking

The CTI case manager should pay particular attention to the key areas of intervention previously outlined, and determine how the client is faring in each area applicable to him. Some areas will need to be targeted for more intensive work, especially those that have triggered a crisis in the past. The case manager must use her judgment about how active to be at this stage; if possible, she should step back and observe how sturdy the client's new community links are. If services seem to be operating smoothly, she can become less active with her client.

However, systems usually need time to settle down and problems will arise which will require mediation and resolution. In this stage, with the basics in place, the CTI case manager should undertake in vivo needs assessment when a difficulty occurs.

Note: When problems arise between the client and new community providers, the CTI case manager might schedule a meeting with all parties to try to resolve the difficulty. It is very important during this stage for the case manager to act as a liaison between the client and his care providers. These new community links are still at an early stage of development and need to be reinforced as much as possible.

The case manager can observe where there are holes in meeting the client's needs, and where more – or less – support or services are required.

(2) Assessment of psychological issues

In the Try-Out phase, the CTI case manager begins to step back to see how well the client can manage new independence, but is ready to get more closely involved again if required.

Note: While some direct, assertive intervention by the CTI case manager may still be necessary, priority should be placed on strengthening the client's skills and his links with community based supports to address changing needs.

The goal is to allow the client to maximize his strengths and capabilities, and to be available to help in areas where the client cannot cope well on his own. In assessing service provision, emphasis must be placed not only on the client's ability to seek help, but also on the ability of community resources to respond to and meet the needs of the client. Clinical judgment is of the utmost importance in these situations, but the team, and an experienced clinical supervisor, can offer guidance.

When crises occur in treatment during the Try-Out phase they can often take the form of the client expressing a simultaneous need for help and a rejection of the very things he most needs. When this dilemma is enacted in the client's behaviour, receipt of services or the security of the client's living arrangements may be jeopardized.

During the Try-Out phase clients might:

- refuse treatment because they are afraid of further progress and independence, or

Note: The CTI case manager might temporarily increase phone or direct contacts with the client to discuss anxieties about moving forward, offer reassurance and perhaps greater structure in the short-term.

- "outgrow" treatment and refuse services that feel too restrictive or paternalistic.

Note: The CTI case manager might meet with the client to formulate a new plan that would allow greater growth and independence, to try to maximise the client's active participation in his treatment and rehabilitation, and in so doing taper down the case manager's contact time.

(3) Assessment of the client's strengths

During this phase, the client will begin to rely on community resources and be consistent in maintaining these new relationships.

For example, he might have monthly meetings with his psychiatrist. This will require the client to be organised, i.e., to know the time and the date of the appointment, and how to get to the site.

Note: If the client is forgetful and has a tendency to miss appointments, the case manager and client might find ways to compensate for this, e.g., putting a reminder sign up in the client's room, or asking someone to remind him.

In general, important strengths during the Try-Out phase are the ability to access and utilise community resources, manage money and demonstrate competency in a range of adult daily living skills. This also might be a time when clients might want to strengthen ties with friends or family that might become good supports.

(4) Summary

The essential task of the Try-Out phase is assessing the client's level of functioning, and working with the client to maximize his strengths, and anticipate his vulnerabilities. To this end, the client and CTI case manager will evaluate the linkages made with community support systems and adjust them as necessary. The CTI case manager will see how well the client can manage his new independence, and be ready to step in, or step back, as necessary. The main psychological task of this phase is working to help the client become more independent, more self-reliant.

E. Phase 4: Transfer of Care

This is the 'end-stage' of the intervention, when the case manager hands over longer term care of the client to community providers.

(1) Assessment of concrete needs and linking

Since the CTI relationship will be ending in this phase, it is vital that all links to community providers are secure.

Last minute fine-tunings may be needed, but ideally everything should be in place for the client's network of long-term support.

Note: The CTI case manager, client, and various key players should meet together before the end of the intervention period to discuss the transfer of care, and go over long-term goals. Key players might include:

- family members
- a therapist or psychiatrist
- someone from the client's residence.

This discussion should take place with enough time to correct any issues.

(2) Assessment of psychological needs

The most salient issue psychologically during this phase is dealing with the end of the CTI relationship. As in the Transition to Community stage, separation issues may be revived because of the upcoming termination of the case manager's involvement:

- anxiety and low mood might develop as termination evokes feelings related to past losses
- underlying feelings of anger and abandonment might fuel a treatment refusal
- clients might also be tempted to sabotage progress as a means of obtaining increased contact with the case manager.

In these instances, the case manager should let the client know that she is available to witness progress, and need not only be called upon in times of trouble.

This stage is also a good time to review and reflect on the work that the client and case manager have done together. They might want to consider:

- where the client was in the beginning of the intervention
- his achievements, how he has developed and where he is now
- the possibilities that lie ahead in the future.

It is important that the CTI case manager conveys her confidence that the client can continue to make progress and grow. The termination of the CTI relationship can then be a step in the journey to greater self-improvement. Now that the client is stabilised, he may begin to feel able to tackle things which have been on the back burner for years.

Note: The CTI case manager and client should:

- discuss the client's strengths, new skills, vulnerabilities, and the "safety net" in place should the client need it
- talk about their relationship – what it has meant to them both.

A celebration might also be a nice way to mark the end of the CTI relationship.

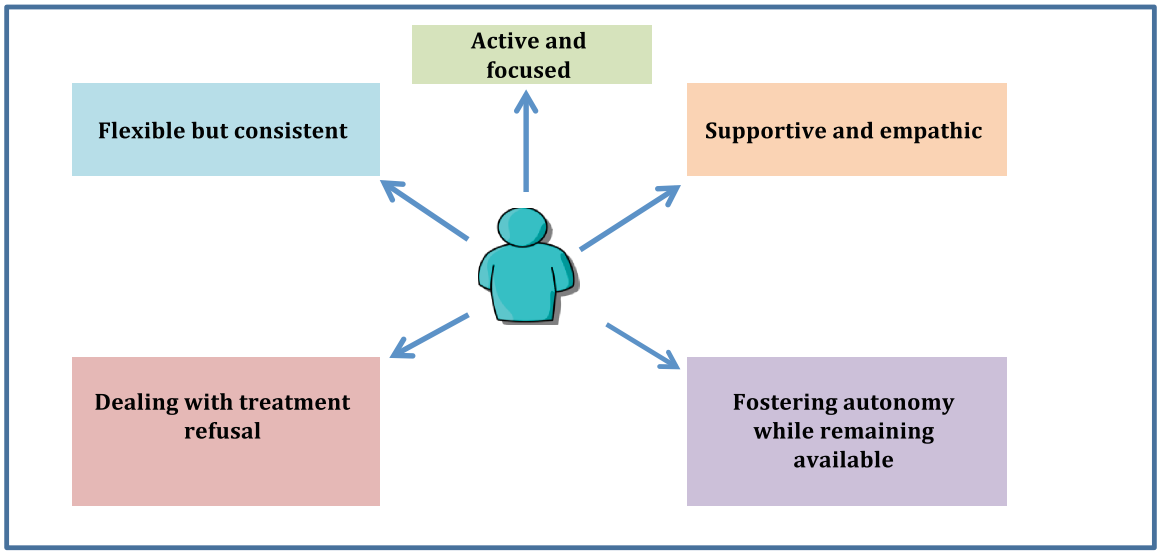
(3) Summary

The essential task of the Transfer of Care phase is to deal with the end of the CTI relationship, and to address the client's long-term needs. Fine-tuning in the client's system of community care may be needed, but optimally everything will be in place at this stage. It is important to bring together all the key players in the client's treatment at this time, to discuss work accomplished and goals for the future. CTI case· managers must be especially alert to dealing with client's feelings about separation, as the termination may bring up painful past losses. One of the ways that the CTI intervention can be effective is in allowing a very different type of separation one that is planned for and dealt with, both practically and emotionally.

A. Introduction

In a review of the psychotherapy research literature, Orlinsky and Howard, (1978) found that the relationship between the therapist and client was a major determinant of successful treatment outcomes. Although the CTI case manager is not a therapist in the strict sense of the word, we believe that the ingredients for a successful therapeutic relationship are present in constructing the CTI case manager and client relationship. With this in mind, CTI recommends a few guidelines which can foster a positive relationship between the case manager and the client and are appropriate for a time-limited intervention.

Figure 5: Therapeutic guidelines to foster a positive relationship between case manager and client.



B. Active and focused

Since CTI is time-limited, CTI case managers must be active and focused to be effective, e.g., when the case manager and client undertake an assessment of needs and agree a treatment plan.

Note: Both client and CTI case manager responsibilities and tasks should be clearly outlined, and a time-table for achieving the plan should bemade.

During this process both parties should collaborate in how to manage the key areas of the intervention identified as priorities. The CTI case manager should:

- obtain a commitment from the client to actively work to accomplish points on the plan
- place issues about which there is disagreement on the back burner to be taken up again periodically
- develop an alternative plan to which the client can agree can be devised.

C. Supportive and empathic

Support and empathy are crucial in the formation and maintenance of the therapeutic alliance between client and CTI case manager. When the case manager is empathic about the client's feelings, needs, beliefs and ideas, the client will feel supported. CTI case managers should be especially sensitive to a client's self-esteem. When a person's self-esteem is injured, he is likely to retreat defensively, or react aggressively towards himself or others. If this happens between a client and CTI case manager, the client

may not be receptive to the case manager's input. Clients may be very sensitive to critical tones and feeling criticized will inhibit their free expression of concerns, perceived failures, and present conflicts.

Paying attention to certain details will also help the case manager to understand her client:

- Non-verbal behaviour

Note: The client's facial expressions, body movement, posture, physical distance, eye contact, and general appearance will yield information about:

- how receptive the client is to the case manager
- how much psychological distress the client is in.

- Verbal statements

Note: The client's choice of words, recurring themes, voice volume, speed and tone of speech all provide an indication of how the client is feeling.

- Whether non-verbal and verbal expressions are discrepant

Note: The client may tell the CTI case manager that he agrees with the plan, but the case manager observes that his speech is clipped, his body averted, and he will not make eye contact.

The following techniques can aid in conveying the case manager's support and empathy:

Reflect the client's feelings. Simple statements to show the client that the CTI case manager has been listening.

Scenario: The client talks for ten minutes about how his neighbour's loud music kept him awake until 2 a. m., the case manager might say, "Sounds like you are feeling angry at your neighbour."

- Obtain clarification. The client's feelings about a particular situation may not be clear. In this case, it is best for the CTI case manager to ask directly, rather than trying to infer what the client might be feeling. This helps to:
  - clear up questions in the case manager's mind
  - give the client the opportunity to think something through in more detail, thus clarifying for himself how he feels about the issue.

- Develop awareness of the client's past experiences. Previous experiences might impact upon the client's present beliefs, expectations, and feelings about others. It is helpful for the CTI case manager to keep in mind:
  - the way each client typically experiences the world
  - how the client perceives others' interactions with him.

However, this understanding should be used with discretion; it is usually ineffective to dispute a client's perception of a situation. Instead, the CTI case manager might gently suggest some alternative explanations for his experiences.

- The CTI case manager to be aware of her own feelings when working with different clients. Case managers may notice that they feel very differently towards different clients. For example, a case manager may feel very protective towards one client, and ready to help whatever trouble arises. With another client, she may feel like giving up, believing that the client does not actually want help. The case manager's feelings can be a valuable indication about how the client feels about himself, and how he typically interacts with others. This can help the case manager deal with the difficult feelings some clients may engender.

Examples might include:

- a client that makes a case manager feel helpless and inept, this might indicate that the client feels these things

Note: Issues should be talked about in CTI team meetings, where the role of a senior clinical team leader or supervisor will play an essential role.

- a client that tries to avoid the experience of being disappointed and so takes the view that the case manager is someone with nothing to offer.

The important thing for the case manager to realise is that her own feelings have an impact on the clinical process, and can bring valuable information to light. For these reasons, they should not be disregarded or considered the case manager's private problem.

- Cultural awareness is also a vital component in providing support and empathy.

Note: A client who abuses alcohol might be asked about what cultural role it plays for him. The case manager can still work with the client's substance abuse as a problem, but be empathic to the extra layer of difficulty in the client's abstention.

When the CTI case manager and client come from different racial, ethnic, or social class backgrounds the case manager must be aware of how these differences may contribute to misunderstandings between the dyad. The CTI case manager might be sensitive to these issues by asking the client how certain issues are viewed within the client's culture. In other areas, case managers might deviate from their standard practice to be sensitive to the client's culture, e.g., accepting a gift, knowing that gift-giving is an important way of expressing gratitude.

D. Flexible but consistent

To be flexible and consistent may seem like a contradiction, but it can be done. Both clinical stances are very important.

Flexibility allows CTI case managers to:

- respond sensitively and practically to a myriad of situations

Note: A feature of the treatment plan designed before the client moved back into the community may prove impractical or undesirable when the time comes to put it into action.

- work more collaboratively with client and service provider than is typically offered in the mental health system

- make a more informed evaluation of a client's failure to take up recommendations; is it 'treatment resistance' or is the client protesting at a poor service link

Scenario: A case manager's trip to a day-treatment program that a client has been refusing to attend might reveal a poor match between client and provider, e.g., the other clients at the program might be much lower functioning than the client.

Where the client's difficulty cannot be attributed to a poor match, the CTI case manager may just have to "roll with resistance" until the client is ready to change.

- respond to the client on an as-needed basis, studies have revealed that clients with mental illnesses prefer this to a more rigid structure (Tanzman, 1993)

- better carry out in vivo needs assessment, which takes into account changing individual needs, and allows for a more realistic appraisal of, and response to, a client's capacities, strengths, and

limitations

- treat their clients differently depending on each individual's particular constellation of strengths and difficulties.

Consistency is the complement of flexibility.

In some situations, the case manager may feel it is not in the client's best interests to change an agreed-upon plan.

Scenario: A client might not want to attend psychiatric appointments. Although the case manager cannot control what the client will do, she would do well to stick to this part of the treatment plan, and engage in psychoeducation with her client.

It is also important for clients to feel that the CTI case manager is consistent as a person, that she remembers their appointments and arrives for them on time, that she reiterates goals agreed upon in the treatment plan, and that she behaves towards the client in a similar manner over the course of their many meetings.

E. Fostering autonomy while remaining available

CTI case managers must try to strike a balance between being responsive and encouraging independence; clients need the ability to move along a continuum of support. At times, the client may need more autonomy in order to grow. At other times, the client may need greater support to maintain psychological or material stability.

These principles are especially important in the second and third stages of CTI, when clients are increasingly caring for themselves, or finding people in the community who can help them where and when they need it.

F. Dealing with disengagement from treatment

In this section, we present two perspectives on dealing with a client's disengagement from his treatment plan.

(1) A client's perspective – helping through trust

People who have mental illness, especially those who are homeless, may have good reasons for refusing services. They may have a history of forced or coerced treatment, which may have done them more harm than good or, at the very least, caused them to feel powerless over their own lives.

The key to overcoming the client's resistance is for CTI case managers to foster the development of a trusting and stable relationship between themselves and the individuals they are seeking to engage. When developing a trusting relationship with the client, it is important for the case manager to remember:

- Don't push it.

  - The CTI case manager should keep making offers of help, but shouldn't take it personally if someone refuses:
    - wait for a while and repeat the offer.

- People are always more willing to accept something from someone they know than from a stranger.

  - The client needs the freedom to make that choice to accept services when they're ready:
    - go at their pace.

- Find out what the client wants; be prepared to give the client substantive help.

  - The full range of services the client needs should be available:
    - when the client is ready to take advantage of those services
    - at the same time, there should be no pressure to do so.

- Don't give up.

  - Providers may discharge people because they say they don't want services anymore:
    - if someone who has been accepting services decides they don't want services anymore, bear with them.

(2) A mental health care provider's perspective

In the course of treating a mentally disordered offender, clinicians must anticipate some degree of treatment refusal at some point in time. However, the significance of the refusal will vary depending on the individual client and the timing of it. As a general rule, CTI holds that:

- treatment refusal should be viewed as a client's way of communicating something to the clinician, not simply as an act of defiance
- the therapeutic stance should be to aim to understand the client and not to engage in a power struggle
- when the CTI case manager is able to help the client put the reasons for treatment refusal into words, the client is less likely to keep expressing the communication through action.

Treatment refusal by a mentally disordered offender can be understood based on the stage of treatment. When a new client refuses treatment, the clinician should:

- gently test his willingness to discuss it, realising that the refusal to accept treatment might preclude any such discussion

  Note: It may be important for the CTI case manager to back-off and reassure the client of her availability when the client is ready to address the issue.

- shift the focus from the usual clinical aims, e.g., taking a history, assessing mental status, making a diagnosis, prescribing treatment, to explore what the client perceives to be his most immediate needs.

  Note: Patience and empathy must guide this nonintrusive approach and of course, the clinician must feel secure that the client is not a danger to himself or others for the approach to be appropriate and effective.

This will often provide an opportunity for engagement.

Should a client continue to refuse treatment despite attempts to engage him, it helps to recognise the importance of periodic monitoring and checking in with that client; the case manager can still be helpful to the client who refuses services. By making contact with the client periodically, the case manager can identify signs of decompensation.

Commonly, clients refuse services when first engaged by mental health providers. Again, the case manager should ask "What is the client telling me?"

Is the client:

- having medication side effects

  Note: The client may feel too embarrassed to discuss side effects, or believe nothing can be done to address them.

- not applying for housing because he fears change
- refusing vocational training because he is worried about losing benefits
- in relapse with regard to substance abuse?

Some clients refuse treatment when they become angry with staff for any number of reasons. Being able to recognise the reason is essential for any clinician working with this population.

5. HOW TO START A CTI PROGRAMME

A. Introduction

The setup of CTI in any given location will be shaped by the:

- type of service taking responsibility for delivering the intervention, e.g., in-reach team vs. a community based service provider; the originators of the CTI model recognised that case managers need not themselves be clinically qualified as long as they had experience of working with the client group and carried out the intervention under the supervision of a psychiatrist or other mental health professional. In some areas therefore the CTI team might include case managers who are experienced social workers
- profile of the prison population targeted, e.g., the balance of long-serving prisoners vs. shorter term prisoners
- nature of the prison accommodation and daily protocols which may constrain the delivery of the intervention
- range of community services that may be required to play a part in the locality.

Other issues may also require consideration at the setup stage, e.g., how contacts might be developed with colleagues in local prisons and community services in other parts of the country – in the event that a prisoner is transferred to accommodation elsewhere prior to release.

The following sections represent the elements of set up, delivery and evaluation of CTI and are intended as a guide to inform the development of the intervention in collaboration with local, community service providers.

B. Establishing the intervention home base

The fundamental principle of CTI is the provision of comprehensive services that are continuous during the transition from prison to living in the community. The target client group of this adapted CTI program are male prisoners with SMI, therefore the home base where the preparatory work for successful transition is carried out is prison accommodation with provision of access to psychiatric services, medical care, and the CTI case manager.

A room in which the prisoner and case manager can meet privately to discuss how the intervention works, undertake assessment of needs and discuss the spectrum of services that the client will require to resettle in the community is crucial. An atmosphere of safety must be created in which prisoners can express their feelings, feel understood, and perceive the staff as advocates.

Once a client demonstrates trust in the case manager, new goals and greater expectations can be introduced.

C. Establishing community linkages

CTI is assertive and takes a holistic approach to needs assessment in the early period of the intervention however community service links must be established and tested throughout the intervention.

The CTI team will meet with all likely community care providers, e. g., ACT, CMHT, housing, drug and alcohol services teams – to outline the principals of CTI, the involvement of their service, and the role the CTI case manager plays.

Note: A presentation at a service provider's monthly team meeting or at a training event might be effective at reaching a broad range of staff from front-line practitioners to service managers. Information about CTI should also be posted to all general practitioners' surgeries within the prison catchment area and to the courts, probation and social services.

It is important that the CTI program has access to an array of service providers so that services can be tailored to the individual's needs. See Figure 6.

Note: A client demonstrating a capacity for relative self-sufficiency might be linked to work opportunities and self-help groups, whereas a client with greater needs might be linked to an ACT team for long-term care.

It is vital that the CTI case manager clearly communicates to the client and service providers the time-limited nature of CTI and longer term reliance on links made during the intervention.

Note: The CTI manager should make contact with all community teams as the prisoner could be discharged at any time. They will telephone care providers and family/friends and meet with them to plan care on discharge.

Figure 6: The key areas of the CTI intervention and expected community links

Area of intervention	Expected community links*
• Psychiatric treatment and medication management	• GP surgeries • CMHT/ ACT/ Crisis Team • Providers of psychological therapies
• Housing management	• Local authority housing services • Individual housing associations
• Substance abuse treatment	• Local 3rd sector providers of substance abuse services
• Money management	• Social Services – for remand prisoners that might require an emergency loan payment • Job Centre Plus – to sign on for Job Seeker's Allowance (JSA), other benefits • Bank/ Post Office – to help clients to arrange an account; bank account may make benefit payments/ payment of wages to client easier , similarly easier for the client to make payments for rent and other outgoing payments longer term
• Life skills	• Community centres providing support in developing/ improving life skills • Drop-in centres that provide advice on job search and the facilities to work on job applications • Local co-ordinators for volunteer opportunities • Faith group meetings/ community support provision
• Family and carer liaison	• Family member that may be enlisted to – monitor adherence to medication schedule • Other family members and friends that can play a role in supporting the client during the transition period and longer term

*The suggestions are not exhaustive; rather they are intended as a guide. The CTI case manager should compile her own list of providers to link clients to (according to need) based upon the available resources in her locality. Local probation teams and community rehabilitation providers will also be important contacts for the CTI case manager to liaise with.

(1) Peer support initiatives

A CTI case manager might explore whether there are local opportunities to introduce a client to someone who has themselves made a successful transition from life in prison to life in the community. Sometimes referred to as 'gate buddies', the opportunity to link a client to someone who has experience of the challenges the client is currently facing may improve the likelihood of the CTI client engaging with service providers, continuing with a programme to address drug and alcohol misuse and generally developing a positive attitude toward building a stable life in the community.

The introduction of a client to a gate buddy may be possible in the Pre-Release phase of CTI so that the client has peer support from the time they walk through the prison gate on release and throughout the first few weeks of resettlement. The availability of a local buddy facility may be particularly relevant for the support of CTI client's with no strong ties to family of previous friendship networks.

D. Recording and sharing client information between care providers

Sharing information across agencies, making sure it is relevant and kept up to date, is a challenge but central to the success of the intervention. The case manager and her primary contacts within each health and social care provider involved with meeting the needs of the client in the community must consider the following issues:

(1) Obtaining the client's consent to share information

An essential part of the Pre-Release phase of the intervention is explaining to the new client how the intervention works. Ensuring the client understands the necessity for the CTI case manager to share relevant information with community service providers is crucial.

Note: During Phase 1 Pre-release: The case manager and client should discuss the circumstances in which information about the client may have to be shared, e.g., to progress making appointments with service providers prior to release, or to secure the accommodation that will best suit the client, or in preparing family and friends who might be directly involved in supporting the client's resettlement in the community. The scope and extent of what might be necessary to share should be explained carefully to the client. It may be helpful to draw up a consent form or some other written form of agreement to help consolidate understanding.

(2) Sharing information between CTI team and community providers

When establishing the intervention with community providers, a critical part of the case manager's role is to agree in what format, and where, information about the CTI client will be recorded and how this information will be shared and kept up to date.

Bespoke, CTI case-file documents have not been developed in recognition that (i) case managers will be bound to the completion of local services approved documentation, and (ii) that the contents of a CTI specific document would duplicate aspects of local documentation and therefore become an administrative burden.

Note: The team implementing CTI in their locality for the first time should review the current paperwork involved in assessment and post-release care planning to establish whether the document(s) provide adequate opportunity for the case manager to record the needs, and action points identified, for the key areas of the intervention. Similarly a review of paperwork shared between service provider organisations should be undertaken with the same aims. A local decision should be then be made with respect to whether an amendment would be helpful.

It is vital that the CTI case manager clearly communicates to the client and service providers the time-limited nature of CTI and longer term reliance on links made during the intervention.

Note: The CTI manager should make contact with all community teams as the prisoner could be discharged at any time. They will telephone care providers and family/friends and meet with them to plan care on discharge.

The following issues should be discussed by the case manager and her primary contact at each provider at the earliest stage of introducing CTI, i.e., setting up the community links identified above for the first time:

- How will information be stored?

Note: The case manager and primary contact within the link organisation must consider the security of paper storage systems, i.e., the location in which documents will be stored and access to this area. If client information is to be stored electronically what system level security policies and procedures are in place to safeguard client records?

- Which members of staff within the link organization will have access to the client's information?

Note: Are the link organisation's staff trained and fully aware of the importance of maintaining the confidentiality of a client's information?

- Does the organisation the case manager is operating from already have data sharing agreements with the link organisation?

Note: A data sharing agreement might already be in place between health and social care providers however this may not be the case when establishing links with, e.g., housing services. The case manager and provider organisation may wish to put in place a data sharing agreement to ensure the client's personal information is protected.

- How will organisations involved in the client's longer term care be informed of changes to service provision, e.g., change in the provision of substance misuse services, changes in the client's residency during the period of the intervention.

Note: In setting up the community provider links in the earliest stages of introducing CTI, a system for updating relevant client information held by multiple providers is very important. Health and social care systems may already be linked – but keeping a 3rd sector provider of changes that might impact on their work with the client must also be considered.

- Ending the intervention.

Note: A process for informing multiple service providers of the end date of the intervention period must also be put into place. CTI post-release from prison extends for 6 weeks from the client's release date. A clear end to the case manager's input, and acknowledgement by all parties that long-term service provision is now handed to community providers, is vital.

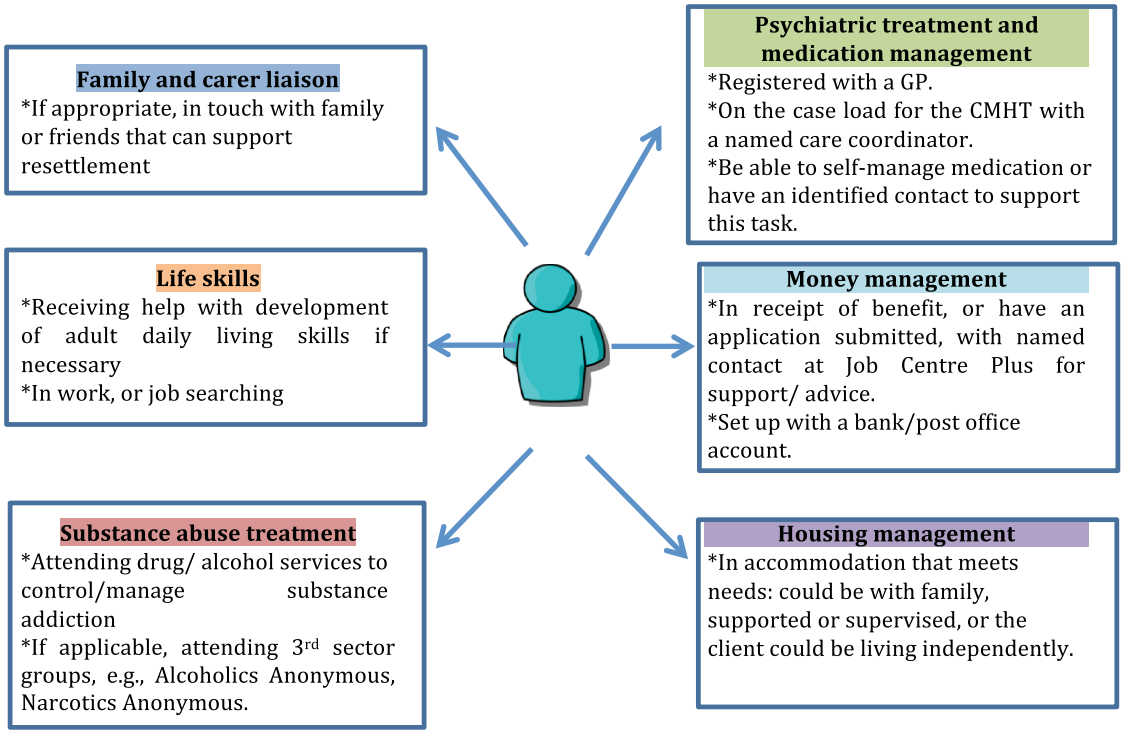
E. Ending the intervention

The CTI program is time limited, extending for a period of 6 weeks following release from prison. Important at this end-stage of the program is the case manager's handling of the 'disconnect' from the client and ensuring that providers of longer term care and practical support understand that the case manager has withdrawn.

(1) Ending for the client

At the end of the intervention, the following issues related to long term care and successful resettlement should have been actioned or should have a clear action plan in place between the client and appropriate service provider to meet the outstanding need:

Figure 7: Key elements of long term care



The case manager should compile for their client a list of the community health care providers and organisations providing financial and employment services providing longer term support for the client. This list should be comprised of named contacts, ideally that the client has met, e.g., in the initial meeting set up and attended by the case manage.

(2) Ending for community based service providers

At the point the case manager closes the intervention for her client, all community service providers and organisations providing practical day to day services must be notified. The case manager will have a continual through put of clients from in-reach and therefore it is important that she and the community providers have a clear method for monitoring where the case manager is along the intervention timeline for any given client – and particularly when her input has come to an end. At this point the service provider should understand that they are now responsible for ensuring continuity of service provision and for assessing any changes in need in discussion directly with the client.

The case manager might find it helpful to set up a regular meeting with her named contact within an organisation during which:

- any documentation related to the handover of a client at the end of his intervention period can be completed
- the contact can be briefed about new clients coming on to the case manager's caseload for whom an appointment with the service provider might be required, etc.

The handover stage is also an opportune moment for the case manager and her service contact to review the systems and processes that they have put into place as part of the implementation of CTI and to discuss any refinements to improve liaison for new clients coming through.

F. Case manager training

The CTI training manual is intended to be a guide for providers wishing to incorporate the CTI approach into the delivery of local services. To this end it is deliberately non-prescriptive in regard to the training of CTI managers; providers may identify members of staff with different healthcare expertise to those elsewhere as most appropriate within their current service structure to deliver the intervention. However tools are available that service managers may find helpful when assessing whether staff need additional support or training to deliver CTI effectively and which can help to structure discussions of professional development needs as the service beds in, e.g. the Dual Diagnosis Framework (2006) developed to assist in the implementation of the Department of Health Dual Diagnosis Practice Implementation Guide (2002)].

Generally CTI is a model which incorporates best practice from a range of existing clinical actions/interventions already developed by service providers to meet national policy or minimum quality standards, e.g., The NHS Patient Experience Framework (2012) published by the NHS National Quality Board or NICE Quality Standards for care.

G. Staffing, safety and supervision

Staffing, case manager safety and supervision require careful consideration during the process of establishing the intervention.

- Staffing: The early work of engaging and treating the mentally ill on discharge from prison can be labour intensive and emotionally demanding.

Note: Case loads should rarely exceed 10-12 clients per full time case manager.

In Phase 2, Transition to Community, clients may require frequent visits (at least one visit per week); by Phase 4, Transfer of Care, much of the CTI work might be managed by phone. Face-to-face visits may still be required in the event of a crisis developing that threatens to overwhelm the client and established service provider organisations. Importantly, personal visits are essential to help the client navigate through the termination of the intervention.

- Safety: The personal safety of case workers visiting clients in the community is vital. Protocols for safe working when on home visits must be in place.

Note: It is likely that community visit protocols have been developed by the service from which the CTI intervention is run however these should be reviewed at time of implementation and regularly thereafter. The range of environments in which the case manager might now find they are engaging with their clients may necessitate amendments or extension to usual safety practice.

- Supervision: Regular supervision with the case manager's clinical lead for CTI is essential. Fidelity to the intervention model can be checked and any difficulties encountered delivering the intervention may be discussed and options for resolution considered.

Note: Fidelity to the model refers to how closely the original procedures for each stage of the intervention were implemented as they were originally conceived by the originators. In the randomized controlled trials that tested CTI with SMI prisoners, a fidelity checklist was devised that was completed in discussion with case managers at intervals during the intervention period. The elements of the checklist are included in Appendix A and may help to structure discussion of procedural issues arising during team meetings.

Ideally supervision meetings will take place on a weekly basis.

H. Performance indicators

The implementation of a CTI programme requires some measures of performance to be collected in order that the efficacy of the intervention can be established; these data are likely to be important during the annual, service budget review to be able to make the business case for resources to enable the intervention to be continued. The necessity for a service to be able to show that it is making a difference is important and therefore the following indicators may serve as baseline evidence to this effect. The number of clients:

- in contact with CMHT at 6 months post release
- on probation that were recalled to prison
- that reoffended
- that were admitted to hospital

These measures may be extended to further time periods e.g., a further follow up check at 12 months, or tailored to include continued contact with a range of other community services as deemed appropriate by the CTI team.

I. Summary

This chapter of the manual gives an overview of the foundation elements to be considered in the set up and delivery of CTI in a new locality. Each element should be considered by the CTI provider service in respect to their target client group and link organisations locally.

Find out more about ...

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National Institute for Health and Care Excellence guidance and Quality Standards:
https://www.nice.org.uk/Guidance

NHS Patient Experience Framework:
https://www.gov.uk/government/publications/nhs-patient-experience-framework

GLOSSARY OF TERMS

3rd sector	Term describing not-for-profit, non-governmental organisations including the voluntary sector
ACT	Assertive Community Treatment team
CQC	Care Quality Commission
CJS	Criminal Justice Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CrISP	Critical Time Intervention for Severely Mentally Ill Released Prisoners
DWP	Department for Work and Pensions
GP	General Practitioner
JSA	Job Seekers Allowance
NICE	National Institute of Health and Care Excellence
SMI	severe mental illness

APPENDICES

APPENDIX A: CTI Fidelity Assessment

CTI Fidelity Scale

COMPONENTS (compliance fidelity)	
Phase 1 (Prison 4 weeks prior to release)	**CMP1 Engagement and early linking**
1) visited client twice weekly 2) communicated (visits, calls and/or emails) with in-reach staff at least weekly 3) visited housing provider/family caregiver at least twice 5) communicated (visits, calls and/or emails) with housing provider/family caregiver at least fortnightly 6) communicated (visits, calls and/or emails) with community mental health provider at least fortnightly	
Phase 2 (Release - 2 weeks post release)	**CMP2 Intensive outreach**
1) visited client at least once a week (or other contact maintained) 2) visited and/or talked by phone with client at least 4 times 3) communicated (visits, calls and/or emails) with community mental health provider at least 4 times 4) visited housing provider/family caregiver at least once 5) visited and/or talked by phone with housing provider/family caregiver at least 3 times	
Phase 1 - 3	**CMP3 Three Phases**
1) created a care plan for each phase 2) completed the care plans on time (± 2 days)	
Phase 1 - 3	**CMP4 Focused**
1) limited each care plan to 1 to 3 actions 2) selected actions only from the 6 CTI areas: psychiatric treatment & medication; money management; living skills training; family intervention; substance abuse treatment; housing crisis prevention & management	
Phase 3 (3-6 weeks post release)	**CMP5 Monitoring**
1) communicated with client no more than once a week during Phase 3 2) communicated with community linkages no more than once a week during Phase 3 3) recorded specific ways support network was/was not working	
Closed cases	**CMP6 Time-Limited**
1) did not provide CTI intervention after the 6 week date (±2 days)	
6 week post discharge	**CMP7 6-Week Follow-Up**
1) CTI manager was in touch with client at the 6-week date (±2 days) 2) CTI manager provided at least 4 weeks active Phase 2-3 intervention (i.e., excluding gaps when client disappeared)	
STRUCTURE (context fidelity)	
Any phase	**STR1 Caseload Size**
Caseload size is 18 standard caseload equivalents or less per worker	
QUALITY (competence fidelity)	
Phase 1	**QUA1 Intake Assessment**
1) demographic history (age, gender, ethnicity, marital status, children, family support/abuse), especially detailed homelessness & reasons for housing loss and criminal history. 2) psychiatric, medical & substance abuse history (diagnosis, symptoms, meds, hospitalisations) 3) talents, training, Activity for Daily Living skills, what gives meaning to life	
Any phase	**QUA2 Phase Planning**
1) recorded today's date & phase start date 2) recorded rationale for each focus area in terms of client's needs 3) recorded general objectives for each area	

CTI Fidelity Scale (continued)

Closed cases	**QUA3 Closing Note**
1) transfer-of-care meeting with client & all primary linkages or evidence of case closure (emails etc) 2) made prognosis for client's long-term continuity of care	
Phases 1 & 2	**QUA4 CTI Managers Role with Client**
1) was accessible to client when in field 2) encouraged contact between client & linkages, and between different linkages 3) mediated & negotiated between client & linkages, and between different linkages 4) took harm reduction approach to behavioural change	
Not based on phase	**QUA5 Clinical Supervision**
1) corrected case management that was inconsistent with CTI principles & practices 2) provided guidance to assure approach was consistent with CTI principles & practices 3) scheduled case presentations for all new clients within a few weeks of enrollment into CTI	
Not based on phase	**QUA6 Organizational Support**
1) minimum staff were hired (CTI-trained supervisor & workers) to maintain small caseloads & ensure fidelity	

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