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Editorial:

Developing a clinical pathway for traumatic stress in prisons

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Identifying traumatic stress amongst people in prison

Within the prison population, the estimated prevalence of post-traumatic stress disorder (PTSD) is 7.7%, and for Complex PTSD (C-PTSD) it is 16.7% (1). The higher prevalence of C-PTSD reflects the fact that people in the criminal justice system - including those attending police custody, courts, prisons and probation services - have often been exposed to multiple and cumulative experiences of inter-personal trauma during their childhoods, and the rest of their lives (2,3). High rates of psychiatric co-morbidity have also been identified amongst prisoners with PTSD, with links to suicidal behaviour, self-harm and aggression (1). However, most people in prisons have had no prior contact with mental health services, and an under-representative proportion of prisoners receive treatment for mental health conditions, so it is likely that there are significant levels of untreated PTSD and C-PTSD in these settings (4).

Barriers to the delivery of healthcare services are often present in prisons, complicating the design and delivery of a clinical pathway in this area (5). However, improving the identification and management of PTSD and C-PTSD, through standardised screening and intervention at prison reception and beyond, provides an opportunity to facilitate treatment and potentially improve wellbeing beyond imprisonment (6). Yet screening and assessment tools used vary in their utility, and there is a specific absence of training to deliver effective assessments for traumatic stress (7, 8). Further research is needed to understand what works best here, but in the meantime it is useful to learn from models that have been applied to other conditions presenting in prisons (9). This suggests that an initial

two-stage process - in which a standardised generic reception screen is followed by a specific triage screen that can identify the presence of PTSD and C-PTSD, then stratifies care according to the presenting need – is worthy of further examination. It is also possible that providing screening at earlier stages of the criminal justice system, such as within liaison and diversion services operating in police custody or the lower courts, as has been recommended for some other mental health conditions, could facilitate identification (10, 11). In any case, it will be important for a traumatic stress pathway to be fully integrated across a range of conditions – including other mental health, substance misuse, and physical health conditions – given the tendency towards diagnostic co-morbidity and complexity amongst prisoners (9).

Interventions for traumatic stress in prisons

To effectively treat PTSD and C-PTSD, evidence-based therapies, including trauma-focussed cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR), are recommended (12). However, prison mental health services often lack the capacity and skill to provide the evidence-based psychological therapies that are required to stabilise and manage these conditions, particularly within primary care mental health services (13). At the same time, barriers to treatment may include high prison turnover, with short stays and transitions between prisons and the community, being on remand or awaiting sentence, and high levels of uncertainty about criminal charges (6). Further compounding these difficulties, studies show that trauma-focused therapies delivered in prisons demonstrate limited evidence of effect on trauma symptomology (14), and that this population face a number of challenges accessing and engaging with effective care (15).

While it is likely to be necessary to build clinical capacity to overcome these difficulties, the development of a conceptual pathway is an important first step. Although bespoke trauma-focussed therapies for C-PTSD are still in development and their effectiveness has not yet been fully tested (16), there is an opportunity to improve trauma-based therapies for people in prison by identifying them as a clinical and research priority (1).

Meanwhile, there is also little research regarding the effectiveness of pharmacological interventions for PTSD and C-PTSD in prisons. Pharmacological interventions are usually recommended as a second-line intervention, either individually, or to augment psychological therapy (17), but in prisons the barriers to access and limited effectiveness of trauma-focussed therapies indicate that pharmacological interventions are likely to assume an enhanced role in these settings. Yet despite this, there is variability in the capacity of medical staff to offer evidence-based prescribing, and these staffing issues may be even more acute in prisons (18, 19).

Further exploration of factors that mediate the effectiveness of psychological therapies and pharmacological interventions is also important. However, for some, the prison environment can be counter-therapeutic, with potential issues including endemic violence and drug use, insufficient staffing, problematic access to meaningful activities, and spending lengthy periods in-cell (20). The experience of imprisonment may, for some, be traumatising, or re-traumatising, and this can limit recovery from traumatic stress (21). To mitigate the complex social, environmental and psychological factors that may alter outcomes, specialist trauma therapies would need to be embedded within a whole-system, trauma-informed approach (22). Within this approach, staff would understand the potential of the prison system and environment to re-traumatise the individual, and attempt to mitigate this, while supporting the individual to build skills and resilience (21). However, there is currently a lack of evidence about the impact of whole-system trauma-informed approaches on outcomes for service-users, along with a lack of consistency when defining its components (23). Exploration of these is likely to be an important element of clinical pathway development in this area, using learning from other areas – such as the offender personality disorder pathway - in which whole-system approaches have been introduced and evaluated (24).

A clinical pathway for traumatic stress

A clinical pathway for traumatic stress should aim to standardise care, by translating clinical practice guideline recommendations and encouraging a whole-system approach that provides integrated care across key domains of mental health, substance misuse, and physical health (25). A core aim is to ensure that healthcare service provision in prisons is similar to that which is provided in the general community in this area, in keeping with the internationally agreed principle of equivalence in prison healthcare (26). Therefore, any such pathway should detail the steps to identify people who have experienced traumatic events; avoid unnecessary and repeated assessments and referrals; and facilitate access to effective, evidence-based trauma therapies for PTSD and C-PTSD that are matched to individual needs (17). A traumatic stress pathway would also need to consider the best possible approach towards community reintegration and access to community mental health services, particularly within primary care, recognising that this part of the pathway presents considerable challenges. Although various models have been developed to optimise reintegration, it is generally understood that planning and preparation for prison release should begin as early as possible (27).

Useful next steps

Although there is a need to develop an effective traumatic stress pathway in prisons, both to manage morbidity in this area and meet the standard of community equivalence that is expected, there is currently a lack of consensus amongst experts and stakeholders about the optimal approach to assessment, intervention and evaluation of traumatic stress in these settings. We therefore recommend the introduction of a consensus approach to the development of a pathway in this area, learning from practical approaches that have been developed for other commonly presenting conditions in prisons (28). The resulting pathway could then be developed further, using a whole-system approach such as the Medical Research Council framework to developing and evaluating complex interventions (29).

The recently revised Royal College of Psychiatrists' Quality Network standards are a useful addition to this field, because the articulation of minimum agreed standards allows services to identify where they are doing well, and consider where further action is required (30). In responding to these standards, Traumatic Stress Wales and the Offender Health Research Network-Cymru (OHRN-C, Cardiff University) are now developing an integrated assessment and intervention pathway for traumatic stress in prisons and the wider criminal justice system in Wales as a matter of priority, with the full support of Welsh Government. Although guidelines are currently in place for the management of depression using a stepped care model (31), and such models have been implemented in prisons in some parts of the United Kingdom, no template exists for the development of specific pathways for PTSD and C-PTSD in the criminal justice system. While this may seem surprising, given the high prevalence of these disorders amongst this group, challenges relating to the design and provision of healthcare in prisons are well-described, and they are compounded during the current Covid-19 pandemic (32, 33). Therefore, recognising the evidential limitations and significant challenges in this area, the design and delivery of a national model to identify and manage these disorders in prisons throughout Wales would be a significant step forward.

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