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.

References:

1. Facer-Irwin E, Karatzias T, Bird A, Blackwood N, MacManus D. PTSD and complex PTSD in sentenced male prisoners in the UK: prevalence, trauma antecedents, and psychiatric comorbidities. Psychological Medicine. 2021 Jan 12:1-1.
2. Ford K, Bellis MA, Hughes K, Barton ER, Newbury A. Adverse childhood experiences: a retrospective study to understand their associations with lifetime mental health diagnosis, self-harm or suicide attempt, and current low mental wellbeing in a male Welsh prison population. Health & justice. 2020 Dec;8(1):1-3.
3. Karatzias T, Shevlin M, Fyvie C, Hyland P, Efthymiadou E, Wilson D, Roberts N, Bisson JI, Brewin CR, Cloitre M. Evidence of distinct profiles of posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD) based on the new ICD-11 trauma questionnaire (ICD-TQ). Journal of Affective Disorders. 2017 Jan 1;207:181-7.

4. Tyler N, Miles HL, Karadag B, Rogers G. An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. Social psychiatry and psychiatric epidemiology. 2019 Sep;54(9):1143-52.
5. Patel R, Harvey J, Forrester A. Systemic limitations in the delivery of mental health care in prisons in England. International journal of law and psychiatry. 2018 Sep 1;60:17-25.
6. Forrester A, Hopkin G. Mental health in the criminal justice system: a pathways approach to service and research design. Criminal Behaviour and Mental Health. 2019 Aug;29(4):207-17.
7. Cloitre M, Hyland P, Prins A, Shevlin M. The international trauma questionnaire (ITQ) measures reliable and clinically significant treatment-related change in PTSD and complex PTSD. European Journal of Psychotraumatology. 2021 Jan 1;12(1):1930961.
8. Martin MS, Colman I, Simpson AI, McKenzie K. Mental health screening tools in correctional institutions: a systematic review. BMC psychiatry. 2013 Dec;13(1):1-0.
9. Forrester A, Till A, Simpson A, Shaw J. Mental illness and the provision of mental health services in prisons. British Medical Bulletin. 2018 Sep; 127: 101-109.
10. Craster L, Forrester A. The early identification of people with personality disorder in the criminal justice system. Medicine, Science and the Law. 2020 Oct;60(4):294-300.
11. Chaplin E, McCarthy J, Marshall-Tate K, Ali S, Xenitidis K, Childs J, Harvey D, McKinnon I, Robinson L, Hardy S, Srivastava S. Allely C. Tolchard B. Forrester A. Evaluation of a liaison and diversion Court Mental Health Service for defendants with neurodevelopmental disorders. Research in Developmental Disabilities. 2021 Dec 1;119:104103.
12. Bisson JI, Olff M. Prevention and treatment of PTSD: The current evidence base. European Journal of Psychotraumatology. 2021 Jan 1;12(1):1824381.
13. Forrester A, MacLennan F, Slade K, Brown P, Exworthy T. Improving access to psychological therapies in prisons. Crim. Behav. & Mental Health. 2014;24:163.
14. Yoon IA, Slade K, Fazel S. Outcomes of psychological therapies for prisoners with mental health problems: A systematic review and meta-analysis. Journal of consulting and clinical psychology. 2017 Aug;85(8):783.
15. National Audit Office. Mental health in prisons. London: National Audit Office; 2017. 54 p. Ref.: 11466-001
16. Karatzias T, Cloitre M. Treating adults with complex posttraumatic stress disorder using a modular approach to treatment: Rationale, evidence, and directions for future research. Journal of traumatic stress. 2019 Dec;32(6):870-6.
17. National Institute for Health and Care Excellence. Post-traumatic stress disorder. 2018. Available at: https://www.nice.org.uk/guidance/ng116/chapter/Recommendations
18. Bisson JI, Baker A, Dekker W, Hoskins MD. Evidence-based prescribing for post-traumatic stress disorder. The British Journal of Psychiatry. 2020 Mar;216(3):125-6.
19. Forrester A, Exworthy T, Olumoroti O, Sessay M, Parrott J, Spencer SJ, Whyte S. Variations in prison mental health services in England and Wales. International journal of law and psychiatry. 2013 May 1;36(3-4):326-32.
20. Ismail N. The politics of austerity, imprisonment and ignorance: A case study of English prisons. Medicine, Science and the Law. 2020 Apr;60(2):89-92.
21. Bradley A. Viewing Her Majesty's Prison Service through a Trauma-Informed Lens. Prison Service Journal. 2021 Jul 6(255):4-11.
22. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. 2014. U.S. Department of Health and Human Services. Available at: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
23. Jankowski MK, Schifferdecker KE, Butcher RL, Foster-Johnson L, Barnett ER. Effectiveness of a trauma-informed care initiative in a state child welfare system: A randomized study. Child maltreatment. 2019 Feb;24(1):86-97.
24. Skett S, Lewis C. Development of the Offender Personality Disorder Pathway: A summary of the underpinning evidence. Probation Journal. 2019 Jun;66(2):167-80.
25. Rotter T, de Jong RB, Lacko SE, Ronellenfitsch U, Kinsman L. Clinical pathways as a quality strategy. Improving healthcare quality in Europe. 2019 Oct 17:309.
26. United Nations (UN). Standard minimum rules for the treatment of prisoners (Nelson Mandela Rules). 2015. Ref: a/RES/70/175.
27. Lennox C, Kirkpatrick T, Taylor RS, Todd R, Greenwood C, Haddad M, Stevenson C, Stewart A, Shenton D, Carroll L, Brand SL. Pilot randomised controlled trial of the ENGAGER

collaborative care intervention for prisoners with common mental health problems, near to and after release. Pilot and Feasibility Studies. 2018 Dec;4(1):1-0.
28. Young S, Gudjonsson G, Chitsabesan P, Colley B, Farrag E, Forrester A, Hollingdale J, Kim K, Lewis A, Maginn S, Mason P. Identification and treatment of offenders with attention-deficit/hyperactivity disorder in the prison population: a practical approach based upon expert consensus. Bmc Psychiatry. 2018 Dec;18(1):1-6.
29. Skivington K, Matthews L, Simpson SA, Craig P, Baird J, Blazeby JM, Boyd KA, Craig N, French DP, McIntosh E, Petticrew M. A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. bmj. 2021 Sep 30;374.
30. Royal College of Psychiatrists. Standards for Prison Mental Health Services. 2021. Quality Network for Prison Mental Health Services. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/qnpmhs-standards-for-prison-mental-health-services-publication-5th-edition.pdf?sfvrsn=c18ba674_2
31. National Institute for Health and Care Excellence. Depression in adults: recognition and management. 2009. Guideline CG90. Available at: https://www.nice.org.uk/guidance/CG90
32. Ginn S. The challenge of providing prison healthcare. BMJ. 2012 Sep 22;345:26-8.
33. Kothari R, Forrester A, Greenberg N, Sarkissian N, Tracy DK. COVID-19 and prisons: providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff. Medicine, Science and the Law. 2020 Jul;60(3):165-8.