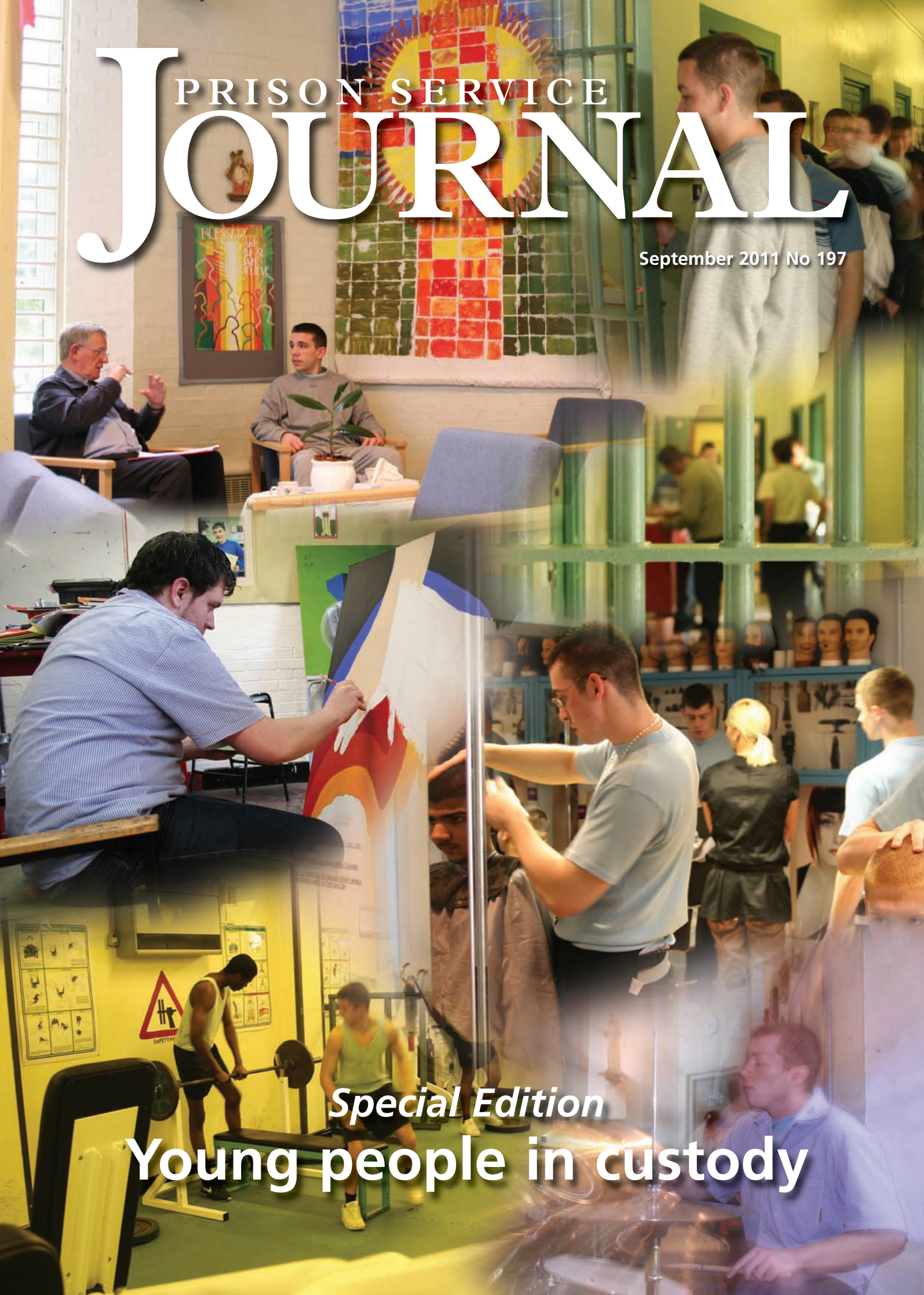

PRISON SERVICE JOURNAL

September 2011 No 197

Special Edition

Young people in custody

Young Prisoners and Their Mental Health:

Reflections on Providing Therapy

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'What I feel I'm trying to do is offer them a bit of an understanding.'

(Clinical Psychologist)

We know that young people in custody are often vulnerable. It is well documented that young people in prison bring with them a range of psychological and social difficulties.[1] In addition to problems with mental health and substance misuse, they may also have learning difficulties, and speech and communication problems.[2] We also know that young people in prison are a socially excluded group.[3] They have often been rejected by their families, peers, schools, and local community. Furthermore, we know that these young people often find the psychosocial experience of imprisonment distressing. Young people in prison report difficulties with uncertainty, a lack of safety, a loss of freedom and the separation from family; the first month in custody has been found to be particularly distressing.[4] Although young people do adapt differently to prison, and some are able to cope, self-harm rates are high among young prisoners, as are reported levels of psychological distress. There is a need for future longitudinal studies to appreciate fully the *specific* effects of imprisonment for young people.

Over the past decade, the government has begun to invest in improving the mental wellbeing of young people in prison.[5] In 2001, a five-year plan to improve the health care provision of prisoners was set out in the White Paper, *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. In general, Mental Health In-Reach Teams (MHIRTs) were set up to support prisoners with mental health difficulties, so-called 'non-criminogenic' needs, rather than to focus solely on the link between mental health and offending. This led to a widening role of psychologists within prisons, with clinical and counselling psychologists being employed to address prisoners' mental health. Furthermore, in 2007/8 the Department of Health provided additional funding to adapt the model of in-reach provision, specifically for young people in Young Offender Institutions (YOIs).These are valuable steps, but there still remains a high level of unmet need and the services face considerable challenges.[6]

This paper focuses on how we might best provide therapy for young people in prison.[7] It draws upon some personal reflections of providing therapy to young people in prison and some qualitative interviews with several clinical psychologists who work with young prisoners.[8] This paper focuses on the work of psychologists working within mental health in-reach teams, rather than the work of psychologists who deliver offending behaviour programmes. It argues that to work therapeutically with young people in prison the therapist must also work with the teams and systems around these young people. Moreover, the therapist must understand the context of the prison and thus its impact on the young person and the therapy being offered. The paper concludes by considering the role of psychological formulation in relation to this therapeutic work in prisons.

Complexity and flexibility

Based on my personal professional practice, and from interviews with clinical psychologists in MHIRTs, it is evident that young people referred for psychological therapy have complex needs. Interviews with psychologists revealed that they work with several overlapping groups of young people: those who struggle to adjust to life inside; those who have a history of co-

1. Harrington, D. and Bailey, S. (2005) *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community*. London: Youth Justice Board; Kroll, L., Rothwell, J., Bradley, D., Shah, P., Bailey, S. and Harrington, R.C. (2002). Mental Health Needs of Boys in Secure Care for Serious or Persistent Offending: A Prospective Longitudinal Study', Lancet, 359: 1975-9; Lader, D., Singleton, N. and Meltzer, H. (2000) *Psychiatric Morbidity among Young Offenders in England and Wales*. London. Office of National Statistics;
2. Khan, L. (2010) *Reaching Out, Reaching In: Promoting Mental Health and Emotional Well-being in Secure Settings*. London: Centre for Mental Health.
3. Ibid.
4. Harvey, J. (2007) *Young Men in Prison: Surviving and Adapting to Life Inside*. Cullompton: Willan.
5. DH and HMPS (2001) *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. London: Department of Health.
6. Khan, L. (2010) *Reaching Out, Reaching In*.
7. The paper will focus on young people aged 15-21 years old who are accommodated in YOIs.
8. I carried out these interviews as preparation for the edited book Harvey, J. and Smedley, K. (2010) *Psychological Therapy in Prisons and Other Secure Settings*. Abingdon: Willan.

morbid difficulties (such as trauma, anxiety, low mood, self-harm or psychotic symptoms); those who are difficult to 'manage' in prison because of their aggressive behaviour; and those who are not particularly distressed but who want to understand their tendency to respond violently. Usually though, the young people referred to psychologists have several interwoven symptoms which stem from chronic traumatic life events and insecure attachment. One clinical psychologist said:

> *The depression and anxiety is usually not on its own, in the sense that it's often part of a really chaotic upbringing, where they've had other problems that might impact on the way they think about themselves and their future and how things are going to turn out and often it's linked with other disorders like PTSD [Post-Traumatic Stress Disorder] [. . .]. People can be very paranoid, hyper-vigilant, guarded, depressed, angry, and that kind of mix of things isn't always best described in one particular diagnosis.*

This psychologist reported numerous clients with 'complex problems'. Given that complexity, it seems rare that a therapist can provide treatment relying only on a single psychological model for a single psychological problem. As another psychologist said:

> *I wouldn't say I'd ever delivered, you know, ten sessions for PTSD or ten sessions for depression, because I don't think there were any of the young people that I saw when you could think that there was a single, simple mental health problem, really.*

Psychologists sometimes thought that prison staff would only refer people with depression, anxiety or obsessive compulsive disorder, when in fact individuals with more complex presentations were appropriate referrals. Prison staff needed to understand that help could potentially be offered to this group and this highlights a role for *all* staff working in custodial settings to have training in recognising symptoms and knowing the referrals pathways.

The complex presentation of young people has important implications when designing therapeutic services to meet the needs of these young people in custody. Such psychologists needed to take a flexible approach to work, to draw on different models and to respond to what was going on for young people in the 'here and now'. They also needed, they said, to be realistic about the goals of their work. To do that, they had to consider what stage young people were at in their sentence and how able they were to cope with discussing difficult topics while in prison. Those considerations influence the type of interventions delivered in custody and the evaluation of their outcomes. Whilst it was important for these psychologists to base their practice on evidence, they stressed a need for flexibility and responsivity within particular models. In particular, there seems to be a need to develop an idiosyncratic understanding of a range of symptoms, rather than relying only on categorical diagnostic labels.

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Systems and Teams

Working in MHIRTs, psychologists report the need to understand the systems and teams which surround the young person, as well as the young person's place within these systems and teams. Young people in custody are at the centre of a number of systems that come and go. It is important for psychologists working within MHIRTs to reflect on the parameters and boundaries of their work and to consider their responsibilities of providing therapy within a custodial setting. Psychologists recognised the complexity of teams and the importance of reflecting upon this complexity. What one clinical psychologist said of 'looked after' children in particular is typical in general:

> *There are so many systems involved [. . .]. We've got all the social services side, all of the YOT side; they pick up in-reach teams in here; they might have mental health input when they're going to leave. And just where your relationship sits within that system, I think, can be confusing — and confusing about what your boundaries are.*

A psychologist who strives to understand where her MHIRT sits among these systems is able to consider where her work starts and ends and to be clear with young people about those boundaries. A psychologist who understands the systems can also ensure continuity of care. The transition to prison life dislodges a young person from one set of systems and teams and lodges him among others. Therefore, relationships between the therapist and other professionals who work with young people are important too. Furthermore, as it is important

that the young person remains 'attached' to systems outside the prison, there is a question who should take the initiative to maintain that connection and ensure that the ruptures of entering prison are as limited as possible. There is a responsibility to integrate, collate and present information, as the young person moves between systems, so that this information is not lost, misconstrued or misinterpreted later. To do this, the mental health professional needs to bear in mind not only the care he or she is currently providing a young person but also the young person's trajectory.

To work therapeutically with young people, the psychologist in prison needs to work alongside the systems outside it, with which the young people are connected, such as the youth offending service (YOS), the family, other mental health professionals, social workers, volunteers and education providers. Contact with the local YOS is especially important, as a YOS officer might have worked with a young person for a lengthy period of time prior to custody; so 'interviewing' the YOS officer allows information about the difficulties which prisoners bring with them into custody. In turn, while the young person is still in prison, it is important for psychologists to start building connections with systems outside the prison, including the prisoner's local Child and Adolescent Mental Health Service (CAMHS), for example, to encourage them to start assessments whilst the young person is inside.

As well as forging links with professionals, it is also important for the clinical psychologist to forge links with the young person's primary care giver. It is well documented that working with families can help reduce reoffending, and in particular, evidence suggests the effectiveness of parenting support and Multi-Systemic Therapy (MST). Besides reducing re-offending, research has found that improving family contact is an important goal for young people in custody and that family contact was one of the most important things which helped young men adapt to life inside.[9] Given that young people often enter prison with fragmented relationships and insecure attachments, prison can be an opportunity to foster different forms of relationships. However, family contact proves difficult in prison: it is often not prioritised. There are therefore well recognised barriers to systemic work with young people and their family when the people are in prison.[10]

It is also important to work with the system of the prison itself, but this too is difficult. One psychologist said:

> *I mean, kind of, the systemic thing is challenged and challenging somewhere like a prison, where it's a closed system and there aren't the links — natural links — with the outside. Even the links* inside *aren't that well fostered sometimes and so you have to keep knocking at the door.*

. . . the mental health professional needs to bear in mind not only the care he or she is currently providing a young person but also the young person's trajectory.

Working collaboratively with other mental health professionals within the MHIRT was also seen as important, but it was acknowledged that this can be difficult as some teams only have input from a psychologist once or twice a week. It has been found that working with prison staff can prove effective in bringing about change for young people in prison.[11] Working directly with prison staff is vital for some psychological interventions, for example with prisoners experiencing Post-Traumatic Stress Disorder.[12] Such collaboration is essential in getting the practicalities right, as in the difficulties of getting clients to attend sessions, which one psychologist noted:

> *Often when you explored beneath the surface why people didn't come, those were reasons to do with the system, and not the person. And they would say to you, 'I did want to come', and they would come again, but this happened or it clashed with this or that . . . They said, 'I couldn't come unless I came at this time'. You know, there would be some other reason within the organisation.*

9. Harvey, J. (2007) *Young Men in Prison*.
10. Shelton, D. (2010) Systemic Psychotherapy in Prisons. In J. Harvey and K. Smedley (eds.) *Psychological Therapy in Prisons and Other Secure Settings*. Abingdon: Willan.
11. It is of interest that a unit (The Willows Unit) has been set up at HMYOI Hindley which is staffed by prison officers but supported in the service delivery by an adolescent forensic mental health team. This unit aims to address high levels of need for those adolescent offenders in custody who pose complex management difficulties. The approach is early in its development and remains to some degree experimental. However, there is a developing outcomes framework and initial outcomes appear promising, at least in the short term (Rogers, personal communication, 2011).
12. Rogers, A. and Law, H. (2010) Working with Trauma in a Prison Setting. In J. Harvey and K. Smedley (eds). *Psychological Therapy in Prisons and Other Secure Settings*. Abingdon: Willan.

Contextual Understanding

Therapists who would work effectively in custody need a grounded understanding of the context, both of the specific prison, its rules, culture and history and of prisons more generally. Such a contextual awareness of the prison can help psychologists to understand the problems which young people present there. It is important for the psychologist to understand the prison experience in a formulation (more on this below) in order to disentangle with clients whether their difficulties result from imprisonment, such as difficulties adjusting, or from pre-existing problems exacerbated in this new context. Otherwise considering the young person in isolation, without considering the psychosocial experience of imprisonment, we might incline more to a pathological understanding of the individual that is devoid of systemic factors. For example, as one clinical psychologist observed, the coping strategies of a young person may have to change in prison, in order to remain out of trouble; and the change may have other consequences for their mental health:

> *They have some vague idea that they shouldn't get into fights because that might lead to adjudication [. . .] which causes them to often withdraw or bottle up a lot of anger, which isn't necessarily the best way of dealing with it.*

Understanding prison life, as a prison researcher might endeavour to, keeps a psychologist mindful of the importance of what has been called 'the presentation of self in everyday life'[13] in the specific context, and the way that this presentation of self can affect a young person's presentation in therapy.

Research on the psychosocial experience of imprisonment has stressed the influence of the ways that young people present themselves with a mask when out on the wing. One psychologist recognised this too:

> *I think there are aspects around the culture here in terms of what it means to be a young male in . . . quite a threatening environment and you don't just walk in a room and then drop your guard. And you've got to go back to it.*

Young men in prison sometimes feel they need to project an aggressive image in order to survive. One psychologist said:

> *They have to put up this image where they're not vulnerable but they are butch and cocky and aggressive and can look after themselves, and therefore it's better to look like that so it's the next guy that gets picked on.*

This has important implications when considering how and why the young person is presenting and considering whether this presentation reveals what they are like out in the community. Indeed, the 'code of the street'[14], may also require such a position to be taken, but without seeing the young person 'on road' it is difficult to draw firm conclusions. Therefore, when carrying out risk assessments, tentativeness is important: the interaction between a young person and his environment can bring about different reactions and so conclusions should be contextually bound.

Moreover, a contextual understanding puts psychologists in a better position to understand their *own* position in the prison and, importantly, young people's perceptions of it, because this may impact upon the therapeutic relationship. Then they can reflect on what might constrain therapy, on who the client is in their work, and on what their goals and interventions are. The psychologist becomes a reflective-practitioner. When asked how they thought young people viewed them, psychologists reported a variety of responses. One said:

> *Some would see me as a benign support. I'm the person you go and talk to [. . .]. There'll be other young people who perceive me as some kind of detective, I think, trying to figure out their heads . . . and trying to have some kind of expert knowledge on them. I think some would see me as an advocate in terms of trying to explain to others what the difficulties are. Some might see me as a psychologist and working on their goals, but I think it's . . . it's confusing to them.*

Yet the negative perceptions of some young people are a distinctive element of therapy in prisons. Another psychologist said:

> *I think, for some of them [. . .] we're seen as just more oppression. Not only have they got a criminal label, they've now got a mental health label on top of that, and that's the last thing they want. Some of the lads are more insightful than others and see . . . and use it for what they can; some people just see it as another way of monitoring . . . You know, we're agents on behalf of the prison system who are monitoring their behaviour and their thinking patterns.*

It is difficult to know how much psychologists should ask young people how they perceive them. Yet they do

13. Goffman, E. (1959/1990) *The Presentation of Self in Everyday Life*. London: Penguin.
14. Anderson, E. (2000) *Code of the Street: Decency, Violence and the Moral Life of the Inner City*. London: W.H. Norton and Company.

need to think about these perceptions, which could impact upon the therapeutic relationships and outcomes.

Furthermore, these perceptions do reflect the fact that the psychologist is providing therapy within a custodial environment. Psychologists carrying out therapy in prisons are employed by the National Health Service (NHS) but they are also working in an institution focused on punishment. To what extent are clinical psychologists *independent* of the prison and its focus? How does this affect their work? Even if the psychologist might feel separate from the prison, he or she is sometimes put in the position of acting as an ersatz prison officer and as an agent of power. One psychologist recognised this:

> *On one hand, us being independent, and us being NHS, and actually holding keys — actually we do make security reports when appropriate. [. . .] We're not custodians. There's all sorts of things which imply we are a bit. I can't just leave someone in the waiting area; I have to actually make sure that they've gone back to the holding cell [. . .] And just what that, kind of, conveys to them, as to who I am, and what my relationship with the system is, I don't know; but it gets murky.*

. . . clinical psychologists also need to think about how the organisation of life in prison might affect their ability to conduct therapy.

The quotation above alludes to the fact that there may be times when the young person is at risk to themselves or others, and so the psychologist shares that information with prison staff. Moreover, if the clinical psychologist has been asked by the court to write a risk assessment or if the person is subject to Multi-Agency Public Protection Arrangements (MAPPA) information will be shared. So psychologists need to be open with young people about their position in relation to confidentiality. As one put it, prisoners 'needed [. . .] to know what kind of information you'd be passing on' but 'they [the prisoner] didn't find that that problematic.'

Similarly clinical psychologists also need to think about how the organisation of life in prison might affect their ability to conduct therapy. One psychologist reported 'so many restrictions' on which, whether, when and how prisoners can attend therapy and while these disruptions might have understandable causes, they do have an impact on therapy too. In some prisons, therapy might not always be a priority and security may often take precedence. Security concerns might lead psychologists and other prison staff to competing views about the best way in which to respond to a prisoner who has been disruptive:

> *The highest organising factor for prisons has been security and the way they manage security is by moving people round [. . .] whereas the therapeutic approach to managing people who are troublesome is to hold them and to keep . . . and work with them and work through stuff [. . .] So essentially you have two very competing philosophies.*

The different agendas — 'competing philosophies' even — have the potential to affect outcomes negatively. They need to be acknowledged in therapy so that clients and psychologists can deal with them and they need to be thought about when designing services to meet the mental health needs of young people in prison.

Those competing philosophies reflect competing ideas of who the client is for therapy in prisons. Indeed, who is the client? Psychologists recognised that 'it varies' and that they had multiple clients:

> *I think some young people who are presenting with, kind of, symptom focused work and it's their symptoms that they want to change [. . .]. They're the client. I think there's other young people with complexity and risk issues, where it feels like much more the system's the client; and services want some kind of view on what might be driving things. And, I think, then it's about trying to manage having more than one client, 'cause the client's also your client as well!*

Another defined the client like this:

> *The young person, but I kind of think sometimes the prison [. . .] and then sometimes the courts ask you to do something so they're the client.*

While both note what the first called 'trying to manage some of the conflicts of interest', both also ended by stressing that, as the second put it:

> *In the end the only way I can keep sane about it is to remember that the lad is the client and it's them and their needs that have got to be heard here and got to be brought to people's attention.*

Another psychologist stressed how important it is to be clear with the young person that they are the client:

> *I was able to say, 'I don't work for the prison and I don't work to the prison's agenda, and you and I will decide what it is we want to talk about. It won't be decided by an officer on the wing or by the governor or … it needs to be something that is what you want.*

This psychologist found something inherent within the discipline which allowed that:

> *Psychology's, kind of, collaborative nature, the, sort of, advocacy role that's embedded in it: I think those things make engagement in a setting where people feel so disempowered . . . I think, they make engagement with psychology easier.*

If consent is there — notwithstanding that some prisoners feel compelled to engage and that psychologists should be aware of this power dynamic — then it can be the start of fruitful work.

Psychological Formulation

As argued above, for therapists to meet the mental health needs of young people in prison they need to work with the multiple systems and teams around the young person *and* need to reflect on the context of the prison — to be both embedded *in* and at a reflective distance *from* the setting. Psychological formulation can be an extremely effective means through which to help them to understand that systemic factors, the prison context and the effect of that context can impact on therapy itself. Formulations can take into account both individual and systemic factors. So what is a psychological formulation? A psychological formulation (or case conceptualisation) is a process where the individual's unique experiences are combined with a psychological model or theory in order to provide an understanding of how the individual's problems have developed and are maintained.[15] The process of drawing up a psychological formulation allows understanding of the young person that is collaborative, and moves away from diagnosis. Once developed, formulations can be shared with staff, with the young person's consent, in order to help them to understand the young person. Importantly, formulations can be used with the young person to provide a rationale for intervention and can also be used with other staff, or with caregivers, to examine their role in helping to alleviate a particular problem.

Formulation can help answer questions about the goals of therapy. Some psychologists said that the young people often had a goal: to *understand* their difficulties, rather than change them. So while developing a good psychological formulation is key to effective therapeutic intervention (for example, to working on changing thinking patterns or behavioural responses) it also offers understanding. One clinical psychologist argued that better understanding was 'a laudable goal' for a young person:

> *I saw a couple of young men who just wanted the understanding bit, and when we'd done it, I said, 'OK, so we've got the formulation. What would you like to do now?' And they'd go, 'No I feel loads better, thanks. That's it.' And I just think: well, that's your right to say you got what you wanted from it.*

Formulation can thus clarify the 'consent', as this psychologist called it, of young people to starting, and stopping, therapy. Formulation can also help the psychologist to respect the young person's problems and explain why they have legitimately developed. As one psychologist stressed that rather than give 'a sticky band-aid to stick over a problem' instead:

> *There are loads of things that, actually it's very hard to say to young people, 'You should just learn how to cope with this,' and I think it's really legitimate to say to them, 'You've every right to be angry about some of those things. You've every right to feel this and to feel that.*

Formulation allows for validation and normalisation of a young person's difficulties and experiences. The development of this formulation might in itself help the young person deal with certain psychological difficulties: but the process of development itself might contribute to that by allowing them to realise that there is another human being who is attempting to develop a shared understanding with them. The process of developing the formulation gives the young person an experience of being explicitly 'held in mind' by someone else. This 'attempt' by another person (i.e. the psychologist) lies at the centre of working towards meeting the young person's needs. Through treating the young person with respect, through communicating to them that they are worthy of being understood, may help the young person feel like a valued member of society.

15. See Persons, J.B. and Davidson, J. (2010) Cognitive-behavioral case formulation. In K.S. Dobson (ed.) *Handbook of Cognitive-Behavioural Therapies, 3rd edition*. New York: The Guildford Press.