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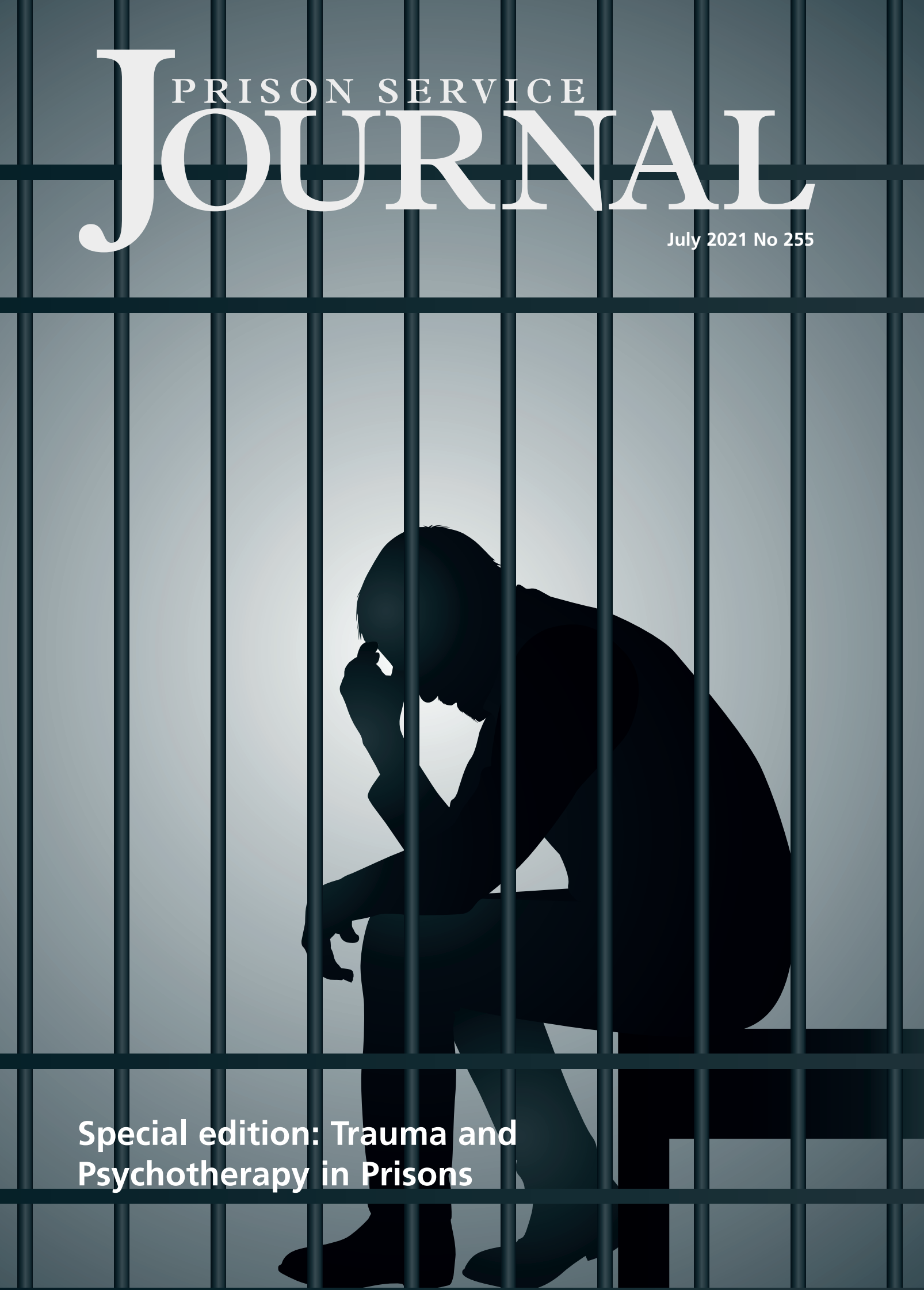

Special edition: Trauma and Psychotherapy in Prisons

Nothing works to reduce reoffending. Could psychological therapies be the answer?

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The endless cycle of reoffending

Breaking the cycle of reoffending is the holy grail of the criminal justice system. And we are no closer to that now than we have been at any point in the last 25 years. Despite the various experiments conducted since the 90s, the reoffending rate has not budged. Public policy initiatives have yielded almost no impact on reduced reoffending — from short sharp shocks, to justice reinvestment; from a focus on prolific offenders, to restorative justice. We've had a rehabilitation revolution, payment by results, the first coalition government since the war, and, since 1992, we've nearly doubled the prison population. Yet the reoffending rate has not changed in those decades. Whatever we do, roughly half of all adult prisoners released from prison reoffend within one year[1]. For juvenile offenders it is nearer 70 per cent. It seems that nothing works.

The reason for that might be staring us in the face. There has been no serious, sustained, or systemic attempt to grapple with the fundamental underlying problem — the sheer extent of mental illness among the prison population. None of the approaches listed above have paid any serious attention to the defining characteristic of the prison population — 90 per cent of prisoners have mental health problems[2]. Or at least that was the figure 20 years ago. The government does not currently know how many people in prison are mentally ill. This unlikely admission surfaced at a recent Public Accounts Committee (PAC) hearing into mental health in prison[3]. It is particularly surprising given that the assessment undertaken by the Department of Health and published by the Office of National Statistics, in 2001, revealed that fully 90 per cent of prisoners have a mental health condition[4]. Given that finding, you might expect the work of the following decades to have been to interrogate, codify and quantify that still further. In fact, we are in the curious position of now effectively knowing less.

We have data on the number of prisoners who protest on the roof, barricade themselves in their cell, and who were released in error. We know what percentage of prison establishments hit their target for riot training, how many prisons operate within budget, how many sick days are lost annually, and how many ex-offenders are in employment six weeks following release (just 4 per cent). And much much more besides[5]. The MoJ is a data-driven department, after all[6]. But there is no information on mental health in that same data-set. Not even basic census data, of the kind that is conducted every seven years in the community by NHS England (the Adult Psychiatric Morbidity Survey)[7].

Although our prison data on mental health is 20 years old, in this edition of the journal, Felicity de Zuleuta, Emeritus Consultant Psychiatrist at the South London and Maudsley NHS Trust, says there is no reason to suppose the estimate of 90 per cent of prisoners suffering from mental ill health has shifted to any great extent. There is certainly no good reason to suppose it has improved. Firstly, the rise in suicide and self harm, lamented at the PAC, indicates a decline in mental health (the number of self-harm incidents rose by 73 per cent between 2012 and 2016, according to the National Audit Office[8]). Secondly, the figure of 90 per cent broadly tallies with international comparison data and also accords broadly with a more local picture. When the PAC visited Wormwood Scrubs as part of

1. Ministry of Justice. Proven reoffending statistics (2018). Published 30 January 2020
2. Singleton N, Gatward R (2001) Psychiatric Morbidity among Prisoners: Summary Report. Office for National Statistics London.
3. Mental Health in Prisons (Eight Report of Session 2017-19) House of Commons Committee of Public Accounts
4. Singleton N, Gatward R (2001) Psychiatric Morbidity among Prisoners: Summary Report. Office for National Statistics London
5. Justice data at gov.uk. https://data.justice.gov.uk/prisons
6. Civil Service Blog Post - 27 June 2016: Sir Richard Heaton '5 ways we are putting data in the driving seat'. https://civilservice.blog.gov.uk/2016/06/27/5-ways-we-are-putting-data-in-the-driving-seat/
7. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England. 29 September 2016. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey
8. National Audit Office Report: Mental Health in Prisons 29 June 2017

their enquiry, the mental health in-reach team reported 70 per cent of the prisoners with underlying mental health needs[9].

Mental illness is the defining characteristic of the prison population

But what precisely do we mean when we talk about mental health? Mental illness comes in different forms and exists on a continuum. Psychosis, schizophrenia and delusional disorders are its extreme forms. But that does not make up anything like the mainstream of mental illness in the community or in prison. The National Institute for Health and Care Excellence (NICE) estimates that schizophrenia affects 0.7 per cent of the UK population[10]. The Office for National Statistics/ Department of Health Survey (ONS/ DH Survey) mentioned earlier, found higher rates of psychosis in the prison population, but estimated only 1 per cent of the adult sentenced male population met the clinical definition for schizophrenia.

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Nor are we talking about the other end of the spectrum — what psychiatrists call neurosis: sleep problems, anxiety, or panic, for example. While sleep problems and anxiety are more manifest in prison, the prevalence of actual neurotic disorders (as distinct from neurotic symptoms) were relatively low in the ONS/ DH survey. Only 3 per cent of the male adult sentenced population met the criteria for panic disorder, while 8 per cent met it for generalised anxiety disorder. At roughly the same time (2000), the government estimated the prevalence of generalised anxiety disorder in the general population at 4.4 per cent[11].

So what does make up the bulk of mental illness in prison? Principally two groups, according to the ONS/ DH survey: those with substance misuse problems and those fitting the criteria for personality disorder (often they are one and the same). In the ONS/ DH survey, 78 per cent of male remand prisoners met the criteria for personality disorder, in line with a contemporaneous estimate in the US. Antisocial personality disorder in particular had the highest prevalence. In the ONS/ DH survey, 63 per cent of male remand prisoners who were diagnosed with a personality disorder were diagnosed with antisocial personality disorder. The latest version of the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders — published by the American Psychiatric Association) states that in prison, the prevalence of antisocial personality disorder is often greater than 70 per cent[12]. In her work on psychopathology, Lemma says that in prison, in the UK, prevalence is anything up to 76 per cent[13].

In terms of substance misuse, 63 per cent of adult male sentenced prisoners reported hazardous drinking in the year before coming into prison, according to the ONH/ DH survey (that is, alcohol consumption which confers a risk of physical or psychological harm). In the same survey, nearly 80 per cent of prisoners described illicit drug use at some time in the past. Of those in prison for burglary, 70 per cent reported drug dependence. Those figures probably make intuitive sense to those of us who know prisons from an operational and/ or policy perspective. When it comes to substance misuse we feel we understand something of the scope and scale of the problem. But what about personality disorder? What on earth is an anti-social personality disorder?

Personality disorders are generally characterised by enduring maladaptive patterns of behaviour and thinking that deviate markedly from social norms. These patterns have their onset in adolescence and are fixed over time. The DSM list ten types of personality disorder (many of which overlap). The specific characteristics of antisocial personality disorder are a pervasive pattern of disregard for others, which starts early (15 years old) and persists into adulthood. Diagnosis also needs to include at least three of the following: failure to respect the law; deceitfulness; impulsivity; aggressiveness; reckless disregard for the safety of self or others; failure to sustain consistent work or honour financial obligations; lack of remorse and indifference to others. Theodore Millon, Emeritus Professor at Harvard Medical School, who specialised in this area, described an individual with antisocial personality disorder as impulsive, irresponsible, deviant, and unruly. He says they act without consideration for others and only meet social obligations when in their own interest. They disrespect society's rules and violate other people's rights[14].

9. Mental Health in Prisons (Eight Report of Session 2017-19) House of Commons Committee of Public Accounts
10. Psychosis and Schizophrenia in Adults: NICE Guideline on Treatment and Management 2014
11. Adult Psychiatric Morbidity Survey (McManus et al, 2009)
12. DSM-5 Diagnostic and Statistical Manual of Mental Disorders. 2013
13. Lemma, A (1996) Introduction to Psychopathology. Sage.
14. Millon, T (2014) Personality Disorders in Modern Life. John Wiley & Sons; 2nd edition

Prisoners are overwhelmingly violent and anti-social too

Taken together, that sounds like a pretty accurate summary of an average prisoner: antisocial, aggressive and often violent. To some, it probably doesn't sound much like a description of mental illness though. Millon tends to agree. Personality disorders are not disorders in a medical sense, he says, rather they are a means of describing the ways in which the personality system functions maladaptively[15]. Put even more simply, a person with a personality disorder has a seriously disturbed way of thinking. In the end, that is what most mental illness is. A personality disorder is a condition that affects how you think, feel, and behave towards other people. It's a disturbed way of thinking that leads to disturbed ways of relating. That pattern has become so ingrained it becomes part of your personality. Personality disorders are perhaps best understood as an extreme personality type. We all have a tendency to be impulsive, irritable or indifferent to others from time to time, but this tends to come and go. For a diagnosis of antisocial personality, these tendencies must be part of the person's everyday personality.

Criminal behaviour is a key feature of antisocial personality disorder. These are the central tenants of the prison population: offenders have tried to solve their problems through antisocial and often violent means, because of their skewed way of looking at the world. A person with an antisocial personality disorder gets easily frustrated and has difficulty controlling their anger. They will likely blame other people for problems in their life, and be aggressive and violent in response. The US Law Professor John Pfaff says we have got to stop kidding ourselves about the characteristics of the prison population. People convicted of violence in the US. are now the single largest group in prison — about 55 per cent. Half of those are in for murder, manslaughter, rape or sexual assault[16]. The same is true in the UK. The most common crime type is 'violence against the person'. The next highest is 'sexual offences'[17]. Non-violent crimes have low custody rates. Government research in 2012 showed only 6 per cent of prisoners have no previous convictions[18]. This tells even those who campaign for prison reform, like Pffaf, that you have to commit a very serious offence, or multiple offences, to end up in prison.

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In an interview in this journal, Professor Danny Dorling says that he had initially assumed the UK had one of the highest rates of imprisonment in Europe because we sentenced more harshly[19]. In fact he found that we were less likely to imprison people for similar offences than countries with a lower prison population. What has actually happened is that we have become more violent, he says. Any initiative which doesn't wrestle with the central fact that prisoners are anti-social and violent will fail, whether it's a scheme for getting them a job on release or another boot camp. Improving literacy, providing more opportunities for employment and somewhere to live on release, are necessary, but not sufficient. Prisoners will squander those opportunities without help for their entrenched and distorted ways of thinking. The rehabilitative schemes that have been successful are the exception. And they are distinctly small scale. James Timpson recently tweeted that his company now employs 645 ex-offenders. As he pointed out, that is roughly the same number held in a medium-sized prison. Impressive. But Timpsons have been working in prisons for 15 years. There are roughly 70,000 offenders discharged every year[20]

So what's the alternative?

So what should we do instead? Well, however difficult, we should treat the sheer extent of mental illness we see around us. We cannot hope a job, a bank account, or a training scheme fixes an ingrained antisocial pattern of thinking and behaving. The management and treatment of personality disorder and substance abuse is challenging — by definition these

15. Ibid
16. Pfaff, J (2014) Locked In: The True Causes of Mass Incarceration and How to Achieve Real Reform. Basic Books; Illustrated edition (4 May 2017)
17. Justice data at gov.uk. https://data.justice.gov.uk/prisons
18. Research Summary: Ministry of Justice, 2012. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/219801/proven-re-offending-after-release.pdf
19. Prison Service Journal, 11, 198, 55-60.
20. Ministry of Justice. Proven reoffending statistics (2018). Published 30 January 2020

are enduring problems. But beyond depriving prisoners of their liberty and not letting them escape (which we have become very good at) this is literally the purpose of the prison and probation service — it exists to change lives and rehabilitate people[21]. We have to start taking the problem of mental illness more seriously and pursuing rigorous and effective treatment options.

The only thing that is known to work with personality disorder, is psychotherapy. The drugs probably don't work. The 2020 Cochrane review concluded that there is insufficient and inconclusive evidence to support the use of pharmaceuticals for antisocial personality disorder. In the US, there are no medications approved by the FDA to treat antisocial personality disorder. So, let us consider what treatment might look like. And let us keep in mind first that therapy is not listening to hard-luck stories, or enquiring into the circumstances that led to the commission of appalling crimes in an overly solicitous voice. We're not doing this to be good samaritans to 'poor murderers', as Dr James Gilligan says of his work with violent offenders in the US.[22]. We're doing this because we need to know what causes violence in society and how to reduce it.

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Therapy done right is difficult, intense work. The task of therapy is to unravel the patterns of the past, in order to make a better future. To 'prevent the next victim', in the vocabulary of prison and probation. Therapy is about understanding how the past affected you, in order to take responsibility in the present. To 'own it', in the modern parlance. Therapy says, you cannot go round it, you have to go through it. For all the tough talk about prison, prisoners are seldom required to take much responsibility for themselves. When prison staff challenge prisoners on their anti-social behaviour it is usually as a last resort and via formal disciplinary procedures, designed to uphold prison rules. Between 2010-15 there were nearly 30 per cent fewer of them to do even this[23].

Therapy on the other hand confronts those anti-social attitudes directly. To work effectively with personality disorder, therapists must confront the default to anger and aggression. Marsha Lineham, the originator of an evidence-based treatment designed to work with personality disorder, says to her angry clients, 'cut it out… I don't like it'[24]. She is aware that anger functions as self-protection, a way of masking the hurt associated with growing up with neglectful or abusive parents. And she acknowledges that the children of such parents are entitled to their feelings. But acting those out in therapy, or in life, is another thing. Extreme anger is probably what landed you in prison. So she intervenes strongly and immediately by saying, this is not effective, cut it out.

A similar principle operates in 12-step recovery. You have got to put down the drink or drug or other compulsive behaviour first. Nothing useful can happen while you're numbing your feelings or in black-out. Therapy only works if you can give an honest description of your experience. Otherwise it is bullshit, as Dr Steven J Lee says[25]. He is a doctor based in the US, who specialises in addiction. Addicts require a strong stance from their therapist. That means, he says, "I confront them respectfully by saying, "I think you're bullshitting me". It is often the only way to break through the denial and rationalisation that often characterises addiction.

Therapy is not about being nice to criminals

Levenson says we need to get away from the idea that the therapist is always a benevolent or concerned person[26]. He says he is absolutely not hanging on every word his client says, nor does he want them to think he is. He is often actually more interested in what they are not saying or what they want to avoid talking about. He's trying to deconstruct their version of events, to question and probe the story they are telling. Therapy, in this model, is not about 'giving a voice' to someone or 'honouring their story'. Therapy may do this, but en route to, and in the service of, a change in some aspect of thinking, feeling and behaviour.

21. Her Majesty's Prison and Probation Service: What Her Majesty's Prison and Probation Service does. https://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service
22. Gilligan, J. (1997) Violence: Reflections on a National Epidemic. Pantheon Books.
23. Institute for Government, Performance Tracker, Prisons, 2019 https://www.instituteforgovernment.org.uk/publication/performance-tracker-2019/prisons
24. Marsha Lineham - Borderliner Notes - https://youtu.be/xFiMTXn5An4
25. Zimmermann, S. (2019) Fifty Shrinks. Steven J Lee.
26. Levenson, E (2006) Fifty Years of Evolving Interpersonal Psychoanalysis. www.researchgate.net

That is the paradox of therapy. Therapy will often be the first time the story of childhood pain and neglect has been told or heard. So part of therapy is listening to and honouring the story of how an individual adapted to those circumstances and survived[27]. But that is only half the story. The behaviour that was adaptive in childhood has often become maladaptive in adulthood. Abuse or neglect is only part of the story. Good therapy does not allow the story to stop there. The point is to move on from self-serving, self-preserving, self-sabotaging versions of events. We see this time and time again in the minimising, obfuscation and 'forgetting' that is characteristic of prisoners accounts of their offending (see Dr Roger Grimshaw's article in this edition). At best those versions of events are incomplete. They represent an incoherent narrative in attachment terms,[28] in which the individual has yet to come to reconcile what happened to them with what they have done to others to land themselves in prison.

That perhaps is the essence of therapy with those who have had multiple adverse childhood experiences — to come to terms with the vulnerability and shame that is inherent in an abusive or neglectful upbringing. Therapy asks us to confront why we have such fear of, and aggression towards, other people. What purpose do those defences serve? Usually to protect us from anything like that ever happening again. 'I don't trust anyone/ 'I am an island'/ 'I'll get my revenge in first' are all presentations aimed at defending ourselves against others. Therapy is relentless. It asks what would happen if you took down the defence? In the service of growth and change and a better future, it asks if you can try? If you can try, briefly? And if you were not ready to try at the start of the session, or during the last session, it asks if you are ready to try again now? Each session of therapy exists to put you in touch with as much of your true feeling as you can bear[29].

This kind of challenge, with addicts and those with personality disorders, is often conducted, at least in part, in groups. Group work is crucial for people with antisocial personality disorder as many live within cultures defined by barely restrained violence and implicit threats. They are more likely to be influenced (and effectively challenged) by their peer group who understand their world. They may see clinicians as unlikely to understand either their socio-cultural context or the constant mental alertness about others motives that is required to survive in such communities[30]. The 12-step model of addiction recovery is famously built around the group too. Group members are often best at spotting, calling out, and challenging, the defences at play in addiction. Defences mask pain. In the case of substance misuse, Edward Khantzian, professor of psychiatry at Harvard Medical School, says addicts are not pleasure seekers or even self-destructive characters, but rather individuals in pain, who are seeking comfort[31]. They cannot regulate their own emotions. They don't have the experience, confidence or trust to turn to others to help them. The pain they suffer is relieved temporarily with addictive substances. This is known as the self-medication hypothesis. It is now one of the best accepted theories in the field of addiction recovery.

A dismissing attachment style ('you don't matter to me/ you can't hurt me'), is the product of neglect or abuse. It defends against the problem of low self-worth.

Adverse early experiences (and broken attachments) are the primary clinical issue

The external presentation which suggests a 'couldn't care less' attitude or general disdain for others, in fact belies anxiety about not being good enough or worthy of love. It is armour. A dismissing attachment style ('you don't matter to me/ you can't hurt me'), is the product of neglect or abuse. It defends against the problem of low self-worth. Bravado and swagger are also used to cover low self-worth — with others cast as 'idiots' or 'enemies', so they can be dismissed[32]. This the devaluing position — redolent of children who now, as adults, are incredibly cautious about risking again the feelings of dependency that were ridiculed or ignored in childhood[33]. Shame is often behind self protection, it speaks to indignity, defeat, inferiority, alienation[34].

27. Crittenden, P (2011) Assessing Adult Attachment. W. W. Norton & Company
28. Holmes, J (2001) Attachment and narrative in psychotherapy
29. Malan, D (2020) Brief psychotherapy: Practice and research. In: The Tavistock Century: 2020 Vision. Phoenix, Bicester, pp. 199-203.
30. Bateman & Fonagy (2019) Handbook of Mentalizing in Mental Health Practice. American Psychiatric Association Publishing
31. Khantzian, E. The Self Medication Hypothesis in Gill, R (2014) Addictions from an Attachment Perspective. Routledge.
32. Yeomans, F et al. (2002) A Primer of Transference-Focused Psychotherapy for the Borderline Patient. Jason Aronson
33. Wallin, D. (2015) Attachment in Psychotherapy. Guilford Press.
34. Henderson, D (2006) Shame as an achievement in analytic training. Psychodynamic Practice: Individuals, Groups and Organisations, Volume 12, 2006 - Issue 3

By confronting these feelings in therapy, the aim is that they diminish over time. You come to realise that your fears of being humiliated or criticised are unrealistic. They diminish as you are exposed to a calm, caring and non-violent individual, in the form of your therapist. The therapist turns out not to simply be like every other figure from your past. In therapy, you can have the experience of being vulnerable and not being taken advantage of. Progressive exposure to previously warded-off emotional states, eventually robs them of their power. In time, you can take those kinds of risks in 'real life' or on the wing — not everyone is out to get you.

Early attachment relationships are deeply ingrained and encoded within us. They form the pathway along which we develop[35]. Our experience of how our first caregivers treat us shapes us. That becomes our internal working model. A child who has an internal working model of caregivers as unloving or rejecting will in turn hold themselves to be unlovable and will anticipate rejection. In time they will find ways to cover up that vulnerability and defend against it. They might pretend they are 'hard as nails', they 'couldn't care less', or they 'prefer being on their own'. Over time, our ways of defending ourselves are woven into the fabric of our adult lives and they become part of our enduring personality. That is probably the easiest way to conceive of a personality disorder.

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The most astonishing finding from attachment research, is that attachment classifications at 12 months accord with attachment classifications in adulthood, approximately 75 per cent of the time[36]. It is a finding replicated over multiple decades of research and one which cements attachment theory as arguably the dominant paradigm in contemporary developmental psychology[37/38]. It suggests that our patterns are set early in life and then repeated over and over. 'We do as we've been done by', in Bowlby's somewhat ominous phrase[39]. But in therapy those attachments can also be undone. And then re-formed. Therapy breathes new life into Bowlby's phrase. Therapy provides an opportunity to have a different relationship. As we deconstruct the attachment patterns of the past, we also construct new ones in the present. An experience of deep and genuine care, even from someone who starts out as a complete stranger, can be powerfully transformative, especially in a life previously characterised by neglect and abuse.

Sure, not everyone can take that kind of intense therapy. But as Fonagy points out, mandated and 'imposed' treatment can work surprisingly well for those who are suspicious and rejecting and who would not come forward voluntarily; they often subsequently find their interest is engaged and, in time, develop trust in the process[40]. Of course still not everyone is motivated. But as Lineham reminds us, more people can take this form of treatment than you might first think. To clients who say they cannot tolerate the feeling of sadness, she says ok, so just tolerate it for five minutes. If they flat out deny they are sad, she says, ok indulge me, if you were ever to be sad, what in your life might you feel sad about. She is making the point that to struggle and find something hard is entirely different to accepting that one is utterly unable to try[41]. This is advice aimed at therapists and service providers too — do not give up on those with more severe problems and presentations.

In part, Lineham takes such a strong stance because she has been there. Literally. She spent two years of her early life on a locked ward, slashing her arms, wrists and abdomen with any sharp object she could find. Banging her head against the wall and floor when she was put in isolation and had her possessions confiscated. 'At times, the most disturbed patient on the ward', her discharge notes read. She had several courses of electro-convulsive therapy during her stay. She tried to kill herself twice. She now regards herself as having suffered from a personality disorder.[42] She is

35 Cassidy & Shaver (2018) Handbook of Attachment, Third Edition: Theory, Research, and Clinical Applications
36 Bateman & Fonagy (2019) Handbook of Mentalizing in Mental Health Practice. American Psychiatric Association Publishing
37 Schwartz, J (2003) Cassandra's Daughter: A History of Psychoanalysis. Routledge
38 Wallin, D (2015) Attachment in Psychotherapy. Guilford Press
39 Bowlby, J (2005) A Secure Base. Routledge.
40 Bateman & Fonagy (2019) Handbook of Mentalizing in Mental Health Practice. American Psychiatric Association Publishing
41 Lineham, M (1993) Cognitive-Behavioral Treatment of Borderline Personality Disorder. Guilford Press
42 Lineham, M (2021) Building a Life Worth Living: A Memoir. Random House.

77, a professor at the University of Washington, a fellow of the American Psychological Association, and holder of the Gold Medal Award for Lifetime Achievement in the Application of Psychology.

Therapy requires proper resource

The Maryland Report[43] in the US made clear some time ago that vague, unstructured counselling with offenders does not work. Bateman and Fonagy are clear that within their protocol for working with personality disorder, challenge or 'stop and stand' as they term it, is a critical component[44]. Impassive 'listening' approaches are contraindicated and should not be used (and may in fact be damaging) according to Khantzian[45]. Counselling in prison — often provided by volunteers or voluntary organisations — put bluntly, has the potential to do more harm than good. The voluntary, small scale nature of most counselling initiatives are the opposite of the serious, sustained, systemic approach needed. Change of this kind — intensive psychotherapy — is a serious endeavour. It needs to be backed by resource. Therapy with those who have a diagnosis of personality disorder is difficult. But not so difficult as we've sometimes chosen to believe[46]. Bateman and Fonagy lament the continued lack of treatment in criminal justice, especially when there are innovative treatment protocols in place (MBT-ASPD, being just one)[47]. The results of the five-year randomised control trial of MBT-ASPD for adult offenders, led by the University College London, are due soon. If successful, it should be rolled out nationally, as soon as possible, in prisons and probation.

We know psychotherapy in the community is incredibly effective. Decades of research in the community consistently show an effect size of 0.8, which is larger than almost all interventions in cardiology, and is greater than the success rate of flu vaccinations[48]. But findings from the community, however favourable, may not simply generalise to forensic settings. They have to be tested. Given the high rates of mental health problems among prison populations, the lack of large-scale intervention studies is puzzling[49]. A recent review in The Lancet points to a lack of funding, and a lack of interest in prisoner health compared with community health, as reasons for this[50].

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Research has consistently shown that prisoners have high rates of psychiatric disorders, and in some countries there are more people with severe mental illness in prisons than psychiatric hospitals[51], yet we still know so little about the outcome of those treatment interventions that do exist[52]. The Lancet review (which looked at recent systematic reviews and meta-analyses from around the world) did nevertheless find that, compared with medication, there have been more controlled trials of psychological therapies in prisons (albeit typically small scale studies). They comment that a variety of CBT-based therapies studied in prison populations, particularly with those with substance misuse issues, demonstrate effectiveness compared to drug and alcohol education or no treatment[53]. In one particular study, 120 prisoners were randomised to receive individual CBT, combined individual and group CBT, or placed on a waiting list. The same study reported improvements in psychological well-being for the sample receiving combined therapy, relative to controls[54]. A further study

43. University of Maryland Department of Criminology and Criminal Justice "Preventing Crime: What Works, What Doesn't and What's Promising (1997).
44. Bateman & Fonagy (2019) Handbook of Mentalizing in Mental Health Practice. American Psychiatric Association Publishing
45. Khantzian, Ed. The Self Medication Hypothesis in Gill, R (2014) Addictions from an Attachment Perspective. Routledge.
46. Salekin, R (2002) Psychopathy and therapeutic pessimism. Clinical lore or clinical reality? Clinical Psychology Review.
47. Bateman, Motz & Yakeley (2019) Ch 20: Antisocial Personality Disorder in Community and Prison Settings. In Bateman & Fonagy (2019) Handbook of Mentalizing in Mental Health Practice. American Psychiatric Association Publishing
48. Lemma et al (2011) Brief Dynamic Interpersonal Therapy: A Clinician's Guide. Oxford University Press.
49. The British Psychological Society Research Digest 2018: Research into the mental health of prisoners
50. The Lancet Psychiatry: Volume 3, Issue 9 P.871-881 September 2016): Mental Health of prisoners: prevalence, adverse outcomes and interventions.
51. Ibid
52. Ibid.
53. Ibid.
54. Khodayarifard M, Shokoohi-Yekta M, Hamot GE. Effects of individual and group cognitive- behavioral therapy for male prisoners in Iran. Int J Offender Ther Comp Criminol. 2010; 54:743– 55. [PubMed: 19721059]

included 63 prisoners who received a modified form of DBT (devised for those with a personality disorder) and were then randomised into receiving eight weeks of further DBT or case management. Those receiving further DBT showed a reduction in psychopathological symptoms at six months, compared with the case management group (but not at twelve months)[55].

Reasoning and Rehabilitation, a 35-session CBT programme focussed on prosocial attitudes, emotion regulation, self-control, and interpersonal problem solving, has also demonstrated reductions in recidivism[56]. Motivational Interviewing, often used in relation to alcohol misuse, was the subject of an RCT with adolescents in prison for drink-driving offences. The study found lower rates of reoffences when Motivational Interviewing was used, compared to the control group[57]. So, the evidence that exists holds some promise. But it is small scale and delivers somewhat inconsistent findings. In the main, we have to conclude, that high quality treatment trials for psychiatric disorders in prisoners have been limited[58]. That leaves us in the frustrating position of being twenty years on from the most recent survey, which told us that mental health conditions affect the vast majority of prisoners, and still not knowing what works for who.

Another recent systematic review and meta-analysis takes broadly the same position; prisoners worldwide have substantial mental health needs, but the efficacy of psychological therapy is largely unknown[59]. In the 37 identified RCTs they considered, psychological therapies showed a medium effect size, but often the psychological gains were not found at three and six month follow-up (perhaps not surprisingly, given most of the trials they considered were short-term treatments, of, on average, just 10 weeks). In the same systematic review, no differences were found between group and individual therapy, or different treatment types. Neither did they find much evidence comparing psychological and pharmacological treatments, and specifically no head to head trials. Their work was conducted in the last four years and yet they write that, to their knowledge, this was the first comprehensive meta-analysis of psychological therapies for prisoners.

Next steps

This is both an indictment and a call to action. The way forward ought to be clear. The Lancet review suggests three actions: prisons should identify those with serious mental health problems; evidence-based psychological treatments that are available in the community should be provided in prison and should be evaluated; and, given the current position, there should be concerted action from government, funding agencies, and researchers, to address the paucity of treatment evidence[60]. All those actions of course apply to the UK, but as The Lancet review makes clear, there are more than 10 million people in prison worldwide. This work would have a truly global effect. They encourage Justice departments around the world to collaborate with researchers in this endeavour. It should be the next cause of prison reform.

A 2012 editorial in the journal Nature stated that the UK government's programme of expanded psychological therapy (IAPT) now leads the world. Other countries (Canada/ Sweden and Norway, for example) have all looked to the UK as the model for their own services. We have an opportunity to do something similar in prison and probation. As the programme of vaccination expands, and we turn our attention to the aftermath of the global pandemic, the inevitable tsunami of mental health need[61] is on everyone's mind[62]. There is already a tsunami of mental health need in prison. It has been documented and known for 20 years. Now is the time to act. Let us go where the data points and finally follow the facts.

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