



**The British  
Psychological Society**  
Promoting excellence in psychology

## **British Psychological Society response to the House of Commons Justice Committee**

### **Prison Reform Inquiry**

#### **About the Society**

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

#### **Publication and Queries**

We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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#### **About this Response**

##### **The response was jointly led on behalf of the Society by:**

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##### **With contributions from:**

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We hope you find our comments useful.

**Dr Ian J Gargan CPsychol AFBPsS**  
*Chair, Professional Practice Board*

Prison Reform Inquiry

	<p><b>This response will address the first topic under the Terms of Reference: What should be the purpose(s) of prisons?</b></p>
	<p>One aim of prisons is to promote desistance from offending behaviour through rehabilitation. As suggested in the context of resettlement pathways (e.g. the domains of attitudes, thinking and behaviour, drugs and alcohol, health; National Offender Management Service, 2005), mental health is one of a number of considerations for moving towards desistance, alongside domains such as skills and employment and accommodation. Arguably, good mental health functioning underpins improved outcomes across activities of daily living and contributes towards lower levels of risk of re-offending. Addressing factors that increase the risk of poor mental health is vital. One area of opportunity, in this context, for example, is addressing Neurodisability (ND), such as from Traumatic Brain Injury (TBI), which is associated with increased levels of mental health problems, violence and self-harm – and difficulty engaging in rehabilitation per se. A brief case is made herein for improved services to support the psychological well-being and mental health of prisoners, in order to support rehabilitation and desistance.</p> <p>The high prevalence of mental health problems in prisons is well established (Birmingham, 2003, reports over 90% prevalence) yet there are limited resources to identify and address the level of need, and communication between and coordination of services within prisons is often ineffective (Edgar and Rickford, 2009). In UK prisons, there is an estimated 61% prevalence of personality disorders (Stewart, 2008), in comparison to an estimated prevalence of 4.4% in the UK general population (Coid, Yang, Tyrer, Roberts and Ulrich, 2006). This indicates that a substantial proportion of prisoners are likely to have offending-related needs that span multiple domains of their lives (such as relationships, employment), sometimes underpinned by adverse early life experiences, pervasive and persistent antisocial attitudes, difficulties with problem solving and thinking skills, and regulation of emotions. Working with an acknowledgement of the origins of the development of these difficulties, such as in the context of trauma-informed practice, and understanding neurodevelopmental processes and impairments - and is likely to support engagement with the process of desistance (Levenson, Willis and Prescott, 2016; Williams, McAuliffe, Cohen, Parsonage &amp; Ramsbotham, 2015). Psychological therapies with positive outcomes in forensic and community settings could offer promise for addressing personality disorders among prisoners. Particularly if when informed by neuro-rehabilitation to address underlying cognitive factors.</p> <p>There is also a disproportionately high prevalence of mental illness in prisons, in comparison to the general population. When comparing prevalence of psychosis in the UK, Stewart (2008) estimated 10% of the prison population and the Royal College of Psychiatrists (2010) estimated 0.4% of the general population met diagnostic criteria. Furthermore, in an international systematic review, Fazel and Seewald (2012) found that the prevalence of prisoners meeting criteria for two or more mental illnesses was between 20.4% and 43.5%, suggesting a high level of complex need. Psychological therapies with positive outcomes in forensic and community settings could offer promise for reducing the impact of mental illness among prisoners.</p>

Mental health is a key consideration in the assessment and treatment of young people and adults in prisons because stress and associated difficulties with coping (e.g. with incarceration) might trigger existing vulnerabilities to the emergence of mental illness. Young prisoners, female prisoners and prisoners in the early stages of a custodial sentence are more likely to engage in self-harming behaviour than their prisoner counterparts (Ministry of Justice, 2015). Self-harm among male prisoners is on the increase and the year between June 2014 and June 2015 saw a 22% increase in self-harm among male prisoners compared with the previous 12 months (Ministry of Justice, 2015). This increase in prevalence reflects an increase in frequency of self-harming among male prisoners who self-harm, as well as an increase in the number of male prisoners who self-harm, in line with trends over the past 10 years (a 74% increase in self-harm incidents and a 35% increase in the number of male prisoners who self-harm). The experience of psychological distress is an important consideration when thinking about rehabilitation of prisoners. Furthermore, in line with the tests of a healthy prison establishment (HM Chief Inspector of Prisons for England and Wales, Annual Report 2015-16) of safety, respect, purposeful activity, and resettlement, supporting improved mental health for prisoners might enhance safety and opportunities for resettlement.

Upholding rights and freedoms of prisoners under the care of safer custody is a difficult task in the balance against safety (Equality and Human Rights Commission, 2012) and recent reports suggest this is in need of improvement (The Harris Review, 2015). Responses to self-harm such as constant observations of at-risk prisoners can be considered to be dehumanising, demonstrating inhuman degrading treatment (Article 3 ECHR) and a lack of respect for the right of a private life (Article 8 ECHR; The Harris Review, 2015). The relocation of prisoners on ACCTs (Assessment, Care in Custody and Teamwork) into segregation was noted to be the result of poor mental health assessments and lack of consideration for alternate management plans (Prisons and Probation Ombudsman, 2015). Furthermore, it could be argued subjecting an individual to alternate, 'safe', clothing can be seen as failing to prohibit humiliation and discrimination (Article 14, ECHR). Responses to self-harm in prisons could be argued to be out of line with the principles of managing people with mental disorders within the least restrictive environment (Glorney et al., 2010) and there are clear implications for the freedoms and rights and mental health of prisoners in this regard. Improving the psychological well-being and mental health of prisoners could enhance respect and improve the health of a prison establishment (HM Chief Inspector of Prisons for England and Wales, Annual Report 2015-16).

There is a growing population of prisoners aged 50 years and there is an increase in demand for interventions to address physical and mental health and social and community support needs. In a case note survey of 203 prisoners aged 60 years and over in prisons in England and Wales, around 53% met diagnostic criteria for a mental illness or personality disorder (Fazel, Hope, O'Donnell and Jacoby, 2001), in contrast to approximately 17.6% of all adults in England (Royal College of Psychiatrists, 2010). The prevalence of depression was between three and 15 times higher among older prisoners than among older adults in the community (Fazel et al., 2001; Royal College of Psychiatrists, 2010), depending on diagnostic approach and age groups. Around 30% of male prisoners met diagnostic criteria for a depressive illness, with just 11.7% of these men receiving medication. There was no information about provision of psychological therapies to address mental health problems. This suggests that older prisoners have multiple health-related needs which are not addressed sufficiently at entry to prison and as they age through a prison sentence. Furthermore, in a systematic review of experiences of older adults in prisons, Maschi, Sullivan Dennis,

Gibson, MacMillan, Sternberg and Hom (2011) reported that older adults feared physical and sexual victimisation in prisons usually perpetrated by young prisoners. Older prisoners also presented with specific anxieties related to dying in prison, access to social care on release from prison and access to services for age-related physical and mental health (Maschi et al., 2011). Services available to older adults in prison and on resettlement to the community are a neglected area and the Prison Reform Trust (2008) has called for staff training in prisons and probation services to support the assessment, treatment and management of older adults in the criminal justice system, as well as a more integrated approach across services. The mental health of older prisoners is a key consideration in resettlement.

Traumatic Brain Injury (TBI) is highly prevalent in adult and young offenders in custody. TBI is also linked to earlier, and more violent, offending. More than half of all offenders have some degree of TBI and about a fifth of these have a moderate to severe TBI. TBI is linked to mental health problems, drug misuse, and to greater risk of self-harm and suicidality (Chitasabesan et al. 2015). New systems for management have been developed. For example, in the Youth Secure Estate in England and Wales neuropsychological and neurodisability screening tools are used, which might inform care planning and offender management. They also allow for assessment for other common NDs (e.g. ADHD, Autism etc.). A report from the Centre for Mental Health describe how a TBI in childhood is linked to doubling of risk of persisting crime across the lifetime (Parsonage, 2016). The report provides strong economic case for managing TBI. For example, there is a cost of about £95,000 (health, social, etc.) per case for a 15-year-old who has a TBI. But an additional cost of £65,000 due to increased risk of crime (court, prison etc.). Moreover, if the 15 year old was already in some in contact with the Criminal Justice System, the increased crime costs are £250,000. Effective measures to address TBI in young people, especially young offenders, have the potential to generate very significant benefits, both for individuals and for society as a whole (Parsonage, 2016; and see Williams et al, 2015). Some systems have been developed and deployed for addressing mental health and TBI, such as provision of Link workers. They enable prison staff to better assess and then manage such issues, and for improved re-settlement (Chitsabesan et al. 2015; and see Williams and Chitsabesan, 2016 in link).

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