CIM Newsletter Winter Edition

PRISON PSYCHIATRY

December 2024

www.crimeinmind.co.uk

As we begin to think of festivities and giving – do think about a gift for Crime in Mind. We need your support to be able to continue with our programme of webinars, but, above all, to be able to support more people on the pathway to research. You will probably have already seen that we have advertised a research building grant – for those who have made a start on a particular research pathway, but need support to build capacity and networking on the way to substantive grants. In the new year, we hope to be able to advertise for another round of seed corn funding to support start-up projects. We can only continue to do this with your support.

Research Opportunities

Among the many areas of our work where we need to build research are prisons and prisoners. Overcrowding in prisons in England and Wales has rarely been out of the news in the last few months. Nor have the government responses to facilitate earlier release for those serving sentences. The likely mental health correlates of the problem are perhaps less widely discussed, but the Ministry of Justice released Safety in Custody statistics in October that highlight some of these[1]. Numbers of people dying a self-inflicted death (n=88) were rather similar in the year to June 2024 to the previous year (n=92), but self-harm rates increased. Although self-harm in prison fell slightly among women prisoners, there was a total of 76,365 incidents. This figure includes a 20% rise in self-harm among male prisoners. Furthermore, not only did the number of prisoners self-harming increase but the number assaulting others rose by 16% to 29, 254, or 335 per 1000 prisoners. All this misery is occurring at the same time as there is an alarming reduction in the amount of legal advice that prisoners can access. Laura Janes has set out the survey findings about this poorly funded but vital service[2]. Unless there is more support for such activity, we may lose a vital specialism.

This newsletter features research in prisons. Andrew Forrester calls for research to underpin a redesign of health service delivery. Prison research is a core feature of the growing research unit in Bangor University, where Rob Poole has pioneered important work into prescription medication among prisoners within the wider portfolio of work relating to substance misuse. Heidi Hales has joined him there, developing research across Wales with younger offenders and those with similar needs. One of us (Pamela) has written about some of the principles of research with prisoners, the rewards, but also growing difficulties, for example with the ever expanding bureaucracy that attends it.

David Honeywell brings a vital perspective – the extent to which ex-prisoners and peer researchers can expand what is achievable with research with prisoners. We have moved beyond the relative tokenism of people with such experience as merely advisers on developing protocols. Restrictions remain on being allowed to enter any prison as a responsible, employed researcher, but at every other level, such researchers can be full members of the research team and expect to be lead authors or co-authors of publications, according to research skills and role.

Finally, Jide Jije considers an important paper recently published from Seena Fazel's Oxford centred but now international group. Having already done so much to bring together information about the prevalence of mental disorder among prisoners and of their risks of self-harm, Jije draws our attention to the latest update – led by Louis Favril, drawing together the physical as well as the mental health information about this substantial population.

In a look forward, we are delighted to announce some new webinars scheduled for 2025. The first will be on Tuesday 3rd February 5.00-7.00 pm and on the contribution of forensic clinical psychologists to criminal investigations in the UK – led by Professor Gisli Gudjonsson. The next one will be about applications of neuroscience in our field – led by Dr John Tully.

Unfortunately, it is likely that we will have to start charging a small amount for future webinars – to support the necessary platform and administration. They will remain free to members – and members can also, of course, go back and view any webinar at their own convenience.

Warmest wishes for the season and for a very happy 2025 to all our readers.

John & Pamela

John Gunn Pamela J Taylor

Co-chairs

References

1. https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2024/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-september-2024-assaults-and-self-harm-to-june-2024

2. https://www.associationofprisonlawyers.co.uk/wp-content/uploads/2023/08/APL_SUSTAINABILITY_REPORT_7_AUGUST_2023.pdf

The special challenges (and rewards) of conducting research in prisons

Written by Pamela J Taylor

After my first ever research project – a randomised controlled trial of ECT for schizophrenia – research in prisons seemed to promise a walk in the park. I was wrong about that, but with extraordinary help and support from prison staff and prisoners, I have found that most challenges to researching in prisons can be met and managed. This is a 'lived experience' account that may help those thinking about doing research in prisons now

Permissions and ethics

The first step in any research is having a question that needs answering. That will be supported by a brief, evidenced account of where current evidence falls short and, thus, the rationale for the question, followed by a preliminary research plan. It is then not too soon to start asking prison governor(s) for permission in principle to work in their prison(s). This will mean a planned visit to talk about what you want to do and hear about what may and may not be possible. It will mean listening. As well as hearing about practicalities, it is helpful to hear what people in prison management really want to know in the area of your interest. With only one exception, years ago – a prison governor who 'didn't believe in research' – I have found such meetings productive in every way. Some have led to idea building and all have led to optimising the research plans for the environment. Only then is it feasible to think about funding applications where applicable and, for all such work, how to refine the proposal in readiness for ethics approval.

Some research, even in prisons, may come within the framework of a 'service evaluation' or 'audit', with a less arduous path to approval. It is always worth having the NHS guidance[1] to hand and checking with the local university or health service ethics committee, preferably getting confirmation in writing when one of these options is appropriate.

In practice, though, almost anything akin to research in prison by people from outside prison will generally need approval through a special ethics process. A first challenge here is that although, in England and Wales, proposed health related research with prisoners goes through special channels, there are few people on the approval panels that have the necessary range of knowledge and experience.

Research ethics approval for all research has become a lengthy, bureaucratic process and there is probably a strong case for its review. Here comes some lived experience! My first prison based research required ethics approval. A four page document sufficed and prison staff and justice management hierarchy were happy to accept the decision of an independent ethics committee on that proposal, without further scrutiny. The last prison based research that I led required a series of preliminary approvals from University and catchment area Health Boards/Trusts. Then, the package for ethics approval had to contain short CVs of participating staff, the protocol, the participant information sheet, the consent form, the invitation to participate, advertisements/leaflets about the study, copies of all the questionnaires or rating schedules, a letter from the statistician … are you keeping up? – and, of course, a covering letter from the principal researcher, who was then expected to travel to the ethics committee meeting in person (some considerable distance because of its specialist nature) for the review. Probably the greatest challenge once this process was underway was to accommodate the ethics committee appetite for putting more and more into the information sheet and our appetite for keeping the sheet not only readable but at the kind of length that would keep prisoners (or any of us) engaged in reading it. In the end, approval was granted, but I return to the question – perhaps for research itself – did the four page application provide less safeguarding than the 40 page one, with its tens of pages of supplements? In both studies prisoners could and did refuse participation, prisoners could and did fail to complete; in both studies most prisoners agreed participation and in neither study was there any evidence of prisoner harm through participation, refusal or withdrawal.

Whatever our concerns, however, current procedures must be followed in order to secure ethics approval for research in prisons. They can and must be negotiated, but the time needed to do so must be factored in to project development. HM Prisons and Probation provides helpful guidance on how to proceed[2]. For health-related research in prisons, applications should be made through the Integrated Research Application System (IRAS)[3].

Reaching the people you want to recruit

A recruitment strategy is essential to any research design. This will, in part, be informed by the nature of the project and in part by what the prison can support.

Early on, consideration may be given to negotiating access to the Prison National Offender Management Information System (p-NOMIS), enabling systematic identification of cases with best fit with research requirements. This first has to be approved both with the prisons involved and through the ethics process. This may be vital for epidemiological research, although in one project we were impressed by how much can be achieved by very simple, strategic questionnaire distribution[4]. We worked with prison staff in Young Offenders' Institutions (YOIs) to devise a method for ensuring that each of the young residents had an opportunity to complete a simple, one page questionnaire about their experience of others' suicide related behaviours, and their own. As far as possible, the principal researcher distributed questionnaires personally with meal trays or in in-cell rest periods and collected responses soon after, for example as meal trays were returned. We trialled the method with a small sample in one institution, leading adjusting readability of the questionnaires and confirmation of feasibility of the distribution strategy. Questionnaires then distributed across one YOI of nearly 500 young residents yielded a 74% response rate way better than in surveys with psychiatrists!

Advertising the research across the prison can be achieved in various ways. Posters and leaflets in reception may be an option - as well as in other key areas such as the wings, in education, in the gym. This is where help from someone who has actually been in prison is invaluable help with the language, help with understanding the subtleties of reaching the people you want to reach. While, however, this process yields volunteers, there may be biases in such recruitment that must be understood.

Managing and measuring your research environment

As an external researcher, you are a visitor in any prison. You will need special security clearance (which the supporting prison will arrange) - and to recognise that that usually takes several weeks to come through, sometimes longer. Once cleared, you will receive prison security training and may be allowed to carry keys and move fairly freely in the prison once that training is complete, but you will not have the same skills or rights as a prison officer. You will not be allowed to escort prisoners. You will have to negotiate carefully with prison staff on where it is safe and reasonable for you to see your research participants. Under current prison staffing levels this is difficult. A good prison will engage in a formal risk assessment process with you so that everyone's safety is maximised. If circumstances change, this will have to be reviewed. Of particular interest, during one project, our most active frontline researcher became pregnant. She felt well and wanted to continue prisoner-facing data collection for as long as possible. The governor personally reviewed the situation and gave permission for restricted work no more unescorted visits to wings, no more conducting of interviews wherever a private space could be found, but rather work only in the visitors' centre where sessions could be highly monitored. This worked well for everyone.

While most research exchanges remain confidential between researcher and prisoner, there have to be exceptions. These have to be explicit with the prisoner from the outset and when disclosure is essential its pathway must be clear. It is wise to have a named officer who will act, in effect, as a liaison officer, to receive such information and start any safeguarding measures. In general, the main exceptions to confidentiality are, as in any research, expressed threat of harm to self or to others. That information, and that information alone, would be conveyed to the designated prison officer.

In one prison, the governor expressly asked that we added disclosure of escape plans as another area for invariable sharing. It had never occurred to us that prisoners would think of telling us about those, but we agreed to the request. This addition to our preamble with each prisoner about what could not stay in the room turned out to be a great ice breaker!

A prison environment is unequivocally different from anything outside prison, and each prison has its own special characteristics and, indeed, may vary over time. Although it is always hard to attribute cause and effect when prisoners change over time in prison, change they do[5] and it is important to include some measures of the environment that may plausibly impact on prisoner health, for example availability of exercise[6], as they may affect your key research measures. Especially in controlled trials, it is important to know the extent to which the groups are experiencing the prison environment in similar ways.

Managing crises

Crises and disruptive events occur in any setting, but researcher capacity for practical adjustment to them when, effectively, a guest in that setting is particularly stretched. Sometimes fate just has to be accepted. At the time of design of one prison project, for example, who could have predicted that a NATO conference would be accompanied by a ban on all new receptions to the prison (so, no new recruitment at a critical moment) and transfer out of existing prisoners (so, potential loss of already recruited cases)? Nothing could be done about the ban we lost a cycle of recruitment, but documented this in case of consequent need to extend the research. With respect to movement, prison staff were extraordinarily helpful, selectively retaining our established research participants when asked. Required introduction of a national smoking ban across prisons had similarly not been on the horizon when planning the study. It was followed by prisoner anger and a week or two of lockdowns, with similar disruption to recruitment. Routinely low in-prison staffing levels commonly restricts any research - there may be no-one available to escort prisoners to the participation point (e.g. the education centre), so intervention sessions and critical

A prison environment is unequivocally different from anything outside prison, and each prison has its own special characteristics and, indeed, may vary over time. Although it is always hard to attribute cause and effect when prisoners change over time in prison, change they do[5] and it is important to include some measures of the environment that may plausibly impact on prisoner health, for example availability of exercise[6], as they may affect your key research measures. Especially in controlled trials, it is important to know the extent to which the groups are experiencing the prison environment in similar ways.

Then there was COVID-19. At the height of the pandemic there was no expectation of researcher access to prisoners, but even efforts to clear all administrative hurdles to be ready as soon as lock-down ended were frustrated. Undaunted, researchers found ways to keep the research alive and developing during this very difficult phase, not least helped by the team's experts by experience[7].

Conclusions

Research in prisons brings special challenges over and above those of research in other settings, but, driven by clear research questions, with optimism, patience, preparedness, researcher flexibility and teamwork and good relationships with prison staff, most obstacles can be overcome and research with prisoners can move forward to everyone's advantage.

References

1 https://www.hra-decisiontools.org.uk/research/docs/DefiningResearchTable_Oct2017-1.pdf

2 www.gov.uk/government/organisations/hm-prison-and-probation-service/about/research

3 www.myresearchproject.org.uk

4 Hales H, Davison S, Misch P and Taylor PJ. (2003) Young male prisoners in a Young Offenders' Institution: their contact with suicidal behaviour by others. Journal of Adolescence, 26: 667–685. doi:10.1016/S0140-1971(03)00063-0

5 Walker J, Illingworth C, Canning A, Garner E, Woolley J, Taylor PJ and Amos T. (2014) Changes in mental state associated with prison environments: a systematic review. Acta Psychiatrica Scandinavica. 129: 427-236. DOI: 10.1111/acps.12221

6 Sanchez-Lastra MA, de Dios Álvarez V and Ayán Pérez C (2019) Effectiveness of Prison-Based Exercise Training Programs: A Systematic Review. Journal of Physical Activity and Health, 16(12): 11 96-1209. https://doi.org/10.1123/jpah.2019-0049

7 Pratt, D. and Crook, R. (2023), Conducting prison-based research during the COVID-19 pandemic and the value of involving people with lived experience. Crim Behav Ment Health, 33: 223-228. https://doi.org/10.1002/cbm.2305

Mental Health in Prisons: Challenges and the Road Ahead

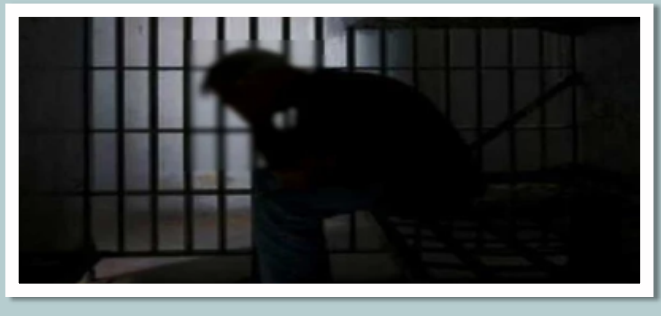
Written by Professor Andrew Forrester, Cardiff

Given the high prevalence of mental health conditions among people in prison, it seems obvious that services should be in place to meet their needs. However, this has not always been the case. A key turning point came with the publication in 1976 of the seminal report Patient or Prisoner, which highlighted significant shortcomings in healthcare for prisoners. At the time, these services were run by the Home Office and staff faced issues such as unclear career structures, professional isolation, and a lack of connection with the broader National Health Service (NHS). The report's solution was clear: transfer responsibility for prison healthcare to the NHS.

This transition took nearly a decade to complete. In the interim, there was an opportunity to rethink how prison mental health services should be structured. The eventual model, mental health in-reach teams, was grounded in the principle of equivalence, as outlined in the Mandela Rules (Rule 24, 2015):

"The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health care services free of charge without discrimination on the grounds of their legal status."

The idea was to replicate community mental health teams within prisons, assembling multidisciplinary teams with expertise from psychiatry, psychology, nursing, occupational therapy, and sometimes social work, supported by administration. By around 2006, these teams were operating across the prison system.



Early Gaps and Subsequent Changes

While these teams were designed with the best intentions, a crucial element was missing: no research had been conducted to inform their composition or, after implementation, their utility or effectiveness. Over the years, various adjustments were made, including the addition of primary care mental health services, sometimes working in parallel with existing services, sometimes within a more integrated framework. In time, these services evolved to include greater input from psychology and an emphasis on talking therapies, aligning with national initiatives like the NHS Improving Access to Psychological Therapies (IAPT).

Substance misuse services, which initially operated separately, were gradually integrated into mental health in-reach teams in some areas. Other initiatives sought to incorporate specialist services, such as memory clinics for older adults or support for neurodevelopmental disorders like autism, ADHD, or intellectual disabilities. Recently, a shift toward fully integrated service provision has emerged, aiming to meet the needs of all prisoners regardless of diagnosis.

Many of these changes were implemented by commissioners working centrally, with a focus on contracts, limited clinical advisory input and little supporting evidence. While well-intentioned, recurring challenges have persisted, including:

1. **Clinical Complexity**: Prisoners often have multiple diagnoses and complex needs, requiring integrated, multidisciplinary approaches.

2. **Severe Mental Illness**: People with illnesses like schizophrenia require intensive support, but services can become overwhelmed by primary care needs, leaving these vulnerable patients overlooked.

3. **Ineffective Diversion Policies**: While some individuals benefit from diversion schemes that steer them away from the criminal justice system, when considered across the board, these services have largely failed to do what was intended.

The Path Forward: Research and Reassessment

Rather than rushing into another uninformed redesign, it is time to pause and reassess. High-quality research is now needed to guide future improvements and several key questions must be answered:

- What is the optimal design and composition of prison mental health teams?
- Should services, and their component parts, operate in parallel with the wider NHS or as fully integrated units?
- How can diversion schemes (e.g., police or court-based programmes) be improved for greater effectiveness?
- Are additional interventions, such as peer support, or enhanced access to activities such as gym, other exercise and occupational therapy, needed?
- How should prison healthcare wings operate, what are they for, and how should they be managed?
- How should mental health teams approach areas of particular concern and vulnerability in prisons, such as segregation?

Now is the time to focus on evidence-based models and rigorous research to ensure the needs of people in prison are met effectively. Only by putting our own house in order, through research, can we achieve lasting progress in this critical area.

References

Home Office. (1996). Patient or Prisoner. Home Office, London.

United Nations Office on Drugs and Crime. (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). UNODC, Vienna.

Centre for Mental Health and Society: research involving offenders

Written by Professor Rob Poole

Bangor University's Centre for Mental Health and Society (CFMHAS) was establish in 2012 as a collaboration between social scientists and mental health clinicians, with a pump priming grant from the Betsi Cadwaladr University Health Board Charitable Fund. Our main office base in in Wrexham. We have long standing interests in substance misuse and in prison medicine, and we have been conducting research with clinical colleagues based in HMP Berwyn, Wrexham, since it opened in 2017.

The primary care team in HMP Berwyn is led by Dr Justin Lawson. He has developed a medicines management procedure to ensure prescriptions of psychoactive drugs for prisoners are safe and appropriate. The aim is to reduce deaths due to the abuse of prescription drugs in the prison. The regime is controversial, and we have conducted and published an evaluation of it. We have further work in progress with Dr Lawson.

We have a funded project in progress to evaluate the HM Berwyn substance misuse treatment programme. It involves analysis of some hard data about who engages with the programme and who drops out, but it also involves interviews with men in the prison who have substance misuse problems, so that their views are properly taken into account in our eventual findings. A unique feature of the research is that we are interviewing a group of men after release.

CFMHAS has a strong interest in the social determinants of mental health, and we have established a module on the subject for medical students on psychiatric placement in Wrexham. It involves getting students to spend time in HMP Berwyn, talking with the men, and helping them to see the link between social circumstances, physical and mental health, and offending behaviour. We are evaluating the impact of the project over four years, into the students early years as qualified doctors. We published preliminary findings.

Most of our research and academic activity is concerned with marginalised and disadvantaged groups of people, which means that it is relevant to, and links with, our work with offenders. For example, we have a programme of research on high-dose opioids prescribed for chronic pain, and have devised an intervention to help people rationalise their medication and achieve better pain management.

Centre for Mental Health and Society: research involving offenders

Dr Heidi Hales is a Consultant Forensic Adolescent Psychiatrist who joined us last year as an Honorary Senior Research Fellow, having previously worked in West London. Heidi was a founder of the Group of International Researchers in Adolescent Forensic Services (GIRAF) and is the current chair. GIRAF meets monthly meetings to bring clinicians and academics together. The group has completed research and has more in progress. There are 52 members from 20 countries. She is part of a CFMHAS international collaboration with colleagues in Belgium and Southampton, conducting research on internet addiction in adolescents.

References

Website: https://cfmhas.org.uk/

Relevant publications:

Nafees S, Matusiak J, Taylor-Clutton A, Newman S, Poole R. INSIGHT: Evaluation of the Psychological Medicine Student Placements at HMP Berwyn, North Wales: Year One Findings. BJPsych Open. 2023;9(S1):S30-S31. doi:10.1192/bjo.2023.147

Bebbington E, Lawson J, Nafees S, Robinson C, Poole R (2021) Evaluation of a framework for safe and appropriate prescribing of psychoactive medications in prison Criminal Behaviour and Mental Health, 31 (2), 131-142 https://doi.org/10.1002/cbm.2187

Bailey J, Nafees S, Jones L, Poole R (2021) Rationalisation of long-term high-dose opioids for chronic pain: Development of an intervention and conceptual framework British Journal of Pain 15(3) 326–334 https://doi.org/10.1177/2049463720958731

Campbell S, Poole R (2020) Disorderly street users of novel psychoactive substances: what might help? Criminal Behaviour and Mental Health, 30, 53-58 https://doi.org/10.1002/cbm.2146

Poole R, Bailey J, Robinson CA (2020) The Opioid Crisis and British Prisons. Criminal Behaviour and Mental Health 30, 1-5. doi: https://doi.org/10.1002/cbm.2136

Roles for ex-prisoners and peer researchers in optimising research in prisons

Written by Dr. David Honeywell

In 2019, I became a co-applicant and full time research assistant for a prestigious four year research project on prison suicide. I was honoured to become a service user researcher to lead a group of PPI's who had volunteered to share their past lived experiences with the research team as part of our methodolical research design.

PPIs (Patient and Public Involvement) refers to individuals with lived experience and are also sometimes referred to as 'service users' but as the title 'Patient and Public Invovlement' suggests, PPI is more relevant to people with lived experience of medical related issues rather than the criminal justice system as a former prisoner. If a person has lived experience of both medical and criminal justice systems, then the term service user is more relevant. It just so happens that my own positionality includes both - that of someone who has experienced mental health services and imprisonment. Therefore, my lived experience biography scales several areas of the lived experience position who has had first hand experience perspective.

All these terms as used interchangeably but all come from the same ethos – that people with personal experience are involved in a project. This resonates with my earlier discussions around liminality and dual identities where past criminal and present academic identities merge. Whereas in this case, the past identities of mental health patient and prisoner merge.

As part of the funding application process, the sponsors insisted that someone with "lived experience" of prison suicide ideation be recruited to give authenticity from a novel insight, one which acts as a voice for others who have also been in that position. It provides a formal platform for those who voices in the past have been muted by the criminal justice system. In recent years, there has been movement by medical and psychological research sponsors to insist on indiviudals with lived experience to be included in research studies (i.e. service users or PPIs) who are actively involved in research projects and research organisations. Their identities are always anonymised, so it's unheard of for a service user to become a fully costed researcher themselves in a psychology-based study and without needing to be

However, that is what happened in my case and so I officially became a full-time costed researcher of what is known as the PROSPECT (Prevention of suicide behaviour in prison: enhancing access to therapy) clinical trial study. Also, as I was part of the funding application process I am still currently a co-investigator on the study.

To give some context, this study aims to:

- Improve treatment for prisoner patients at risk of suicide;
- Promote patient access to a Cognitive Behavioural Suicide Prevention (CBSP) programme within prisons
- Help to reduce the economic and social costs of inefficient or ineffective treatments.

Put simply, the project is developing a talking therapy which is tailor made for suicidal prisoners becuase talking therapies are not specific for this residing in prison. Our projectconsists of four studies, designed to help us to improve the quality of suicide prevention treatment for patients in prison. I felt I'd finally arrived where education and research had merged and taken me on a different career path that so far had just been teachhing based. I expected it to open doors I could never have imagined - particularly as part of the research would include going the very prison where I served my last prison sentence and gained my university entrance qualifications.

I knew that gaining permission to work inside a prison long term for me could never be straightforward. Even before that stage, it was a worry whether I could even bypass the initial university recruitment process and be accepted into this prestigious institution. I was honoured when I crossed that bridge, but there was still the next stage to gain access into prisons which will be the bane of my life forever because of the indelible it has put on my character. DBS checks[1] was the initial stage of our prison vetting process which unfortunately but not unexpectedly led to my application to work in prison being rejected. The day we all received the generic email from the prison which listed everyone's initial vetting outcome left me feeling completely deflated. Although I expected this, seeing 'rejected' next to my name on the list invoked past feelings of rejection by employers, colleges and members of society. Higher Education has enabled me to rise above all these in the past but now it became a catch 22 situation where although I was employed by the university, I was unable to fulfil my role as a prison researcher.

There are many more questions than answers but questions that need to be asked because although no one has specifically said I can't enter prison, neither has anyone progressed my application. This silence threw the study into such a disarray that the team had to find a replacement and even change the recruitment criteria from 'lived experience - essential' to 'lived experience – desirable'. The key problem underpinning all of this is the complete lack of regard for rehabilitation and self-change and eventually, after two years of waiting for my initial rejection to carry out prison research to be overturned, I decided it was time to move on rather than allow the establishment to continue (what I felt)

My appointment at the University of Manchester within the psychology department has broken new ground and though I wasn't able to gain access to the prison estate, a lot has been learned about the important contributions service users can proivde, as well as highlighting aspects of prison research that need to be reviewed when it comes to service users gaining access. It has also been an important landmark for future ex-offenders who wish to follow the same path as myself and want to conduct clinically based prison research.

Funders of research are increasingly requiring research projects to involve patients, the public and ex-prisoners in their research. Therefore, I argue that there needs to be a streamlined approach of communication that includes research teams, funding bodies and the prison estate to create a smoother process for those with lived experience.

[1] DBS checks are background checks of possible criminal records of someone applying for a role. This is known as getting a Disclosure and Barring Service (DBS) check. They do not just apply to employers. For example, DBS checks can be made in relation to certain research projects that include vulnerable participants such as prisoners.

Mental and Physical Health Morbidity amongst people in prisons.

A commentary on Favril L, Rich JD, Hard J, Fazel S. Mental and physical health morbidity among people in prisons: an umbrella review. Lancet Public Health. 2024 Apr;9(4):e250-e260. doi: 10.1016/S2468-2667(24)00023-9. PMID: 38553144

Written by Dr Jide Jeje MBBS MRCPsych

This article summarises the recently published paper by researchers at the University of Oxford which examined the hugely important area of mental and physical health morbidity amongst people in prisons, an often neglected area.

The authors (Favril et al. 2024) highlight the poor physical and mental health of this group as compared to the general population, emphasising that they are an underserved and vulnerable group. The large number of individuals passing through prisons annually is estimated to be around 30 million people worldwide therefore the sheer numbers make it crucial in public health terms to improve their health

Articles

Mental and physical health morbidity among people in prisons: an umbrella review

It was recognised by the authors that there was a growing body of meta-analytic research on the health of people in prisons but there had not yet been a comprehensive synthesis of this evidence, which the authors set out to remedy in this study, thereby arming service providers and policymakers with vital information when service planning.

The authors conducted an umbrella review synthesising 17 meta-analyses which had been published over two decades.

The key findings of the study for mental health were that the burden of mental health problems was substantial (major depression affects 11.4% of prisoners, PTSD 9.8%, and psychotic illness 3.7%). There was also a high prevalence of substance use disorders on entering prison (23.8% for alcohol use disorder and 38.9% for drug use disorder at prison admission). There was a difference between the sexes, for example, women had higher rates of PTSD and drug use disorder than men, while antisocial personality disorder was more common in men. Low- and middle-income countries (LMICs) had higher prevalence of mental health conditions (psychotic illness and major depression). In addition non-communicable diseases (such as chronic conditions like cancer, cardiovascular disease, and diabetes) is not well understood, particularly among younger prisoners.

The key findings of the study for physical health were that Infectious diseases were common (hepatitis C virus affecting 17.7%, hepatitis B 5.2%, and HIV 3.4%) and sexually transmitted infections (STIs) were prevalent (chlamydia (8.9%), gonorrhoea (3.3%), and syphilis (2.9%)). There was a substantial number of HPV infections found in women prisoners (29.8%) and 8.4% had cervical intraepithelial neoplasia.

These findings point to the substantial burden of physical and mental health conditions in prison populations and therefore the importance of early screening on reception into prison and an opportunity, in public health terms, to access a difficult to reach group.

The authors highlighted that it was as yet not fully clear on the reason for such health disparities between the prison populations as compared to the general population (the chicken or the egg conundrum) – did prisoners have these pre-existing health problems or was it that being in prison caused them such poor health ? The answer probably lies somewhere in between. The authors note that mental illness and substance misuse are risk factors for offending and incarceration and that many prisoners are homeless before arrival, increasing the likelihood of poor health.

To improve outcomes, national health standards in prisons therefore must be strengthened, so that incarcerated individuals receive the same level of care as those in the general community. At the same time, addressing the causes of health disparities—whether through early interventions, improved living conditions, or mental health support — is essential.

Further research is important to understand the long-term effects of incarceration on health and to fill gaps in knowledge regarding non-communicable diseases, incidence rates, and gender-sensitive interventions.

More research is needed on the long-term health consequences of incarceration, including the effects of accelerated aging in prison populations.

Ultimately, as the authors conclude, improving the physical and mental health in this group will have longer term benefits to the whole of society and communities.

Research can transform lives.

We want to support discoveries about what helps people with mental disorder who have been victims of criminal behaviour, or perpetrators of criminal behaviour, and their families, and the clinicians and others who treat them and, indeed, the wider community when its members are in contact with these problems.

More effective prevention is the ideal, when this is not possible, we need more effective, evidenced interventions for recovery and restoration of safety.

We are very grateful for any donations to assist us in this mission. Donations help us to fund research projects and educate policy makers and communities.

Donations can be made to the Charity via the link below and can be a one off or regular payment.

As a charity we would welcome donations however small.

Please donate at https://cafdonate.cafonline.org/3520#!/Donati onDetails

Join us !

For details on joining Crime in Mind,

please visit our website at https://www.crimeinmind.co.uk/

CRIME IN MIND