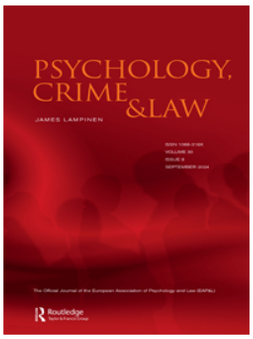

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An optimal trauma-informed pathway for PTSD, complex PTSD and other mental health and psychosocial impacts of trauma in prisons: an expert consensus statement

Clare Crole-Rees [a,b], Jack Tomlin[c], Natasha Kalebic[a], Sarah Argent[d], Claudia Berrington[a], Edward Chaplin[e], Jason Davies[f], Matthew Hoskins[g], Lucie James[g], Manuela Jarrett[h], Oliver John[i], Lewis Jones[g], Radha Kothari[j], Imogen Kretzschmar[j], Deirdre MacManus[k], Michael Martin[l], Iain McKinnon[m], Gwen O'Connor[n], Madeline Petrillo[c], Marie Phillips[o], Rob Poole[p], Isidora Popovic[a], Alexander Simpson[q], Pamela Taylor[a], Sarah Wigham[r] and Andrew Forrester[a]

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ABSTRACT

People in prisons have high levels of trauma exposure throughout their lives. Presentations are often complex, with a high prevalence of PTSD and CPTSD and other mental health comorbidities. Prisons themselves can be stressful and traumatising environments. There are challenges in the delivery of effective treatments for PTSD and CPTSD. There is a need for the development of effective clinical pathways for these conditions that are embedded within trauma-informed organisational approaches. Responding to this need, this report is the result of a multidisciplinary expert consensus meeting and review of the research literature on PTSD, CPTSD, associated comorbidities and optimal approaches to trauma-informed practice. The group consisted of 24 expert representatives from psychology, psychiatry, healthcare, academia, social care and Welsh Government. The meeting commenced with presentations on

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various aspects of the clinical pathway for PTSD and complex PTSD in prisons, and of applications of trauma-informed practice within prisons. Small sub-groups then provided practical recommendations and solutions relevant to their assigned topic. Findings were presented to all meeting attendees for another round of discussion and debate, until consensus was reached. The resulting recommendations provide guidance to improve identification, treatment and support for people living in prison who have experienced trauma.

Background

People in prison experience a high prevalence of adverse and traumatic events across their life span, with many experiencing symptoms of post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD). For a diagnosis of PTSD, the 11th edition of the International Classification of Diseases (ICD-11) requires one intrusion symptom (flashbacks or nightmares), one avoidance symptom and one symptom indicating a current sense of threat. CPTSD includes the three core elements of PTSD as well as three additional elements called disturbances in self-organisation that are pervasive and occur across various contexts: emotion regulation difficulties, negative self-concept and relationship difficulties (International Classification of Diseases, Eleventh Revision (ICD-11), 2019/2021; Brewin, 2020). Within community populations, there is a point prevalence of 3.7% for PTSD, and between 1 and 8% for CPTSD (Baker & Kirk-Wade, 2023; Maercker et al., 2022). By comparison, a recent study found that, amongst male prisoners in a UK prison, point prevalence rates of PTSD were 7.7%, and for CPTSD, 16.7% (Facer-Irwin et al., 2022). As in the community, female prisoners have a higher prevalence of PTSD than male prisoners, and in one international meta-analysis, this was found to be 21% (Olff, 2017; Karatzias et al. 2018; Baranyi et al., 2018; Shalev et al., 2019).

The elevated prevalence of CPTSD compared to PTSD points to the high rates of developmental, interpersonal and poly-traumatisation within the prison population (Karatzias et al., 2019). CPTSD diagnosis amongst male prisoners is particularly associated with high levels of functional impairment, and high levels of comorbidity including depression, substance misuse, psychosis, chronic physical ill-health, ADHD and personality disorder (Facer-Irwin et al., 2022). PTSD and CPTSD are also associated with higher rates of prison violence, violent crime and re-offending, and their identification and treatment therefore have the potential to reduce violence in prison populations (McCallum, 2018; Facer-Irwin et al., 2023; Paulino et al., 2023).

However, international evidence suggests that PTSD often goes undetected or untreated in correctional and mental health settings. Here is increasing international attention on the challenges of implementing standardised methods for screening and assessing PTSD and the need for improved identification and treatment of this condition within custodial settings (Dulisse et al., 2023; Jakobowitz et al., 2017; Zammit et al., 2018). One estimate suggests that 90% of those with a PTSD diagnosis in prisons are not receiving treatment for this condition (Bebbington et al., 2017). Until recently, the lack of formal recognition of CPTSD as a diagnosis may have led to misdiagnosis, with limited access to services and appropriate psychological treatment (Cloitre, 2021). Identification of PTSD and CPTSD may also be complicated by high rates of co-morbidity within prisons and

under-recognition of prisoners' trauma histories by healthcare professionals. Around half of people with serious mental illness in prisons have co-morbid substance use disorders, and up to a third may present with the triad of serious mental illness, substance use and personality disorder (Baranyi et al., 2022; Mundt & Baranyi, 2020; Fazel & Seewold, 2012.

Specifically, there is substantial co-morbidity in people with PTSD and CPTSD, with this population being more likely to receive treatment for co-morbid conditions (Fovet et al. 2022; Facer-Irwin et al., 2022). While there is evidence that trauma-focused therapy can improve PTSD for some individuals with substance use, average treatment effects are modest (Roberts et al., 2022; Molina & Whittaker, 2022). In addition, particular populations, such as foreign national prisoners and military veterans have higher rates of mental health needs, and may be particularly likely to be exposed to traumatic events and to develop PTSD (Finlay et al., 2019; Sen et al., 2021). PTSD symptoms may also be exacerbated in prisoners in later life, and can be associated with traumatic brain injuries (Duarte et al., 2023; Mota et al., 2016). Designing and delivering fully integrated care and effective interventions where there are high levels of co-morbidity remains a significant challenge (Kothari et al., 2022).

There is considerable international variation in access to evidence-based psychological therapies in prisons, particularly for PTSD and Complex PTSD (Facer-Irwin et al., 2023). Trauma-focused cognitive behaviour therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) are both recommended for PTSD within the NICE guidelines (National Institute for Health and Care Excellence, 2017). In a systematic review and meta-analysis, Malik et al. (2023) found a small but significant effect size for trauma-focused interventions delivered within prisons. They found that trauma-processing interventions, and interventions delivered individually led to greater reductions in PTSD symptoms than non-trauma-focused interventions and group-based interventions.

The effectiveness of trauma-processing therapies for CPTSD within prisons remains unclear. In community samples, existing interventions for the treatment of PTSD are less effective for people with CPTSD, and there is a lack of clarity about the optimal approach to delivering these (Coventry et al., 2020). CPTSD has additional treatment considerations, and studies recommend multi-component therapies starting with a focus on safety, psychoeducation and patient-provider collaboration, as well as treatment components that include self-regulatory strategies and trauma-focused interventions (Mahoney et al. 2020; Maercker et al., 2022). Overall, evidence for the efficacy of trauma-focused therapies in prison settings is limited, and the absence of controlled studies compound the difficulties which the delivery of such therapy in prison presents (Yoon et al., 2017).

Additionally, the prison environment and regime can be inherently damaging to mental health. Factors include disconnection from family and social support, loss of autonomy, diminished meaning and purpose, boredom, overcrowding, unpredictability of sentencing and other adverse experiences (Armour, 2012; Edgemon & Clay-Warner, 2019). Reception and release into the community are particularly difficult times that are associated with higher rates of suicidality (Pratt et al., 2006; Favril et al. 2020). In addition, exposure to violence, suicide, or self-injury, bullying and victimisation lead to a high risk of traumatisation or re-traumatisation within prisons, with 75% of prisoners in one UK prison reporting that they have experienced a traumatic event while resident in prisons (Wood and Dennard, 2017; Facer-Irwin et al., 2022).

Malik et al. noted the majority of interventions offered in prison are group-based, non-trauma-processing interventions, such as stabilisation or emotion-regulation groups. In part, this may be associated with the complex environmental and contextual factors within prisons that also impact on the feasibility and effectiveness of trauma-processing therapies. Factors such as remand and short sentences and high levels of mobility across the prison estate impact on ability to deliver trauma-focused therapies. Some authors have suggested that trauma-focused therapies should be considered with caution, because the prison environment cannot guarantee the physical and psychological safety that is crucial to undertaking trauma work (Miller & Najavits, 2012). However, in a recent systematic review of the effectiveness, feasibility, and adaptations of psychological interventions for individuals living with ongoing interpersonal threat, Yim et al. (2024) found that psychological treatments can be beneficial under these conditions. Despite the challenges for therapy in prison, it also presents many opportunities to engage therapeutically at a time when they are more likely to be substance free (Campbell et al., 2016).

Recently, there has been increasing interest in the development of trauma- and psychologically informed approaches in prisons (Substance Abuse and Mental Health Services Administration, 2014; McAnallen & McGinnis, 2021). National trauma frameworks detail the knowledge and skills needed by all patient or client-facing workers to respond to those affected by trauma at different stages in their recovery, and delineate the roles or practice levels. In addition, organisational approaches have been developed that identify the components of trauma-informed organisations, such as leadership, policies and physical environments (Grandison & Homes, 2021; Grandison and Homes 2021).

The Royal College of Psychiatrists (RCP) have developed Standards for Prison Mental Health (Rodriguez et al., 2023), which act as a framework to assess the quality of prison mental health services through self and peer review. Standards include admission and assessment, case management and treatment, referral, discharge and transfer, environment, workforce capacity and capability, training and support, and governance (Georgiou & Townsend, 2019). Although not explicitly trauma-informed, these elements mirror the organisational elements identified in the trauma-informed toolkits described. Similarly, the offender personality disorder pathway (OPDP) is based on a set of psychologically informed services operating across criminal justice and health, underpinned by a set of principles and quality standards and evidence-based relational and environmental approaches (Moran et al. 2022; O'Meara et al., 2019).

Recent evaluation of the OPDP, and psychologically informed planned environments (PIPEs) indicate that integrated pathways and psychologically informed approaches can be applied within custodial settings (Moran et al., 2022). However, there is currently a lack of evidence about the impact of whole-system trauma approaches on the outcomes for service users, and a lack of consistency when defining their components (Jankowski et al., 2019). Similarly, various trauma-informed initiatives have been piloted within prisons (Petrillo, 2021; Bradley, 2021). However, the impact and effectiveness of trauma-informed training for staff within prisons is unclear (Jones & Willmot, 2022).

Although trauma-informed training with prisons has an impact on knowledge, skills, attitudes and behaviour of staff in the short term, it is less clear whether the training translated into meaningful outcomes for people in prison, and little is known about the long-term impact of trauma-informed training (Purtle, 2020). Although staff identify a clear role for themselves in creating a more trauma-informed environment, there are significant

organisational challenges that mediate the effectiveness of any training, and significant barriers to embedding a trauma-informed environment with prisons (Martinez-Vaswani & Paul, 2019). Both staff and prisoners view the quality of relationships between staff and prisoners as a key aspect of trauma-informed practice (Martinez-Inigo, 2021; Crole-rees et al., 2023). However, little is known about the organisational factors that impact on outcomes, and there is a vital need for further evaluation of the mechanisms of change and the long-term mental health and offending outcomes of trauma-informed approaches (Auty et al., 2023).

In response to these challenges, there is a need to develop an optimal trauma-informed pathway within prisons. Responding to this need, this report is the result of a multidisciplinary expert consensus meeting and review of the research literature on PTSD, complex PTSD, associated comorbidities and optimal approaches to trauma-informed practice. It provides practical guidance to professionals working within prisons, to improve identification, treatment and support for people living in prison who have experienced trauma.

Method

This consensus process followed the methodology developed by Young et al. (2020), as well as established consensus methods (Jones & Hunter, 1995). It provides practical recommendations, drawing on the scientific literature and the professional experience of the attendees. The group convened virtually on 28 March 2023, for a meeting hosted by a UK University. Meeting attendees included 24 representatives of healthcare (GPs, psychiatrists, mental health practitioners and applied psychologists); trauma experts (including psychiatrists, psychologists and academics); social policy representatives (including the third sector); a UK Government (with specialisms in substance misuse, mental health and prisons) and prison experts (including academics, psychiatrists and psychologists). A total of 13 of the members were female, 9 male, and 2 preferred not

Table 1. Consensus process.

Stage of the consensus process	Components
Stage 1	
Presentations from experts on topics relevant to the pathway	Providing a review of the international evidence, clinical guidelines, and current practice issues as applicable in prisons.
Stage 2	
Sub-groups of 5–6 experts with a facilitator.	Introduce and clarify the issue, identify questions to be answered within the consensus group Initial 'go-around' to elicit the initial thoughts, feelings and views of each member of the sub-group Exploring ideas for implementation and the pros and cons of these Form a proposal and agree on recommendations to bring to a bigger group. These recommendations may be for concrete implementation, call for further research, or for further discussion.
Stage 3	Larger consensus group reconvenes. Facilitator from each sub-group presents their initial recommendations for discussion and to look for points of agreement and disagreement.
Stage 4	Research team analyses transcripts and checks recommendations for fidelity and accuracy. Based on this, a draft consensus document is developed.
Stage 5	Draft consensus document is circulated for comments, views and recommendations. Based on this, a final consensus document is developed.

to answer. Years of experience ranged from 2 to 43. Members represented England, Wales and Scotland, as well as Canada and New Zealand, providing a broad international perspective.

Attendees engaged in discussions throughout the day, with the aim of reaching consensus. The structure of the day and these discussions are summarised in Table 1.

The meeting commenced with presentations on various aspects of the clinical pathway for PTSD and complex PTSD in prisons, and of applications of trauma-informed practice within prisons. The purpose of these presentations was to provide information about up-to-date research evidence, clinical guidelines, policy and best-practice case examples within prisons internationally.

The topics included

- Prevalence and methods for identification and treatment of PTSD and complex PTSD in prisons
- Prevalence, identification and treatment of comorbidities of PTSD and complex PTSD within prisons.
- Screening, triage, assessment, intervention and reintegration (STAIR) model (Simpson et al., 2022)
- Trauma-informed practice within prisons
- Learning from the OPDP (Moran et al., 2022)
- Royal College of psychiatry prison standards (Rodriguez et al., 2023)

Following a question and answer session, attendees then separated into four breakout groups that covered different themes within the pathway.

Sub-groups included

- Identification and assessment of PTSD and complex PTSD within prisons
- Clinical interventions for PTSD and complex PTSD within prisons
- Assessment and interventions for comorbidities
- Trauma-informed pathways within prisons and reintegration into the community

Each group was tasked with providing practical recommendations and solutions relevant to their assigned topic. Discussions were recorded, facilitated by group leaders and summarised by note-takers.

The process for the small-group discussions was an initial 'go-around' where each of the group members were invited to share their initial thoughts, feelings and reflections about the topic. The group then discussed the issues relevant to their area in turn, identifying possible solutions or recommendations, exploring the pros and cons and these solutions, before agreeing on a number of recommendations to take back to the larger group. Within the small-group discussions, care was taken to ensure that all members views were heard; that there were no dominant voices and that the content of the discussions stayed within the topic. Following the small-group work, all attendees re-assembled.

Group leaders then presented findings to all meeting attendees for another round of discussion and debate, until consensus was reached.

All consensus proceedings, including group and feedback sessions were video-recorded and transcribed using the Teams automatic captions function, which were then checked by two members of the research team The recommendations generated in each small group were checked against the transcription from the groups to ensure accuracy and fidelity to the views of members. These recommendations were then synthesised for the consensus report, which was circulated to all authors for review and feedback. A final draft was circulated to all authors for agreement and approval.

The consensus group incorporated evidence from a broad range of sources internationally. However, the assessment, pharmacological treatment, policies and multiagency support features reflect clinical practice and legislation in the United Kingdom (UK), and these details may differ in other countries. Consensus recommendations are summarised by topic: (1) IDENTIFICATION and assessment, (2) interventions, (3) comorbidities, and (4) pathways and context.

Results and consensus outcome

Identification and assessment of PTSD and complex PTSD

The majority of people in prison have been exposed to traumatic events throughout their lives (Facer-Irwin et al., 2022). Many people in prison present with complex behavioural and emotional sequalae of trauma, and trauma-related distress ranges in severity from mild to severe. Much of the management of these sequalae is carried out within the general prison environment, rather than mental health services. Therefore, an optimal pathway for screening and assessment needs to extend beyond the identification of mental health conditions, to inform the support offered within their prison wings. We suggest that the function of this support is to mitigate the person's distress and maximise their functioning by informing interventions within the whole prison environment.

To improve rates of detection and treatment for PTSD and CPTSD, screening and identification should broadly follow the STAIR model of screening, triage, assessment, intervention and re-integration (Forrester et al., 2018). This provides an evidence-based framework to define and measure prison mental health services as a clinical pathway, with a series of measurable and interlinked functions that help to define best practice (Simpson et al., 2022). We suggest that identifying trauma sequalae is a dynamic process that may occur beyond the initial screening session and can usefully be done within the routine practice of trained frontline staff or peer supporters (Bagnall et al., 2015). However, we recognise that staff may be reluctant to enquire about trauma due to fears of retraumatising or distressing the individual and a lack confidence in how to respond. Therefore, staff should receive training and supervision in trauma-informed practice that is appropriate to their role (Sweeney et al., 2018).

The potential for distress and re-traumatisation at intake should be recognised, and processes for screening should mitigate this where possible. In addition, the high prevalence of poly-traumatisation, and of multi-morbidity of mental health, personality disorder and substance use conditions, would suggest that it may not be possible or beneficial to elicit details of trauma exposure at intake screening or to screen for every

co-morbid condition at this stage. Therefore, the design and evaluation of a brief, general trauma identification tool is advocated, which does not elicit details of traumatic events, but instead elicits the level of distress the main current symptoms; the behavioural and emotional sequalae of trauma; and identifies treatment priorities. This brief identification tool may also be beneficial in the many cases in which people present on remand (pre-trial), or for short sentences, and in which a comprehensive or clinical assessment may not be possible or beneficial.

Assessment of PTSD and CPTSD should be carried out within a subsequent, in-depth and comprehensive mental health assessment, that is implemented by trained mental health practitioners. At this stage, validated measures with a high level of specificity that assess for PTSD and CPTSD are recommended. One such measure is the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018). The use of this screening tool facilitates the identification of people with PTSD and CPTSD and could allow them to then be directed to specialist, diagnostic assessment and treatments. However, the identification of these conditions should facilitate access to a broad spectrum of support within the general prison environment consistent with trauma-informed principles. These may include environmental adaptations to reduce re-traumatisation, or enhanced relationships with staff or trained peer supporters.

Many people in prison, particularly those with complex mental health presentations, have repeated stays within prisons, and experience multiple, repeated mental health screens and assessments, both within prisons and community services. The impact of repeated assessments can be distressing and retraumatising for the individual, as well as preventing continuity and consistency of care and are an ineffective use of clinical resources. Therefore, we recommend that agencies within the criminal justice system should improve methods of data sharing, so that identification of mental health disorders, including PTSD and CPTSD, are streamlined, and individuals do not have to undergo multiple or redundant assessments. The adoption of a single electronic care record/passport that allows consistency of care between different prison and community services is recommended. We suggest that this record summarises the individual's trauma history, trauma sequalae and personalised care plan, and accompanies the individual between prisons and settings. Table 2 outlines the recommendations for identification and assessment.

Interventions

Access to evidence-based psychological interventions for PTSD and complex PTSD is variable within prisons. A wide range of factors impact on the provision of specialist psychological therapies for trauma. A systematic process such as the STAIR framework should be evaluated, with a view to implementing a comprehensive, integrated system to identify and manage all mental disorders, including PTSD and CPTSD (Forrester et al., 2018).

Currently, trauma-focused therapies for PTSD within prisons are less effective than those delivered in community settings (Facer-Irwin et al., 2023; Malik et al., 2023). There are likely multiple reasons for this, including factors associated with the prison environment, high levels of complexity and co-morbidity within the population, short stays and multiple episodes of care. To improve continuity of care, we recommend that

Table 2. Identification and assessment.

1	Care for individuals with PTSD/CPTSD should broadly follow the STAIR model of screening, triage, assessment, intervention and reintegration.
2	Where possible, identification of trauma exposure and PTSD/CPTSD to be brought forward at first presentation to the criminal justice system, followed by further assessment in an appropriate setting
3	Liaison and diversion services are provided within all areas (Ryland et al., 2022).
4	The term 'identification' is preferred over 'screening', to make it clear that all members of staff can build an awareness of signs of trauma in prisoners.
5	A brief general mental health identification appointment should be offered at reception. Specialist assessment of PTSD, CPTSD should not be offered immediately following reception.
4	Initial identification should include previous involvement with mental health services, current trauma sequalae and level of distress and identify treatment priorities.
5	A bespoke trauma identification tool for prisons should be developed and validated for this purpose. This should be accessible and validated for different groups, including for example, neurodiverse populations, or people with intellectual disability.
6	The adoption of a single electronic care record/passport so that identification of mental health disorders, including PTSD and CPTSD, is streamlined and individuals do not have to undergo multiple or redundant assessments.
7	Diagnostic assessment should be used, using validated identification and assessment measures as well as clinician-led interviews. These should be used to inform the level of distress and impairment; identify those that are most in need for specialist interventions; and to plan and sequence interventions.
8	Validation of the International Trauma Questionnaire and International Trauma Inventory (ITI) for prisons should be a research priority (Cloitre et al., 2018).
9	Across the prison estate, a standard dataset should be collected on the number of individuals being identified, triaged, assessed, and diagnosed for all mental health disorders, including PTSD and CPTSD. This data should be used to understand prevalence and shape service design.
10	All staff that are required to identify and assess for trauma and PTSD should receive training on how to respond appropriately and helpfully to disclosures and have knowledge of the trauma pathway.

integrated treatment pathways for PTSD and complex PTSD are developed so that multiple re-assessments are reduced. We do not recommend that trauma-focused therapies be commenced during remand, as this is often a highly stressful and uncertain time with lots of change. Instead, psychoeducation and emotion-regulation approaches should be offered during remand, and trauma-focused therapies commenced when sentenced.

We recommend that the full range of NICE-recommended therapies for PTSD are available for sentenced prisoners across the prison estate (NICE, 2018). This allows the modality of therapy to be based on the presentation and preferences of the individual, enabling them to continue treatment within a different service in the same modality. An emphasis on the development of a therapeutic relationship, with extended treatment time and adaptations for literacy and language difficulties, is needed (Campbell et al., 2016). Further development and evaluation of the optimal approach to integrating, adapting or sequencing existing therapies for this population is a priority, and an interdisciplinary, case formulation-based approach is recommended (Jeffcote et al., 2020).

The recent RCP prison drugs strategy places emphasis on reducing the misuse of prescription medication (Rodriguez et al., 2023). However, pharmacological interventions may have an important role for people with these conditions in prisons, both where psychological interventions have not been accessed or completed, because they are not available, or when the person hasn't benefited from these. In the first instance, NICE prescribing guidelines, should be followed, given that these represent a nationally agreed, state of the evidence approach to prescribing in this area (National Institute of Health and Clinical Excellence, 2018). However, it is important to acknowledge the contribution of groups seeking to add further knowledge in this area, through, for example, the use of an evidence-based algorithm for prescribing for PTSD and CPTSD (Bisson et al., 2020). We also acknowledge the need for individual prison establishments to consider

their own security, as regards the risk of medication misuse and the promotion of the illicit economy (Duke & Trebilcock, 2022).

In addition to trauma-specific approaches, it is also recognised that the emotional, behavioural and mental health sequalae of trauma extend far more widely than diagnoses of PTSD and CPTSD, and that the management of these can occur outside of specialist therapies and mental health services. Trauma-informed approaches that enable environmental and relational adaptations to reduce the risk of re-traumatisation and distress should be informed by the needs of the individual (Jones & Willmot, 2022). The emotional and behavioural sequalae of trauma are associated with the aetiology of many mental health conditions and these should be targeted within individualised psychoeducation and stabilisation-based approaches, both within groups and in routine staff practice (Crole-rees et al., 2023).

Prisons should ensure that all staff delivering trauma-specific interventions, as well as working in a trauma-informed way within their roles, have access to MDT support, appropriate training and regular supervision and consultation by a specialist in trauma-informed interventions, at an intensity and duration appropriate to their role. Integrated case formulation should also allow for sequencing of trauma-focused interventions with offence- and risk-focused interventions (Wheable & Davies, 2024). Integrated care-plans that allow a continuity of approach between services within and outside prison should be considered. The majority of prisoners have multiple morbidities and complex presentations that require MDT decision-making, and psychological therapies should be offered within joined-up pathways that are integrated across prison and community services, building on successful utilisation of this approach within mental health in-reach teams (Brooker & Forrester, 2017). To improve continuity of care, this integrated pathway should ensure that the individual can continue to access effective treatments at a different service without delay or additional wait. Therefore, 'through the door' referral processes to community mental health services and specialist services should be developed (UK Parliament, 2022b).

Table 3. Psychological interventions.

10	Where possible, psychological interventions within prisons should be offered within physical environments that are consistent with the enabling environments standard of the Royal College of Psychiatry guidelines (Roriguez et al., 2023).
11	In general, psychological therapies should not be commenced during remand, due to high levels of psychosocial stress and uncertainty. Instead, we recommend that stabilisation or emotion-regulation-based approaches are offered during remand, and that trauma-focused therapies commenced when sentenced.
12	The full range of NICE and ISTSS (International Society for Traumatic Stress Studies) recommended evidence-based trauma-focused therapies should be offered within all sentenced prisons within the UK (NICE, 2018; Forbes et al., 2020). The individual should be offered a therapy modality based on best practice guidelines, clinical judgement and their own preferences.
13	Inmates who have started therapy and are moved to a different prison should be offered recommencement of the same modality of therapy at the earliest opportunity, and their assessment details should be effectively shared to avoid repeated assessments.
14	All practitioners offering psychological therapies should be appropriately trained and offered supervision at a duration and frequency that is appropriate to their role, based on guidelines from accrediting bodies and by an appropriately trained specialist.
15	Therapies should be clinically indicated, evidence-based and offered based on clinical decision-making, rather than being court-mandated interventions.
16	Further research into the optimal delivery of trauma-focused interventions for CPTSD in this population is recommended.

Table 4. Pharmacological interventions.

17	Pharmacological interventions should be offered following the NICE guidelines for post-traumatic stress disorder (NICE, 2018)
18	Every individual living in prison should be offered a review of their medication at reception, to ensure that they are on appropriate and evidence-based prescribed medication.
19	At present, medication may play an enhanced role in prisons due to barriers to accessing psychological interventions. Therefore, consideration of offering pharmacological therapy as a frontline intervention based on an individual's preference may be indicated

Tables 3–5 summarise recommendations for psychological, pharmacological and non-trauma-focused interventions.

Comorbidities

The prevalence of dual diagnosis and multi-morbidity within prisons is extremely high (Facer-Irwin et al., 2022; Mundt & Baranyi, 2020). In addition, patient complexity is such that, for completeness, a full perspective on comorbidities might include related economic, cultural and social factors (Huntley et al., 2012). People with co-morbid mental health conditions and substance misuse are likely to be amongst the vulnerable and complex populations within prisons and are particularly likely to have experienced poly-traumatisation throughout their lives and to have short stays and multiple returns to prison (Khoury et al. 2010; Karsberg et al., 2021; Caravaca-Sanchez et al. 2016). Times of transition may be associated with enhanced vulnerability. Presentations of PTSD/CPTSD may vary in the context of other disorders being present. In addition, this population is less likely to benefit from trauma-focused therapies, and further research into the optimal approach to identification and assessment, as well as to treatment planning, is recommended (Roberts et al., 2022; Simpson et al., 2021). In particular, for individuals who present with PTSD or CPTSD in the context of personality disorders, interface with the OPDP is recommended (O'Meara et al., 2019).

There is also increasing awareness of the prevalence of neurodevelopmental conditions and intellectual disability within prisons (Chaplin et al., 2017; Young et al., 2018). People with neurodevelopmental conditions are more vulnerable to trauma exposure throughout their lives and to the development of complex mental health conditions, including PTSD and Complex PTSD following trauma (Andrzejewski et al., 2023). They are also more vulnerable to victimisation and traumatisation within prison and are more likely to experience sensory and environmental stressors within prison (Mundt & Baranyi, 2020).

Because of the high levels of co-morbidity and service use, we recommend a person-centred, individualised and formulation-driven approach to care-planning (Roberts et al.

Table 5. Non-trauma-focused interventions.

20	All inmates who have experienced trauma should have access to good quality psychoeducation or stabilisation resources, regardless of whether they will access psychological therapy.
21	Non-trauma-focused, stabilisation-based interventions, either within groups or individually, maybe of particular importance in prison settings, and further research into the optimal delivery of these is recommended.
22	All staff that offer trauma-informed approaches or interventions such as psychoeducation or stabilisation should receive regular supervision, reflective practice and consultation that are appropriate to their role.
23	Accessible, individualised and integrated care-plans are shared so that treatment can be integrated across prison stays, and across different prison and community services.

Table 6. Co-morbidity.

24	The experience of developmental trauma is associated with the aetiology of many mental health conditions and substance use disorders within prisons. Therefore, the principles of trauma-informed practice should be adopted in the care of every person in prison, consistent with recommendations in section 4.
25	People with co-morbidities are a particularly vulnerable group, likely to have repeated stays in prison. Where possible, continuity of care and partnership working across services and institutions, should be delivered.
26	An inter-disciplinary and integrated case formulation approach should be adopted, leading to multidisciplinary treatment plans that effectively coordinated, sequenced or integrated.
27	Extended duration of treatment should be offered where necessary to ensure sufficient stabilisation, preparation and adequate treatment of traumatic stress.
28	Rapid re-entry back into services in prison and community settings should be supported, to account for rapid turnover and to ensure that progress is sustained.
29	Staff within community services and prisons should be provided with trauma-informed training and supervision, to ensure a consistent approach and shared understanding of the person's emotional and behavioural presentation.

2020). It is recognised that many people with complex and co-morbid presentations may not be able to access or benefit from trauma-focused interventions. Therefore, high-quality, evidence-informed psychoeducation and stabilisation-based interventions, that target the emotional and behavioural sequalae of trauma are important. Due to the increased prevalence of remand and short sentences, and multiple stays in prison in this cohort, people with comorbidities may face high levels of disruption to their care (UK Parliament, 2022b). To increase continuity of care, we highlight the importance of rapid re-entry into services following breaks, with tiered care that is matched to their needs, and a consistency of approach between community and prison services (Office for Health Improvement and Disparities (2023). This approach may allow the individual to build on the progress that they have made in previous treatment episodes, and consolidate stabilisation skills, within a strengths-based approach. Tables 6 and 7 present recommendations for working with co-morbidity and neurodevelopmental conditions.

Pathways and context

The experience of traumatic events throughout the lifespan is associated with the aetiology of many mental health and neurodevelopmental conditions, as well as substance misuse (Sweeney et al., 2018). Individuals with the most complex presentations have a higher prevalence of poly-traumatisation and are disproportionately likely to experience a 'revolving door' of multiple stays in prison and multiple contacts with community mental health and substance misuse services (Bramley et al., 2020; UK Parliament, 2022a). The management of these individuals requires an inter-disciplinary, enhanced case formulation approach and integrated pathway that is embedded within both community and prison services, that recognises the prevalence and impact of traumatic

Table 7. Mental health and neurodevelopmental conditions.

30	Consider routine screening for neurodevelopmental conditions, using a validated screening measure such as the LDSQ, Adult ADHD self-report scale, or AQ-10
31	Where neurodevelopmental conditions are present and co-morbid with PTSD and Complex PTSD or other mental health conditions, consider adapting the delivery of psychological interventions based on good practice guidelines for autism.
32	Environmental adaptations to take account of issues with sensory processing, such as reducing noise levels and sensory stimuli, and communicating changes in routine in advance.
33	Further research into co-morbidity between neurodevelopmental conditions and mental health conditions within prisons is recommended so that appropriate services can be provided and funded.

Table 8. Trauma-informed pathway and context.

34	Prisons should adapt trauma-informed organisational approaches that encompass environments, policies, relationships and practice. The use of trauma-informed organisational toolkits, such as those developed in NES Scotland and Trauma-informed Wales are recommended to guide the elements of trauma-informed organisational approaches. These include communication, environment, policies, training and service delivery (Grandison & Homes, 2021).
35	The majority of people in prison and the criminal justice system experience multiple forms of disadvantage and may belong to particular marginalised communities and groups. Integrated working, improved communication and a consistency of approach between prison and community services is recommended.
36	Identification and assessment should be used to inform environmental and relational adaptations within the prison, as well as to inform mental health interventions.
37	Trauma-informed programmes and initiatives should be gender-responsive and take into account women's experiences of sexual harm, domestic violence and repeated revictimisation (Tripodi et al., 2019; Jewkes et al., 2019; Petrillo, 2021).
38	Training, supervision and reflective practice should be offered to all frontline staff within community and prison settings in order to develop a consistent, person-centred and trauma-informed approach within the whole pathway.
39	An organisational trauma-informed approach that considers the impact of the job roles on mental health and offers an effective pathway for staff wellbeing, in addition to considering the physical environment, policies, leadership and service delivery (Crole-rees et al., 2023).
40	Any trauma-informed initiatives and training initiatives should be co-produced with service users.
41	Further research into the components of these, the mechanisms of change, and the effectiveness of these approaches is a priority. Outcomes should be looked at broadly using a health economic model of reduced offending, improved mental health outcomes and quality of life outcomes.
42	It is possible that therapeutic units for people with high levels of trauma may be beneficial in order to provide trauma-informed environments and support the delivery of interventions (Rawlings & Haigh, 2017). However, the clinical and cost-effectiveness of these units is untested, and therefore further research is indicated into possible outcomes such as reduction of self-harm, violent incidences and further offending. We recommend a pilot unit is established to evaluate the feasibility and outcomes of this.

experiences, and offers a consistent approach to supporting people with the impact of these.

The interface between forensic mental health in-patient services and prison as well as the transition from youth custody should also be considered (Leonard et al., 2020). Delivery of a trauma-informed approach is carried out within the everyday practice of frontline staff within the prison, outside of specialist mental health services. Therefore, training for all frontline staff in a trauma-informed approach, with regular supervision and reflective practice is recommended. However, the impact of working in a high-stress environment in which there are high levels of exposure to stressful and traumatic events is also acknowledged. Frontline staff experiences high levels of traumatisation, burnout and mental health difficulties as a result of their work (Kinman & Clements, 2022). This has a significant impact on staffing levels, absenteeism, consistency in staffing, and impacts staff ability to work in a trauma-informed way. It also has a significant impact on the wellbeing of staff (Bell et al., 2019).

Trauma-informed environmental adaptations should also be inclusive of neurodevelopmental needs, and it is suggested that the principles of trauma-informed and developmentally informed environments are closely related. For individuals with complex comorbid presentations, effective pathways between community and prison services and continuity of care are paramount. Principles from the OPDP and Psychologically Informed Planned Environment initiatives can be applied (Moran et al., 2022). Post-release, lack of access to housing, finances and employment increases the risk of further multiple prison stays, and poses significant ongoing barriers to treatment access and effectiveness. Both directly and indirectly, these factors increase the continuation and chronicity of trauma sequalae. Therefore, effective reintegration into community healthsocial care and voluntary sector services should be prioritised, by offering mentoring and support during the

transition phase. Effective cross-sector processes to address barriers to housing, employment and finances should be developed. Table 8 summarises recommendations for the trauma-informed pathway and context.

Discussion

This report provides guidance to improve identification, treatment and support for people living in prison who have experienced trauma. This was developed through a multidisciplinary consensus meeting according to clinical expertise and research evidence.

Practice and service development implications

The report emphasises the prevalence of poly-traumatisation throughout the life span within this population, and the complexity of trauma-related sequalae that are associated with a range of mental health conditions and substance misuse, as well as PTSD and Complex PTSD. In line with Facer-Irwin et al. (2022), these recommendations highlight that the identification and treatment of PTSD and CPTSD in prison settings should be made a clinical and research priority, given that they appear to represent distinct groups with different clinical treatment needs and associated risks.

The expert group stressed the challenges of implementing standardised processes for identification and assessment of these conditions (Dulisse et al., 2023). In response to these challenges, they highlighted the importance of developing structured clinical pathways that allow for the matching of screening, triage, assessment and intervention rates under care with epidemiologically derived standards (Simpson et al., 2022). This information can be used to estimate caseloads and service levels, as well as benchmarking and evaluation of performance. However, the group also stressed the importance of situating clinical pathways for the treatment of PTSD, Complex PTSD and other mental health conditions within a system-wide trauma-informed approach. Continuity and integration of care between prisons, and between prisons and other settings such as youth justice, forensic in-patient and community drug and alcohol services, was stressed as a priority. However, it is acknowledged that this integration of care is made possible in the NHS, and in countries in which there is a single provider. In other countries, where there are separate health systems across provinces and services, this may not be possible (Dulisse et al., 2023).

Multi-morbidity is common, and the clinical challenges of identification and assessment of these co-occurring conditions are recognised. Prison populations exhibit high levels of psychopathology and have elevated levels of comorbidity, including personality disorder and substance use. There are significant clinical challenges in developing effective interventions where there are high levels of co-morbidity, and there is a lack of robust evidence about the benefits of integrated treatments for co-morbid disorders, in comparison to sequenced, parallel or uni-diagnostic treatments (Foa et al., 2009; Roberts et al., 2022). If research and treatment pathways fail to take these comorbidities into account, treatment approaches identifying and interpreting the true clinical effect or may exclude individuals with notable health and social needs (Yoon et al., 2017).

The offender personality disorder (OPDP) may provide a framework that could be adapted for the development of an integrated trauma-informed pathway. Such a

framework could underpin the commissioning of services, and provide specialist training and support for staff, whilst providing different functions to support people through their sentence and according to their intervention and management needs. The impact of the work on staff's mental health and wellbeing, and the importance of the trauma-informed approach for staff as well as prisoners was emphasised.

Given the rates of complex trauma in this population, there is a pressing ethical need to integrate trauma-specific therapies more widely into forensic pathways, with a focus on interventions before imprisonment and during the crucial resettlement period after prison. An emphasis on vulnerable groups, such as those with long and indeterminate sentences, foreign nationals, and those with intellectual disabilities, is needed (Chaplin et al., 2017). There is also a need to specifically consider women in research and service development.

Research implications

Research should be undertaken to explore a bespoke brief trauma screening measure for prisons that can be administered at intake and is tailored for identifying the emotional and behavioural sequalae and level of distress. The ITQ has been validated to assess for current PTSD and CPTSD within community samples, according to the International Classification of Diseases 11th revision (ICD-11) diagnostic criteria. However, it remains a relatively new scale not previously used within prisons and validation work within this population is needed (Cloitre et al., 2018). Similarly, the development of a clinician-administered diagnostic interview for ICD-11 PTSD and CPTSD, the International Trauma Inventory (ITI) is ongoing (Gelezelyte et al., 2022). It is likely that standard structured assessments may need to be adapted to ensure appropriate definition of need and to ensure appropriate design of care (Forrester et al., 2018).

Across the population, as well as within prisons, improving the effectiveness of psychological interventions for CPTSD is also a priority (Cloitre, 2021). Further research should investigate the contextual factors that are important for the successful delivery of trauma-focused interventions for people with complex PTSD, such as access to expert supervision and team support. However, it is likely that group-based non-trauma-focused therapies may play an enhanced role within this population (National Institute of Health and Clinical Excellence, 2018). Therefore, further research into the acceptability and effectiveness of non-trauma-focused group and individual interventions, such as stabilisation, emotion-regulation and mentalisation-based interventions to target symptoms of Complex PTSD, in this setting is recommended.

In addition, the group acknowledges the lack of evidence for the clinical and cost-effectiveness of trauma-informed organisational approaches, and currently, there is a lack of evidence for the mechanisms of trauma-informed approaches within prisons. Therefore, the group emphasises the need for a robust evaluation of this approach (Auty et al., 2023). Challenges of effective assessment, care-planning and treatment of people with complex and multi-morbid conditions are highlighted. Integrated trauma-recovery models that contain inter-disciplinary formulation and care-planning, and provide a framework for sequencing and integrating interventions, show early promise within youth offending settings (Skuse & Matthew, 2015). Adaptation and evaluation of these integrated models within adult settings could be a promising direction for research.

Strengths and limitations

To our knowledge, this report represents the first consensus statement of a trauma-informed pathway within prisons. It has brought together international experts that offer a broad perspective on research, policy and best-practice. It spans recommendations for the identification and assessment of PTSD, complex PTSD and other trauma-related sequalae, psychological and pharmacological therapies and other interventions for these conditions. It also provides recommendations for identification and intervention for co-morbidities, and for the development of pathways and a whole-system approach. It provides practical and pragmatic guidance that can be implemented within prisons, as well as identifying gaps in current knowledge and areas for research.

However, the panel recognises that, in order to deliver these recommendations of an appropriately trained workforce, enabling environments and continuity of care, investment and resources are needed. The changes that this panel is recommending will likely involve significant financial investment and structural reform, and we recognise the structural barriers that will need to be overcome (Galletta et al., 2021). We also acknowledge the wider challenges that prisons are facing within the UK and internationally. Under-funding and overcrowding have a documented impact on self-harm and suicide, increase levels of re-traumatisation and exacerbate mental health difficulties. In addition, procedures for community support and care for prisoners upon release can be variable, with many being released to no fixed abode. These procedural factors are exacerbated by wider structural and social issues around access to adequate housing, finances and vocational opportunities. These issues post significant ongoing barriers to treatment access and effectiveness, and increase the likelihood of multiple prison stays, as well as the continuation and chronicity of trauma sequalae (Mitchell et al., 2023). Although the group were clear that there were significant challenges in implementing these recommendations, the high level of consensus for a whole-system approach is welcomed.

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