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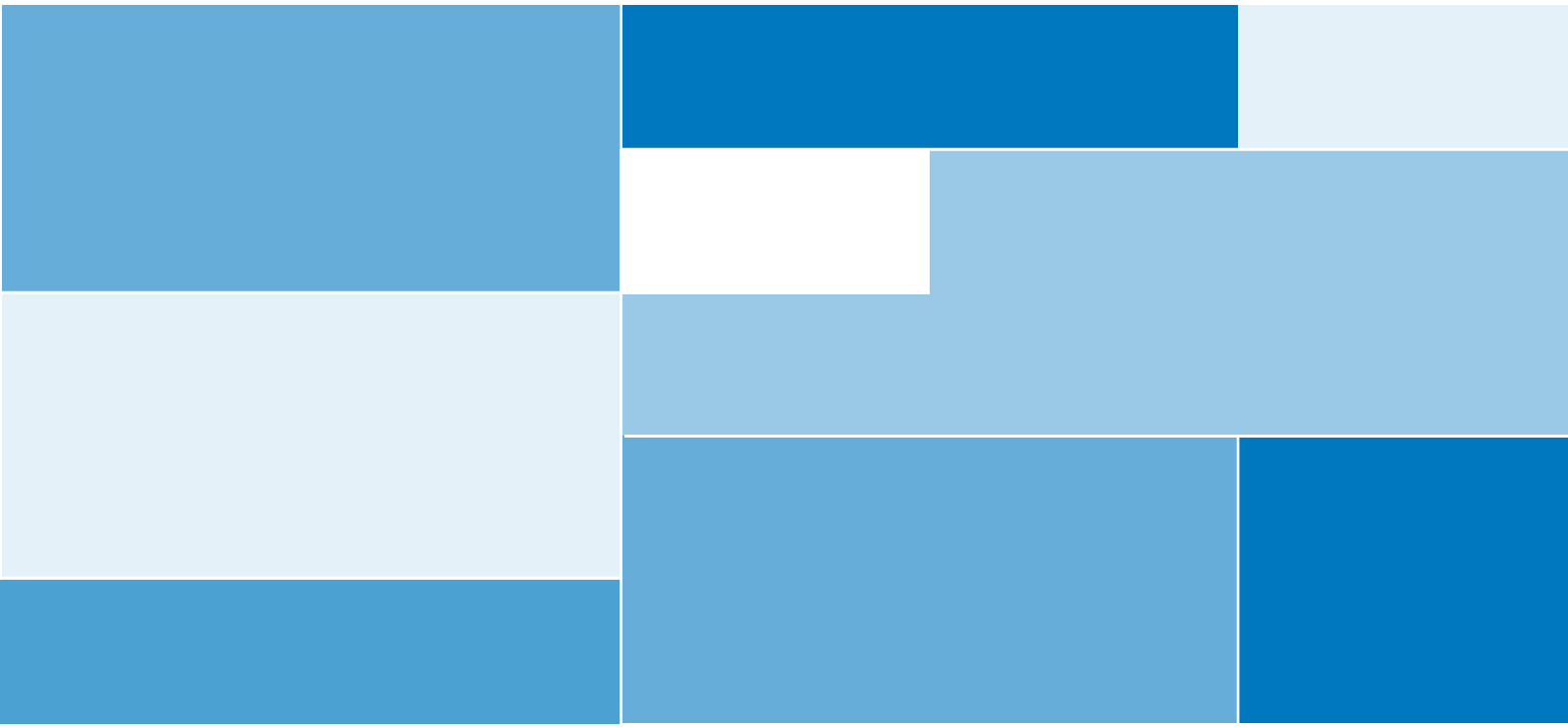
Improving Access to Psychological Therapies

NHS

Offenders

Positive Practice Guide



September 2013

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1. Background and policy framework

1.1. Offenders and their families represent one of the most socially excluded groups in our society, with some of the highest levels of morbidity, in terms of both physical and mental health problems. More than half the offenders in prison experience common mental health problems such as depression and anxiety which is often associated with issues such as a history of family poverty, family breakdown and substance misuse.

1.2. Offenders frequently experience significant problems gaining access to adequate health and social care services, adding to their problems of exclusion and putting them at greater risk of continued offending[1]. Initiatives to improve the mental health of offenders experiencing mild to moderate mental health difficulties represents a valuable opportunity to identify and address the wider health needs of offenders and potentially reduce re-offending rates.

1.3. England and Wales has the highest imprisonment rate in Western Europe, with the population nearing 84,000[2] at the end of 2012. The majority of these prisoners require mental health support and experience high levels of mental distress[3].

1.4. The quality of mental health care (either in prison or in the community) for offenders with common mental health problems still lags behind services available to the rest of the population. Service provision for offenders is either not provided or very patchy and poorly resourced. Offenders and their families should receive the same standards of care as the wider community, similarly resourced, and with effectiveness of care measured and designed to meet their needs.

1.5. Since April 2006 the National Health Service (NHS) has been responsible and accountable for the commissioning and quality of health care delivered in prisons. This includes the general principle that the same range and quality of

[1] Byng et al (2012). COCOA: Care for Offenders, Continuity of Access. Final Report: NIHR Service Delivery and Organisation programme.
[2] http://www.justice.gov.uk/statistics/prisons-and-probation/oms-quarterly
[3] Durcan, G. (2008). *From the Inside: Experiences of prison mental health care,* London, Sainsbury Centre for Mental Health

health and mental health services should be accessible to prisoners, appropriate to their needs, as are available to the general population through the NHS.

1.6. The formal transfer of responsibility for healthcare within prisons from HM services to the NHS led to the development of a number of In-Reach Community Mental Health Teams (CMHTs) operating wing-based services in prisons. These teams typically address secondary care mental health needs and contribute to transfer arrangements and suicide prevention. In practice, most of these teams have confined themselves to working in prisons with offenders with severe and enduring mental health illness. Therefore, there is often no service available to offenders with mild to moderate mental health problems.

1.7. In October 2007 the UK government announced a large-scale initiative for Improving Access to Psychological Therapies (IAPT) for depression and anxiety-based disorders within the NHS. IAPT services have now become an integral part of wider health and care systems and therefore, should be available to offenders.

1.8. In January 2009 the first IAPT: Offenders Positive Practice Guide was published, which acknowledged that providing IAPT services that meet the needs of offenders is a significant challenge but has the potential for considerable rewards and a number of consequential benefits such as:

- Reducing offending behaviours that is health related or linked to the offender's mental health problems;
- Reducing further symptoms and rates of depression among offenders;
- Reducing or preventing the onset of more serious mental health problems;
- Improving the quality of life for offenders in a prison or living in the community;
- Reducing rates of attempted and completed suicide; and
- Improving the health and social care of women and their families.

2. Understanding the needs of offenders

2.1 Offenders tend to come from the more deprived and socially excluded sections of our communities and have significantly higher than average health care needs.

2.2 Health and social characteristics among offenders include:

- Significantly poorer physical health compared to non-offenders
- A greater level of mental health problems that are not being adequately addressed
- Poor educational attainment
- At least ten times more likely to commit suicide and self - harm
- Unlikely to have been registered with a primary care practice prior to commencing sentence
- Significantly greater incidence of drug and alcohol abuse.

2.3 Up to 90% of prisoners have a mental health problem, with 10% of male and 30% of female prisoners having previously experienced admission to an acute psychiatric hospital. Most prisoners with mental health problems have common conditions such as anxiety and depression, with a smaller number experiencing more severe conditions such as psychosis[4].

2.4 As many as 12–15% of all prisoners have 4 or 5 co-existing mental disorders; 30% of all prisoners have a history of self-harm; and the incidence of mental health disorder is higher for women, older people and those from ethnic minority groups.[5] A significant number of offenders also experience personality difficulties which may or may not be formally diagnosed.

2.5 Post-traumatic stress disorder (PTSD) and complex trauma constitute a significant problem within prisons. The prevalence of PTSD amongst sentenced prisoners is considerably higher than that of the general population and there is

[4] Sainsbury Centre (2009). Briefing 39: Mental health care and the criminal justice system. London. Sainsbury Centre for Mental Health

[5] Brooker, C., Repper, J., Beverley, C., Ferriter, M., & Brewer, N. (2002). Mental health services and prisoners: A review. Retrieved October 31, 2007, from http:// www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyand guidance/dh_4084149

currently a significant unmet need for PTSD and trauma-specific treatment for prisoners[6].

2.6 The needs of men and women who come into contact with the criminal justice system differ. Women are far more likely to be the primary carers of children, which can make their prison experience significantly different from men. Women also tend to be located in prisons a long way from their homes, as there are fewer prisons for women, which can have detrimental effects on family relationships, receiving visits and resettlement in the community.

2.7 Over half of the women in prison have experienced domestic violence and a third have experienced sexual abuse[7]. The Fawcett Society estimates that 40% of women in prison will have received help for a mental or emotional problem in the year prior to custody. In contrast, male offenders rarely receive any specialist mental health care.

2.8 It is important to consider the needs of offenders in three broad groups:

- Offenders serving lengthy prison sentences;
- Offenders remanded in custody or serving short prison sentences; and
- Offenders living in the community.

2.9 Offenders serving lengthy prison sentences (of two years or more) are likely to be (more) stable geographically, located in one prison for much (or all) of their sentence. Their needs are probably met best by the primary care mental health service in their prison.

2.10 Offenders remanded in custody or serving short prison sentences are much more challenging to engage. They are likely to move between prison, hospital and community, as well as moving between different prisons. They are likely to be the responsibility of different services with each change of location.

2.11 Offenders living in the community will consist of those serving community sentences or remanded on bail, and some of those remanded in custody or serving short sentences at various times.

2.12 The psychological needs of the three broad groups of offenders may be similar, but IAPT services will require a flexible approach to meet their complex health and social care needs effectively. Key principles of this should be that:

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[6] Goff, A., Rose, E., Rose, S., & Purves, D. (2007). Does PTSD occur in sentenced prison populations? A systematic literature review. *Criminal Behaviour and Mental Health, 17,* 152-162.

[7] Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners*, London, Office of the Deputy Prime Minister, p. 138.

- IAPT services should be designed to give effective support to all three groups of offenders;
- IAPT services should deliver the same quality of care to offenders as any other member of the community, measured by patient outcomes, to reduce health inequalities;
- Community of care as people pass into, through and out of the criminal justice system is a critical issue in respect of delivering effective care; and
- Effective IAPT interventions need to be proactive, incorporating assertive outreach, patient tracking, identified support personnel and advocates.

2.13 Commissioners should ensure that IAPT services are available and effective for men and women offenders from a range of circumstances. While offenders should be regarded as part of the ordinary community population, with many offenders in prison for only short periods and their needs broadly similar to other members of the local community, commissioners should be aware that there are also complexities and distinct differences from the rest of the population

2.14 In planning and commissioning IAPT services that are effective for offenders, commissioners may wish to include the expertise of professionals from other organisations, such as:

- Social services;
- Probation;
- Area prison representation;
- National Offender Management Service via regional representatives;
- Prison governors;
- Police;
- Sexual abuse services;
- Womens' centres;
- Forensic mental health services;
- Housing; and
- Substance misuse services.

2.15 Clinical Commissioning Groups (CCGs) should ensure that, as with any service they commission, there is:

- A Joint Strategic Needs Assessment (JSNA) that establishes the needs of offenders and plan to meet those needs;
- Standards of access and quality of service provided by suitably qualified professionals equivalent to those enjoyed by anyone else living in the CCG area;
- Robust performance management of health services in prison settings, with mechanisms in place to identify and tackle poor performance; and
- Continuity of care when offenders leave prison.

3. Removing barriers to access and continuity of care

3.1 Offenders face a number of barriers that prevent them from accessing psychological therapy services for their mental health needs. The main barrier is that services are not available – or offered – to them. In some prisons, the mental health care may be commissioned using general prevalence studies rather than a local needs assessment and thus may not cater for the higher prevalence among offenders.

Gateway to Health Project within Plymouth Probation

The service was started in 2009 as a part of the general practice outreach clinics run by Plymouth Community Health Care. The primary aim is to engage and ensure access for vulnerable individuals in the probation service who have no GP or have disengaged from primary care. Most individuals seen have mental health problems which are complex due to associated social exclusion and co-morbidity usually involving substance misuse and personality disorder. The service has a number of important features, and these have been retained during the development of the wider service, involving practitioners from the forensic mental health team working with the GPs. Firstly, the service is highly accessible, with a simple booking system so that Probation Officers can easily book offenders in for an assessment or on-going care, therefore making it much more likely that reluctant or vulnerable individuals will attend. Secondly, the service collaborative, the practitioners working closely with Offender Managers to ensure that care is coordinated with shared goals often agreed together. Thirdly, individuals can be seen for a number of sessions during which engagement and trust is developed, assessment is completed and treatment initiated. Referral on to a range of mental health services is often required; these include IAPT as well as early intervention for psychosis or personality disorder. Next steps include developing improved procedures for ensuring a smooth transfer to IAPT services in order to transfer trust and facilitate ongoing joint work between health and criminal justice practitioners.

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3.2 High levels of social exclusion can mean that some offenders do not have access to GPs and therefore have poorer access to primary care, limiting their access to IAPT services. Practices can and do provide effective services for offenders, but if offenders cannot access them, the value of these services is diminished. Promoting self-referral routes into IAPT services or promoting referral from probation officers or court officials could be a valuable method of removing this barrier for offenders without access to GPs.

3.3 The frequent changes of location among offenders on remand or serving short sentences mean that treatment received before imprisonment is often not continued to the same standard – if at all – in prison. Similarly, those offered treatment in prison are often not able to continue treatment on release into the community. Onward pathways should be developed which bridge disruption caused by prison. Incarcerated prisoners nearing release are often not informed of the location to which they will be held on licence until very close to the release date. Effectively compounding their stress levels and reducing the opportunity to access community support.

3.4 Offenders need continuity of care between prison establishments and through the gate into the community. An effective offender pathway would enable transfer of care when needed between services as well as when care is potentially disrupted within the community criminal justice system (courts, probation, police contact).

3.5 Offenders living in the community often have no access to psychological therapies because of organisational or professional boundaries. Health professionals may not believe that they have the necessary skills to deal with the needs of offenders and therefore may not be willing to offer treatment.

3.6 Co-morbidity with substance misuse and personality difficulties can result in exclusion from some IAPT services. Services must be commissioned to allow treatment of anxiety and depression whatever the other diagnoses.

3.7 Striving to ensure continuity of care when referring offenders to other IAPT services or “stepping up or down” between low and high intensity interventions is good practice. It may not be possible for offenders to remain with a therapist across establishments, between prison and community or even within teams, but an offender can be provided with a sense of continuity through the style and type of care that is provided.

Leicester City IAPT Service: Open Mind and Leicestershire & Rutland Probation Service

There is a high prevalence of mental health problems amongst probation service users, but low utilisation of services. Leicester City IAPT Service: Open Mind and Leicestershire and Rutland Probation Service have collaborated to develop a specific IAPT Pathway for offenders who are subject to probation supervision. Key features include:

- The location of therapists within the main probation office.
- Therapy offered that matches what is available to services users who access IAPT through the GP surgery.
- Therapy is offered on a voluntary basis.
- Cognitive Behavioural Therapy and Integrative Therapy available.
- Co-location of therapists supports collaborative working with Offender Managers.

The service has been operating since December 2012 and to date all service users who are in treatment or who have completed their contact with the service have experienced a reduction in Minimum Data Set scores. Offender Managers report observing a benefit for their cases and identify that their own knowledge and confidence in dealing with mental health issues has increased.

Future developments include expanding the service to offer group work with an emphasis on anger as the main presenting symptom for the offender. The group work will be based on the skills training manual by Marsha Linehan.

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3.8 Collaborative working with other services, such as social care, regional partnership boards and probation offender managers offers CCGs the opportunity to improve GP registration of offenders, develop effective strategies for tackling the health inequalities of offenders and improve access to psychological therapies by opening up other possible referral pathways.

Removing Barriers to Access and Promoting Continuity of Care from Prison to Community within Lincolnshire

The Lincolnshire IAPT for Offenders service was established in April 2010 and currently serves HMP Lincoln and HMP North Sea Camp with an ethos of providing equitable and equivalent access to mental health care for people within prisons as they would receive within the community and ensuring continued access to IAPT services upon release.

The service accepts self-referrals from prisoners and all parties working within the prison. A person-centred assessment is offered, aims goals for therapy are identified and a treatment plan is collaboratively developed based upon a Five Areas Model of the service users difficulties. Service-users are provided with information regarding a range of interventions and offered a choice of treatment options. The potential time-frame for any offered intervention is identified and based upon the earliest release date / court date. Interventions which are unlikely to be completed are discussed and with consent a referral is made to community IAPT services within the home NHS Trust.

Clinical care is organised around Stepped Care principles and interventions offered are in line with current NICE recommendations. The "least intensive first treatment" approach adopted by the service is particularly useful in addressing the needs of offenders remanded in custody or those serving short sentences as the low-intensity treatments are short-duration interventions.

The model of care and service delivery matches that which is offered within Lincolnshire's community based IAPT services as closely as possible, in terms of standards of practitioner training and therapeutic interventions offered (the length of treatment is longer). Therefore, people within prisons in Lincolnshire who are experiencing common mental health problems have equal access to IAPT services of the same range and standard as those available within the community and any care started within the prison is able to continue within community IAPT services, in Lincolnshire, upon release, thereby contributing to a seamless service and continuity of care for offenders.

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4. Engaging with offenders

4.1 Commissioners may find it useful to utilise the expertise of voluntary and community sector organisations, faith groups and other statutory organisations, such as probation services, to encourage engagement with offenders. Such organisations may act effectively as intermediaries by :

- Providing commissioners with information that helps to engage the target group;
- Raising awareness and signposting individuals to the IAPT service (by being included in the referral pathway to IAPT services); and
- Providing useful feedback to help IAPT services improve the way they encourage engagement.

4.2 Offenders serving long prison sentences may be easier to engage than the other groups of offenders, as they are more likely to remain the responsibility of a single CCG and are less likely to move from prison to prison.

4.3 Offenders on remand or serving short sentences need careful collaboration and co-operation between a range of services such as different prisons, different NHS trusts, probation services, addiction services, women's centres and so on. Their brief periods in custody might provide a unique opportunity to begin to engage them with psychological services, but excellent liaison with other services will be essential to meet their needs.

4.4 CCGs should treat offenders living in the community as a socially excluded group who experience significant health inequalities, and work with other agencies, such as probation services, in assessing needs.

4.5 Criminal Justice System (CJS) contact, particularly in prison or probation, is an opportunity for engagement and to address issues such as PTSD which would be self managed through offending. For many offenders prison is the first/only stable place they may have experienced.

Liaison and Diversion Services

Liaison and Diversion services are now being commissioned in England. These are based around courts and police custody suites and aim to ensure that offenders with mental health problems in these settings are recognised early, engaged with and receive treatment in a timely way. In some cases they will be diverted from the criminal justice system to mental health care. More often ongoing assessment of mental health along with other needs may be carried out during progress in the criminal justice system.

5. Assessment and Treatment

Assessment:

5.1 IAPT services working with offenders should consider the use of screening assessments given evidence that offenders often do not present to mental health services (but will often accept a service if offered) owing to:

- Beliefs that mental health problems are shameful and so deliberately hiding symptoms from health professionals;
- Fearing that they may serve longer sentences for having mental health problems;
- Believing that the effort, stigma and shame will outweigh the benefits of receiving help;
- Self medicating with alcohol, violence or drugs (particularly men) to mask and neutralise their moods or feelings and stop them being detected;
- Distrust in general and towards practitioners in particular;
- Not believing that talking interventions for mental health problems are useful;
- Having difficulty accessing general services such as GP surgeries in the first place (especially relevant for offenders serving community sentences);
- Fearing statutory services and not wishing to engage with health professionals;
- Fearing that mental health problems will invite an investigation from social services and may result in children being removed; and
- Fearing that they may have to disclose violence and abuse that has occurred (or is occurring).

5.2 Offenders tend to access Primary Care Mental Health services with secondary symptoms. Depression, post traumatic stress disorder (PTSD) and anxiety may present as anger, self harm, drug misuse, sleep issues, obsessive behaviour and self-harm.

5.3 Offender mental health needs are frequently complex and multiple. There are relatively few psychometric tools that are specifically normed for use with offenders experiencing mental health problems or which take into account literacy difficulties experienced by many offenders.

5.4 The IAPT Minimum Dataset (MDS) and the disorder-specific measures advocated by the IAPT programme should be delivered in an offender friendly manner. When working with offenders within prison settings there is a need to alter the wording of specific items referencing the community activities.

5.5 Services and clinicians working with offenders may wish to consider the use of outcome measures in addition to the IAPT MDS and disorder-specific measures to inform their clinical practice and monitor psychotherapeutic progress, but will need to be mindful not to overburden the person and risk rupturing the therapeutic alliance.

Treatment:

Collaborative working to ensure mental health needs as a whole are met

Peter referred himself to PCPS Services at HMP Liverpool with low mood and thoughts of self-harm. He had diagnoses of Borderline and Anti-Social Personality Disorder. He also had a history of illicit and prescribed drug use which he reported as a way of managing his memories of childhood trauma. A combination of Cognitive Analytic Therapy and a Low Intensity Psychological Intervention was implemented. As Peter was perceived as a high profile prisoner because of his difficulty interacting with professionals at times and because he was on an ACCT document at the start of therapy he agreed to the sharing of information with other professionals and prison staff involved in his care. The therapist and Primary Care Graduate Mental Health Worker (PCGMHW) saw Peter together for the therapy to gain an understanding of how his problems had developed and what maintained them and to devise a formulation. The PCHMHW would support Peter between sessions by providing low intensity interventions for anger management and assertiveness skills. Change was demonstrated by Peter coming off his ACCT document and his Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM) reducing from 75 mean score 2.2 (demonstrating clinical caseness) at the beginning of the intervention to 37, mean score 1.08 (non-clinical caseness) at it's completion. Peter was also able to attend a multi-professional meeting regarding his care where his psychological formulation was discussed and he was able to demonstrate change by engaging with staff in a respectful and meaningful way.

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5.6 Clinicians working with offenders face a number of challenges which may hinder therapeutic progress, therefore the length of intervention may need to be longer than within standard community IAPT services:

- Practitioners need to be mindful that the person they are working with is likely to present with with complex and frequently co-morbid difficulties
- Offenders may present with undisclosed literacy difficulties

- There may be difficulties in establishing a therapeutic relationship within the criminal justice system that may inhibit therapy and therapeutic progress
- Interventions may require adaptation when working within the security of prisons
- Prison regime changes may disrupt the flow of therapy
- Appropriate therapeutic spaces may be difficult to access within prisons

5.7 Recommendations made by the National Institute for Clinical Excellence (NICE) and other best practice guidance are equally appropriate for offenders as non-offenders. The complex mental health needs offenders and the challenging environments in which psychotherapeutic work is often carried out may clinically indicate the need for a flexible and integrative therapeutic approach and the need to develop and disseminate practice-based evidence to support effective clinical work with this population

Personality Disorder – a frequent co-morbidity, along with self harm

Within prison individuals deemed at risk of suicide are placed on an ACCT (Assessment, Care in Custody, Teamwork). This tool and method of monitoring individuals is used to prevent deaths in custody, and risk behaviour such as self harm. Self harm can reinforce interpersonal outcomes such as functioning as a way to communicate, and obtain resources (Linehan, 1993). Within a number of prisons within Leicestershire and Northamptonshire management support plans from a multi disciplinary viewpoint, using Dialectical Behaviour Therapy principles has been implemented. Training for IAPT and other staff to understand Personality Disorder and self harm to prevent labelling and frustration has been applied. Where this way of working has been applied there has been a reduction in reported incidents of high risk behaviours, such as going to outside hospital, incidents of attempted suicide, period of time individuals remain on an ACCT, indicating a reduction of risk of self harm and suicide. Implications of this finding are that having a multi-disciplinary, coordinated approach can reduce the number of high risk behaviours that could lead to death in custody, admissions into hospital and thus has a cost saving implication.

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5.8 Although pragmatic issues such as regime constraints and limited access to appropriate therapy space may influence numbers treated and possibly the type of therapy that can be offered, IAPT services working with offenders can potentially offer access to numbers of people treated which compare with community IAPT outcomes.

5.9 The delivery of treatment within IAPT services adopts a Stepped Care framework.

5.10 At Step 2 interventions such as guided self-help, psycho-education and manualised Cognitive Behavioural Therapy (CBT) may be helpful if provided in a flexible and supportive manner, which is sensitive to offender needs and circumstances.

5.11 At Step 3 psychotherapeutic approaches such as CBT, Interpersonal Therapy (IPT), Eye Movement Desensitisation and Reprocessing (EMDR) may be useful when delivered with an awareness of the complexity of the offenders' clinical presentation.

5.12 At Step 4 clinicians have found a range of therapeutic approaches clinically beneficial for example, Mindfulness Based Cognitive Therapy, Compassionate Mind, Acceptance and Commitment Therapy (ACT), Integrative Therapy and Cognitive Analytic Therapy.

5.13 The IAPT MDS and disorder specific measures can be used to monitor clinical progress by offenders and their therapist.

5.14 There is currently a dearth of offender-focused resources for intervention purposes.

5.15 Psycho-educational material adapted for use with offenders is available from Northumberland Tyne and Wear Trust for some psychological difficulties[8]

5.16 Jim White's Stress Control group has been adapted for use with a prison population[9].

5.17 Offenders presenting with PTSD or experiencing psychological distress from experiences of complex trauma may benefit from psycho-education regarding their symptoms, associated difficulties and sharing effective coping strategies and skills to promote psychological wellbeing and reduce the distress experienced. At Step 3, the traumatic experience can be directly addressed though Trauma-Focussed CBT and or EMDR. At Step 4 clinicians have described Cognitive Analytic Therapy, Schema Therapy, Mindfulness Based Cognitive Therapy and Compassionate Mind work as helpful.

[8] www.ntw.nhs.uk/pic/selfhelp
[9] www.glasgowsteps.com

Trauma Psycho-educational Group for Offenders at HMP Lincoln

Post-traumatic stress disorder (PTSD) and difficulties related to complex trauma constitute a significant problem within prisons and may be a factor predisposing prisoners to suicide, self-harm, substance misuse and recidivistic offence-related behaviours.

The IAPT for Offenders team in Lincolnshire have designed and delivered a Trauma Psycho-educational Group for Offenders. The group is a structured closed short group programme which aims to enable prisoners to develop a psychological framework for understanding the impact traumatic experiences may have had on their lives, symptoms they may have experienced / continue to experience and maladaptive ways they may have used to cope with trauma symptoms. The programme encourages prisoners (both men and women offenders) to personalise the content of each session to their own experiences and promotes the use of alternative adaptive methods of coping with trauma and trauma-related difficulties. Prisoners elect to participate within the group.

The Trauma Psycho-educational Group for Offenders adopts a recovery-focused low-intensity cognitive-behavioural approach and is delivered by facilitators from clinical psychology and mental health nursing backgrounds. The group programme consists of six sessions in total which were held on a weekly basis. The programme includes education and information sharing on the following trauma-specific subject areas:

1) What is Trauma?

2) Stress and Trauma

3) Coping with Dissociation and Flashbacks

4) Trauma and Substance Misuse

5) Trauma and Self-Harm

6) Recovery and Psychological Therapies for Trauma

Initial evaluation of groups held at HMP Lincoln and HMP Morton Hall indicates clinically significant reductions in trauma related difficulties, depression and anxiety as assessed by IAPT advocated measures for both men and women offenders.

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PTSD is more common in prisons

Within HMP Gartree which holds life sentenced prisoners for murder, individuals regularly present to mental health services for problems related to anxiety, depression and an inability to sleep. PTSD symptoms are often reported for a range of experiences including physical, sexual and psychological abuse during childhood as well as witnessing traumatic experiences; some individuals are traumatised by their own offence, causing them to experience symptoms of PTSD. The Ehlers and Clarke (2000) cognitive model of PTSD has been applied within the In Reach Psychology clinic at HMP Gartree and for many individuals PTSD symptoms were significantly decreased and levels of functioning much improved within 20 sessions. Treatment includes psycho-education, formulation and understanding schemas that may have been activated at the time and looking at the meaning of the offence, understanding anxiety and guilt, reliving and giving up avoidance strategies. This type of work can only be completed once a good therapeutic relationship has been established due to high levels of shame that are often experienced within this group of individuals. Implications are that thorough assessment identifying avoidance and other PTSD symptoms need to be completed before offending behaviour programmes are targeted, in order to decrease the risk of re-offending, due to the intense focus of the offence when conducting this type of work.

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6. Training and developing the workforce

6.1 Prisons and criminal justice settings are quite literally "closed door environments". In order to engage effectively with the experiences of offenders it may be helpful to staff offender IAPT services with therapists who have had previous experience working within the Criminal Justice System or with offenders.

6.2 Therapists will need training and supervision to deal with a range of personality traits and comorbidities often found in offender populations.

6.3 Staff training is an important aspect of addressing inequalities within an IAPT service. It is essential to improve the competences and capacity of the IAPT service workforce to overcome any possible professional bias and personal prejudices. Commissioners should be satisfied that service providers are taking steps to ensure that the therapy workforce understand, are aware of and are sensitive to the specific needs of offenders (including those within the community, those in prisons and those who frequently move between prison and the community).

Helping staff express feelings about their work

The IAPT service in a prison in Staffordshire has introduced Schwartz Center Rounds ® to help staff explore emotions and share experiences of work with a difficult patient/client group. At bimonthly meetings, held at lunchtime (with free lunch!), the multidisciplinary group of staff discuss themes such as work with sex offenders; patient suicide and confidentiality. Future themes will include self-harm and the influence of families. The atmosphere is supportive and accepting, allowing honesty about doubts and feelings, and enabling compassion both for each other and for prisoners. The group includes primary care and in-reach nurses; forensic psychologists, drug and alcohol workers; healthcare management, admin, chaplaincy and library staff, as well as those from the IAPT service. *www.kingsfund.org.uk/projects/point-care/schwartz-center-rounds*

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6.4 Therapists may need additional training and supervision when working in a prison setting. It is advisable for IAPT staff working with offenders to access the training and experience already present within Criminal Justice settings. For example for prison based IAPT staff attending prison trainings covering, key control, ACCT reviews, personal safety and safer custody.

6.5 There is a need for specific supervision for practitioners: they may be affected by vicarious trauma, transference, disclosure of other criminal information.

Offender Psychological Therapy Network

Aim:
To support practitioners to develop and deliver psychological therapeutic interventions for offenders

Objectives:

- To act as a forum for discussion of how best to meet the psychological needs of offenders across the diagnostic categories of common mental health problems, personality disorders, substance misuse and cognitive deficits;
- To develop practice based evidence for psychological therapeutic interventions for use in criminal justice settings;
- To support the development of IAPT services suitable for offenders;
- To support any forthcoming development of NICE guidelines for common mental health problems for criminal justice settings;
- To support the adaptation of psychological therapy training to meet the needs of practitioners working with offenders;
- To support Continuing Professional Development for those working with offenders;
- To promote research that develops an evidence base for best practice in therapeutic work with offenders;
- To develop a network of practitioners working psychologically across the criminal justice system;
- To contribute to strengthening pathways across the criminal justice system to improve continuity of access to appropriate mental healthcare; and
- To promote understanding of psychological therapies between health and criminal justice professionals, ensuring system wide interventions.

More information can be found at http://www.ohrn.nhs.uk/optn/

Acknowledgements

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