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COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff

Introduction

The coronavirus disease 2019 (COVID-19) pandemic presents substantial challenges to global health and social care systems. Mental health services have faced restrictions in service delivery, risking the deterioration of already vulnerable individuals. Mental health staff have been working with new risks, in unfamiliar ways, for which they often feel inexperienced and untrained, for example accessing and using personal protective equipment (PPE).

Prisons face unique additional hazards to both prisoners and staff. Public Health England's recent report describes limited and variable COVID-19 testing, concerns about an outbreak in prisons and the unsuccessful follow-through of the early release strategy which, according to modelling, would considerably reduce deaths from COVID-19. The report also highlights the longer-term challenges.[1] Whilst recognising these additional difficulties, we argue that there is precedent and evidence from which we can learn. We propose ways to optimise the support to staff and prisoners.

Prison challenges amplified by COVID-19

Recent public and media support for health care has been considerable, with, for example, weekly 'claps' in the UK and private-sector companies providing staff and resources. However, such largesse seldom reaches the underfunded and overcrowded prison sector, which is already struggling as a result of austerity measures, and is an ideal environment for contagion spread.[2,3]

England and Wales have a prison population of 139/100,000 (85/100,000, in Northern Ireland and 148/100,000 in Scotland) – the highest in Western Europe.[4] Two to a cell is standard, as is limited access to hygiene facilities and showers. Prisoner care may worsen during COVID-19 due to prison officer quarantine and sickness. Prisoners, many of whom are physically vulnerable, will have understandable worries about infection, resulting in high anxiety and increased need for support.

Further, the prison population has always contained greater rates of mental ill health, neurodevelopmental disorders, substance misuse and adverse childhood experiences than the outside world.[5] Early reports from mental health staff suggest deterioration in those without pre-existing conditions and exacerbation of symtoms among those with a prior mental health difficulties. Such staff are concerned that some are avoiding disclosure of potential infection for fear of further segregation at a time when feelings of loneliness and isolation may be at the fore.

Like external mental health services, clinical emphasis is understandably focused on the neediest, with suspension of non-essential services. The impact of this will vary between prisons, which have variable resources, but will likely preclude education and training as well as therapeutic and pastoral interventions. Welfare checks and interventions via in-cell telephones may be possible in some places, but in shared cells, these raise concerns about confidentiality, stigma and shame, which can be particularly high amongst prisoners. It remains unclear – and is likely variable – if referrals to mental health teams are increasing; however, the assessment threshold has generally risen, risking a build-up of problems that may later require more complex interventions.

For clinical staff, demands are greater, yet so are staff absences. 'Moral injury' is the term used to describe the complex psychological distress individuals feel when exposed to situations they feel outweigh their skills, training and experience. The availability of PPE has proved erratic, and social distancing in prisons is challenging, leading to anxiety amongst staff, which competes with the need to provide support to high-risk and complex service users requiring immediate mental health support.

Staff will worry about their health and that of their loved ones, aware that their environment is prone to

rapid disease spread, something that might be heightened in black, Asian and minority ethnic staff, given emerging differential risk data.[6] Research shows[7] that mental health symptoms are more frequent in health-care workers unable to work, feeling they burden colleagues, and in those on site concerned that they are protecting themselves and not adequately supporting the most vulnerable people (or vice versa). Mental health staff in prisons may also feel more sidelined in custodial settings than their health-care counterparts do in hospitals and clinics.

Doing good in difficult circumstances: caring for prisoners

New ways of working are needed now and post COVID-19. Service, team and professionals' functions need to adapt as a result of a broad discussion. Managers will need to engage staff to build consensus and to foster a sense of inclusion and renewed team morale.

Perhaps most simply, provision of distraction materials (e.g. puzzles, colouring, playing cards) might be reviewed and optimised. Many psychological self-help materials are available for a wide range of mental health difficulties, as are well-being materials such as instructions for in-cell yoga and physical exercise. These vary from generic to specialised, across a range of media from online to printed; local modification might be required to facilitate access. Recent feedback suggests that inmates are currently highly appreciative of these basic interventions.

Staff roles may need to be reviewed, with common functions being performed by professionals from different backgrounds necessitating additional support, training and supervision. Assessments may need redefining in terms of both explicit criteria and expectations of how and where they might occur. These might include prioritising identification and care of prisoners with severe and enduring mental illness and those at high risk of harm to themselves or others. For effective transition into new methods of working, clarity will be required for staff and prisoners, and constant review and redevelopment of these new practices will be vital.

Consideration should be given to novel prisoner stresses, for example reactions to lockdown conditions, illness, death of relatives, delays in parole/court hearings and so forth, whilst also staying mindful of the underlying context in which drugs are endemic, coercion common, and violence and self-harm a daily occurrence. Prison officer sickness and quarantine will likely reduce prisoner contact further, which may hinder early tackling of any rising tensions, risking more extreme escalations. Responsibility for this sits with the prison, not mental health staff, though the latter may wish to provide a consultatory, advisory or educational role.

Protecting staff

We have written in more detail on the evidenced 'tiered approach' to managing staff well-being more generally in COVID-19.[8] This is applicable, with modification, to the prison estate. It involves the tested occupational health model of primary prevention – minimising the occurrence of ill health, secondary prevention – intervening early when there are emerging indicators of impending difficulties, and tertiary prevention – rapid treatment of ill health to optimise recovery.

The model should aim to 'de-medicalise' normal distress. Honest, frank conversations are required with staff, supporting them in undertaking their meaningful roles whilst being honest about the difficulties faced. Whilst moral injury should be discussed, it should also be emphasised that this will not be the case for most, and indeed personal and professional growth and pride in one's work are expected to be more common. The organisation must provide accurate up-to-date information on local and national supports which should be well advertised through a variety of media, from emails to posters.

There is good evidence to support enhancing team bonds between staff and with their managers.[9] 'Buddying' systems and beginning and end of shifts are good opportunities to debrief. Whilst less discussed, stigma about mental illness is clearly prevalent, even in staff working in mental health. There are evidenced peer-support systems, such as the TRiM model adapted from the UK armed forces.[10] This helps de-stigmatise mental illness and encourages accessing services, whilst avoiding the need to approach one's manager. Environmental and safety issues should be addressed, albeit resources are typically quite limited, including for example adequate rest periods and annual leave.

Managers have an obligation to engage their staff, ensuring that they feel heard and supported, and that their concerns are being acknowledged and held in mind. Some professional groups – for example psychology and psychiatry – might wish to help facilitate discussion and promote more psychologically savvy conversations. Importantly, managerial input should not feel more distant at this time of change and increased risk.

A range of stress-induced mental health difficulties might be expected to be seen in some staff, including anxiety and depression. The PIES system of formal support – proximity, immediacy, expectancy, simplicity – may be usefully invoked.[11] Optimally, rapid formal mental health assistance should be provided for those

who need it, with an expectation of a positive, strengths-based approach aiding staff to return to service. Clear guidance on pathways to access such support should be available and, if possible, psychological and therapeutic staff on site should provide informal opportunities for debrief and discussion. In the UK, during the COVID-19 pandemic, staff with NHS contracts are able to access a suite of national support services, and these should be advertised.

Better-resourced services might wish to allocate specific time to senior mental health professionals to provide direct staff support, from facilitating handovers and emerging stresses to potential one-to-one time.

Conclusion

The challenges of COVID-19 for the prison estate are distinct and changing. Some aspects are more generalised, akin to those experienced elsewhere in society and health care; however, the nature of prisons brings additional difficulties. Business as usual is not viable, and both inmates and staff are increasingly vulnerable.

As has often been repeated in relation to COVID-19, perfect is the enemy of the good; however, whilst resources are stretched, failing to support our staff is a false economy. Presenteeism is a greater burden on organisations than absenteeism, and sickness rates and staff retention will be worse in those organisations which fail to support staff adequately.

We propose that naming these issues locally is essential, identifying the problems for both groups and actively determining positive steps to mitigate them as best as possible. There will be acute difficulties and longer-term ones building up that will manifest post COVID-19. There is evidence on steps to help and an onus on professionals, teams and prisons to implement them.

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ORCID iD

Radha Kothari https://orcid.org/0000-0003-0569-2432

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Radha Kothari[1], Andrew Forrester[2,3], Neil Greenberg[4], Natasha Sarkissian[1] and Derek K Tracy[5,6]

[1]*North London Forensic Services, Barnet, Enfield and Haringey Mental Health Trust, HMP/YOI Pentonville, UK*

[2]*Greater Manchester Mental Health NHS Foundation Trust, UK*

[3]University of Manchester, UK
[4]Health Protection Research Unit in Emergency Preparedness and Respsonse, King's College London, UK
[5]Cognition, Schizophrenia and Imaging Laboratory, Department of Psychosis Studies, the Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK
[6]Oxleas NHS Foundation Trust, UK

Corresponding author: Radha Kothari, North London Forensic Services, HMP/YOI Pentonville, Caledonian Road, London N7 8TT, UK.
Email: radha.kothari@nhs.net