Family intervention in a prison environment: A systematic literature review

ANNA ROBERTS1,2†, JULIANA ONWUMERE1,2†, ANDREW FORRESTER1,2, VYV HUDDY2,3, MAJELLA BYRNE1,2, CATHERINE CAMPBELL1,2, MANUELA JARRETT1,2, PATRICIA PHILLIP1,2 AND LUCIA VALMAGGIA1,2, 1Institute of Psychiatry, Psychology and Neuroscience, King’s College London, London, UK; 2South London and Maudsley NHS Foundation Trust, London, UK; 3University College London, London, UK

ABSTRACT

Background The prison population in England and Wales is approximately 85,000, and elevated rates of mental health difficulties have been reported among the prisoners. Despite frequent recommendations for family interventions to optimise prisoner outcomes, the evidence for its use and impact in prison remain unclear.

Aim The aim of the study is to conduct a systematic review of published literature on family interventions in prisons.

Methods Embase, PsychINFO and Medline were searched using terms for family interventions and for prisoners or young offenders. No limit was imposed on study design, but, for inclusion, we required that papers were written in English and published in peer-reviewed journals.

Results Nine hundred eighty-three titles were retrieved. Twenty-two met criteria for inclusion. Three were case studies, 12 were descriptive, 6 were quasi-experimental and one was a randomised controlled trial. Interventions and study methods were too heterogeneous for meta-analysis. All studies gave positive conclusions about family interventions, but empirical data on effectiveness were slight.

Conclusions Consistency in findings across the wide-ranging studies suggested that family therapies may indeed be helpful for prisoners and their families, so further research is warranted. The fact that a randomised controlled trial proved feasible should encourage researchers to seek more robust data and to determine which form of intervention is effective and in which circumstances. It would also be useful to develop an
Introduction

Since the emergence of family and systemic psychotherapies in the 1960s (Rasheed et al., 2011), a growing body of research has shown the importance and effectiveness of involving families in treatments for a range of relationship issues and health conditions. These include eating disorders, addictions, psychosis, domestic violence and parenting issues (Pinsof and Wynne, 1995; Association for Family Therapy and Systemic Practice, 2015). The importance of working in partnership with families within mental health services is also embedded in government policies (Department of Health, 2011) and international treatment guidelines (Gaebel et al., 2005).

Notwithstanding guidance from professional bodies on terminology (e.g. Association for Family Therapy and Systemic Practice, 2015), different terms are commonly used in the literature to refer to family work – including psycho-educational, family education, family support, family therapy and family interventions. Family treatments comprise several different strategies, which may include forming alliances with family members, helping family members to communicate difficult thoughts and experiences with one another and promoting helpful change in relatives’ beliefs, patterns of behaviour and relating to one another (Pharoah et al., 2010; Association for Family Therapy and Systemic Practice, 2015). Given the lack of agreement on terms used to describe family approaches and the variability in provision across clinical conditions, treatment and settings (Eisler, 2005), for the purpose of this review we have opted to use the unitary term ‘family intervention’ to encompass different terms and approaches.

The important role that families can play in the treatment of individuals with mental health conditions (Meis et al., 2013) has underpinned the development of service initiatives within community settings that integrate greater involvement of families in treatments (Burbach and Stanbridge, 2006). Despite government policy promoting equivalence of care in prisons (HM Inspectorate of Prisons, 2007), however, prison mental health care has enjoyed much less development in implementation of family intervention services (Liddle, 2014). Family interventions could be particularly relevant given the elevated rates of common mental disorders (Singleton et al., 1998; Brugha et al., 2005; Prins, 2014) and schizophrenia spectrum conditions in prisoners (Brugha et al., 2005; Jarrett et al., 2012), the numbers of individuals with severe mental illnesses who access mental health services through the criminal justice system (Ghalli et al., 2013) and the history of offending behaviours recorded in early psychosis samples (Marion-Veyron et al., 2015).
Understanding of the devastating impact on children of parental separation by imprisonment is improving (Murray and Farrington, 2008; Wildeman, 2014). Regardless of mental health needs, imprisonment has a negative impact on family relationships, including reduced access to social support, stigma and shame (Murray, 2005). Reoffending rates are significantly lower amongst individuals who maintain close and supportive familial relationships (Visher and Travis, 2003), including regular family visits (Cluley, 2009). Prison settings can offer an opportunistic environment to engage individuals in treatments (Harvey and Smedley, 2010). Thus, greater use of family interventions in prison is often recommended (Klein et al., 2002).

Aims of the review
Our aim was to identify, summarise and critically evaluate published research on family interventions in a prison environment, for any prisoner irrespective of mental health status.

Our research questions were as follows:

i What are the characteristics of studies that have investigated family interventions in prison populations?
ii What type of family interventions have been delivered and by whom?
iii What outcomes detailing the efficacy and effectiveness of family interventions in a prison population are reported?

Methods
Inclusion and exclusion criteria
A broad classification for ‘family intervention’ was employed. All studies with a reported focus on family functioning and relationships, and either involving family sessions and/or individual interventions that explicitly focused on family relationships, were included. Family interventions amongst all prisoner groups were included.

We included studies only if they had been published in English and in peer-reviewed journals and included (i) participants who were prisoners or young offenders and (ii) had been incarcerated throughout the study period. Exclusion criteria were (i) articles focusing on secure health service settings (mainly because people in such services are detained under mental health legislation, and their release is dependent on their recovery, while release from prison is not; (ii) studies completed with sex offenders alone (as they tend to be under a specific sex offender treatment programme); (iii) studies describing family interventions with offenders in community settings.
Search strategy

The databases Embase, PsycINFO and Medline were searched from inception until April 2015. Studies were identified using the terms ‘family therapy’, or ‘family intervention’ and ‘prisoner’, or ‘delinquent’, or ‘offender’, or ‘juvenile delinquency’. Appropriate truncations and wild cards were used to identify mutation of the terms searched, e.g. prison to search for prison, prisons, prisoner and prisoners.

Subsequently, reference lists of all accepted articles were searched to identify any relevant articles that may have been missed by the electronic search strategy. Grey literature was searched using Google, GoogleScholar and Dissertation Abstracts International to counteract publication bias. In line with the PRISMA statement (Moher et al., 2009), duplicates were removed and online titles and abstracts were reviewed for the remaining articles. Articles that did not meet the inclusion criteria were excluded, and the full text was obtained for potentially eligible articles.

Quality criteria

All articles selected were evaluated to assess methodological rigour, and risk of bias, using an extraction sheet based on the Cochrane Consumers and Communication Review Group data extraction template (http://ccerg.cochrane.org/author-resources). Two independent reviewers (AR and JO) rated the articles, blind to each other, using the extraction sheet. The level of agreement between the raters was 100%.

Figure 1 shows the outcome of the selection process. The database searches initially identified 983 records. After the removal of duplicates and exclusion based on the criteria detailed earlier, 15 studies remained. A manual search of the references of these 15 papers yielded 7 further papers suitable for inclusion in the review. Twenty-two papers in total met criteria for inclusion into the review. Table 1 provides a summary of included studies.

Case reports

There were three case reports reporting a total of 15 different cases, all from the USA and exclusively with male prisoners, and where the focus was on the clinical descriptions (Ostby, 1968; Chaiklin, 1972; Cobean and Power, 1978). Each described their focus as supporting the individual and their family to accept the reality of their situation and promote family adjustment; two used a group family treatment programme (Ostby, 1968; Chaiklin, 1972) and the other an individual intervention with the prisoner and his family unit. Information on who delivered the interventions was limited; Chaiklin (1972) reported facilitation by social
workers, Cobean and Power (1978) listed ‘prison counsellor’ and Otsby (1968) a psychiatric social worker, in consultation with a senior staff psychiatrist.

Indications of the beneficial effects of the interventions were noted by all authors, pointing to their success in establishing adequate family adjustment (Chaiklin, 1972; Cobean and Power, 1978), helping to establish plans for release and facilitating more meaningful modes of interaction (Ostby, 1968). Only one study offered quantitative data on recidivism for prisoners, reporting four of 165 men in receipt of the intervention returned to prison (Chaiklin, 1972).

Descriptive studies

Twelve of the 22 studies were best categorised as descriptive, with their main focus on providing commentaries about the area, description of therapies and discussion of implementation issues. They were from the USA and included male and female adult offenders. Four papers focused on specific subgroups in prison; for example, African American prisoners (King, 1993; Seling, 2003), adolescents with conduct disorder (Keiley, 2002) and incarcerated mothers and caregiving grandmother prisoners (Engstrom, 2008).

Four of these papers detailed the use of multiple-family group interventions (Wilmer et al., 1966; Millard and McLagan, 1972; Keiley, 2002; Engstrom, 2008), two described couples or family therapy (Kaslow, 1978, 1987) and four advocated integration of different interventions in a multi-systems approach (Nash, 1981; Van Voorhis, 1987; King, 1993; Rose et al., 1996).

The remaining papers proposed the introduction of family work as part of an overall rehabilitative effort (Rieger, 1973; Seling, 2003). They described a range of aims for the family interventions, including strengthening family communication and the conflict resolution processes, enhancing stress management skills.
Table 1: Accepted studies in the review

<table>
<thead>
<tr>
<th>Study design</th>
<th>Study</th>
<th>Country</th>
<th>Population/setting</th>
<th>No. of pps*</th>
<th>Gender</th>
<th>Type of family intervention</th>
<th>Who delivered intervention</th>
<th>Format of intervention</th>
<th>Main findings/conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case studies:</td>
<td>Chaiklin (1972)</td>
<td>United States</td>
<td>Prison pre-release programme at a correctional centre</td>
<td>165</td>
<td>Male</td>
<td>Psychosocial assessment and socio-drama groups</td>
<td>Social workers</td>
<td>Prisoner and family work together in groups</td>
<td>Only 4 out of 165 offenders in the programme returned to the correctional system</td>
</tr>
<tr>
<td></td>
<td>Cobean and Power (1978)</td>
<td>United States</td>
<td>Offenders in American prisons</td>
<td>4</td>
<td>Male</td>
<td>Family intervention</td>
<td>Prison counsellor</td>
<td>Family and prisoner seen together</td>
<td>Helped establish family adjustment and assist in re-adapting to family life</td>
</tr>
<tr>
<td></td>
<td>Osby (1968)</td>
<td>United States</td>
<td>Inmates at the California Medical Facility</td>
<td>&gt;10 couples</td>
<td>Male</td>
<td>Multiple-family group intervention</td>
<td>Psychiatric social worker in consultation with senior psychiatrist</td>
<td>Multiple families with at least two members of each family present</td>
<td></td>
</tr>
<tr>
<td>Descriptive:</td>
<td>Engstrom (2008)</td>
<td>United States</td>
<td>Mothers who are incarcerated and caregiving grandmothers</td>
<td>N/S</td>
<td>Female</td>
<td>Multiple-family group intervention</td>
<td>N/S</td>
<td>Multiple families with at least two members of each family</td>
<td>There is a need for effective multigenerational family interventions for incarcerated mothers and caregiving grandmothers</td>
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<tr>
<td></td>
<td>Kaslow (1978)</td>
<td>United States</td>
<td>Offenders in American prisons</td>
<td>N/S</td>
<td>N/S</td>
<td>Marital or family therapy</td>
<td>N/S</td>
<td>Prisoner and spouse/family seen together</td>
<td>Family therapy should be offered 3 months prior to release and continue 3–6 months post-release</td>
</tr>
<tr>
<td></td>
<td>Kaslow (1987)</td>
<td>United States</td>
<td>Offenders in American prisons</td>
<td>N/S</td>
<td>N/S</td>
<td>Conjoint couples therapy or family therapy</td>
<td>N/S</td>
<td>Prisoner and spouse/family seen together</td>
<td>Including family therapy may lead to a more pro-social post-release lifestyle</td>
</tr>
<tr>
<td></td>
<td>Kelley (2002)</td>
<td>United States</td>
<td>Incarcerated adolescents with conduct disorder and their parents</td>
<td>N/S</td>
<td>Male and female</td>
<td>Multiple-family group intervention</td>
<td>Treatment staff with training delivered by authors of paper</td>
<td>Multiple families with at least two members of each family present</td>
<td>Improvement in affect regulation strategies and attachment</td>
</tr>
<tr>
<td></td>
<td>King (1993)</td>
<td>United States</td>
<td>African American prison inmates</td>
<td>N/S</td>
<td>Male</td>
<td>Family support groups, family life education programmes, family</td>
<td>N/S</td>
<td>Family and prisoner receive separate services</td>
<td>Group work is an appropriate intervention method because of the group experience for African Americans</td>
</tr>
<tr>
<td>Study design</td>
<td>Study in</td>
<td>Country</td>
<td>Population/setting</td>
<td>No. of pps*</td>
<td>Gender</td>
<td>Type of family intervention</td>
<td>Who delivered intervention</td>
<td>Format of intervention</td>
<td>Main findings/conclusions</td>
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<tr>
<td>Millard and McLagan</td>
<td>United</td>
<td>Juvenile delinquents committed by the Utah Juvenile Court System</td>
<td>N/S Male and female</td>
<td></td>
<td>Multifamily group therapy</td>
<td>Group workers/therapists</td>
<td>Multiple families with at least two members of each family present</td>
<td>N/S</td>
<td>Parents are more informed and cooperation between parents and the institution is greatly facilitated</td>
</tr>
<tr>
<td>Nash (1981)</td>
<td>United</td>
<td>Prisoners and their families</td>
<td>N/S N/S</td>
<td></td>
<td>Psychosocial intervention and social systems model</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>Counselling needed to help families adjust to the shock and crisis caused by the loss of a family member. Public education and advocacy are also required</td>
</tr>
<tr>
<td>Rieger (1973)</td>
<td>United</td>
<td>Offenders in American prisons</td>
<td>N/S Male</td>
<td></td>
<td>Family therapy</td>
<td>Social workers and prison case workers</td>
<td>N/S</td>
<td>N/S</td>
<td>Conjugal visits and family therapy should be introduced as components of an overall rehabilitative effort</td>
</tr>
<tr>
<td>Rose et al. (1996)</td>
<td>United</td>
<td>Institutionalized juvenile offenders</td>
<td>N/S Male and female</td>
<td></td>
<td>Multi-systems approach</td>
<td>Family worker</td>
<td>Prisoner and family seen together</td>
<td>N/S</td>
<td>Family, group and residential treatment needs to be integrated to offer a multi-systems approach to treatment</td>
</tr>
<tr>
<td>Selling (2003)</td>
<td>United</td>
<td>African American prisoners</td>
<td>N/S N/S</td>
<td></td>
<td>Multidimensional therapeutic approach</td>
<td>N/S</td>
<td>N/S</td>
<td>Prisoner and family need to be seen together</td>
<td>Family therapy is needed to decrease intergenerational crime and imprisonment</td>
</tr>
<tr>
<td>Van Voorh (1987)</td>
<td>United</td>
<td>Offenders in American prisons</td>
<td>N/S N/S</td>
<td></td>
<td>System-level interventions</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>Successful interventions must target social institutions and groups as well as individuals</td>
</tr>
<tr>
<td>Wilmer et al. (1966)</td>
<td>United</td>
<td>Prisoners in a group therapy programme at San Quentin prison</td>
<td>13 Male</td>
<td></td>
<td>Group family counselling</td>
<td>Counsellors, correctional officer, psychiatric nurse and psychiatric consultant</td>
<td>Multiple families with at least two members of each family present</td>
<td>N/S</td>
<td>The family counselling programme helped to strengthen family ties and work out difficulties and misunderstandings prior to the husband’s parole</td>
</tr>
<tr>
<td>Quasi experimental studies:</td>
<td>United</td>
<td>Inmates at an Alabama medium security prison</td>
<td>54 Male</td>
<td></td>
<td>Family life education course</td>
<td>Prison mental health staff</td>
<td>Prisoners complete course</td>
<td>N/S</td>
<td>Narcissism significantly lower and perception of ideal family</td>
</tr>
<tr>
<td>Study design</td>
<td>Study</td>
<td>Country</td>
<td>Population/setting</td>
<td>No. of pps*</td>
<td>Gender</td>
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<td>Who delivered intervention</td>
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<td>Main findings/conclusions</td>
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<td></td>
<td>Fox (1996)</td>
<td>United States</td>
<td>Inmates from a medium risk prison (and their families)</td>
<td>4</td>
<td>2 male</td>
<td>Brief strategic family therapy</td>
<td>Doctoral-level counselling students</td>
<td>Prisoner and family seen by team of four therapists</td>
<td>No family involvement functioning changed towards healthier attitudes</td>
</tr>
<tr>
<td></td>
<td>Hagan and King (1992)</td>
<td>United States</td>
<td>Juvenile offenders in a secure state facility</td>
<td>55</td>
<td>Male</td>
<td>Intensive treatment programme: included family therapy, group therapy and individual psychotherapy</td>
<td>Social worker and two unit youth counsellors. Directed by staff psychologist</td>
<td>Prisoner and family seen together in the home</td>
<td>Effective for families that attended six sessions, indicated by an increase in family functioning Recidivism rates two years after the programme: 49% were not further incarcerated</td>
</tr>
<tr>
<td></td>
<td>Keiley (2007)</td>
<td>United States</td>
<td>Incarcerated adolescents in juvenile correctional institutions</td>
<td>73</td>
<td>43 male</td>
<td>Multiple-family group intervention</td>
<td>Master's level family therapists</td>
<td>Multiple families with at least two members of each family present</td>
<td>Recidivism rate of only 44% (compared with national norm of 65-85%). Significant decline in adolescents' externalising behaviours</td>
</tr>
<tr>
<td></td>
<td>Perkins-Dock (2001)</td>
<td>United States</td>
<td>Juvenile offenders engaged in a 90-day commitment at a detention centre</td>
<td>10</td>
<td>Male</td>
<td>Brief strategic family therapy</td>
<td>Family therapist</td>
<td>Prisoner seen alone by therapist or jointly with family</td>
<td>Incarcerated juvenile offenders experienced change in both the conjoint family intervention and the one-person family intervention</td>
</tr>
<tr>
<td></td>
<td>Shavet et al. (2003)</td>
<td>United States</td>
<td>Incarcerated adolescents in a juvenile justice facility and their parents/guardians</td>
<td>10</td>
<td>7 male</td>
<td>Family Check Up</td>
<td>Bachelor's, Masters, or Doctoral-level staff member</td>
<td>Prisoners and their parent/guardian</td>
<td>Adolescents more confident in ability to resist drug use. Parents more confident in ability to impact their adolescents’ risky behaviour</td>
</tr>
<tr>
<td></td>
<td>Liddle et al. (2011)</td>
<td>United States</td>
<td>Incarcerated adolescents aged 13–17</td>
<td>154</td>
<td>128 male</td>
<td>Multidimensional family therapy – Detention to community</td>
<td>MDFT clinicians</td>
<td>Prisoners and their parent/guardian seen together</td>
<td>Superior treatment enrolment and retention, and higher satisfaction with treatment services in MDFT group.</td>
</tr>
</tbody>
</table>

*Participants.
N/S = not stated; MDFT - Multi Dimensional Family Therapy.
(e.g. Engstrom, 2008), improving the structure and functioning of the family (e.g. Millard and McLagan, 1972) and facilitating open communication and handling readjustment issues (e.g. Kaslow, 1978). Information was again limited on who delivered these interventions, with seven papers failing to record the professional delivering the intervention or only describing them in broad terms such as ‘family worker’ (Rose et al., 1996) ‘treatment staff’ (Keiley, 2002) or ‘group workers’ (Millard and McLagan, 1972). Wilmer et al. (1966) reported the use of counselors, correctional staff and psychiatric nurses.

Two papers within this section offered provisional conclusions on improvements in family ties (Wilmer et al., 1966), and in attachment and affect regulation strategies (Keiley, 2002). They also reported several difficulties in implementing interventions within the prison settings, including collaborating with prison staff (Keiley, 2002), reluctance from families to become involved, financial issues (Millard and McLagan, 1972; Rose et al., 1996) and problematic substance use complicating the intervention (Engstrom, 2008).

Quasi-experimental studies

Six studies were quasi-experimental in design, together including 206 participants, in a range of 4 to 73 participants per study. They were all from the USA, with male and female inmates, and four of them focused on young offenders (Hagan and King, 1992; Perkins-Dock, 2001; Slavet et al., 2005; Keiley, 2007). All studies used a pre–post design, comparing family intervention with no treatment (Bayse et al., 1991), treatment as usual (Hagan and King, 1992) and one-person family intervention (Perkins-Dock, 2001); the remainder did not include comparison groups (Fox, 1996; Slavet et al., 2005; Keiley, 2007).

In terms of approaches, one study used the ‘family check-up’ intervention, which is based on motivational interviewing principles designed to improve parental awareness of risk behaviours in their children and support for implementing interventions to help with these difficulties (Slavet et al., 2005). Two other studies used brief strategic family therapy (Fox, 1996; Perkins-Dock, 2001). The studies using group interventions also used role play techniques alongside cognitive behaviour modification strategies (Hagan and King, 1992; Keiley, 2007), with a focus on improving dysfunctional attachment and affect dysregulation. The remaining study used a psychoeducational intervention based on a cognitive-systems approach (Bayse et al., 1991), emphasising healthy attitudes to family functioning and improving communication and negotiation skills. The interventions were reported as being delivered by a range of professionals – including prison mental health staff (Bayse et al., 1991), social workers (Hagan and King, 1992), Master’s level family therapists (Keiley, 2007) and students (Fox, 1996; Slavet et al., 2005).

Two studies reported reoffending rates as an outcome. Less than half of the young participants in these studies were no longer incarcerated at the 6 month
and 2 year follow-ups (Hagan and King, 1992; Keiley, 2007), a rate of release reported as being considerably lower than the national norm. One study noted that ‘a significant number of individuals’ who received the intervention obtained subsequent convictions and had further contact with the courts, although these new offences were defined as minor in comparison to their original crimes (Hagan and King, 1992). Other outcomes reported included reductions in inmate distress and substance misuse, externalising and internalising problems (Keiley, 2007), significantly lower narcissism scores amongst inmates who completed the family life education course (Bayse et al., 1991) and family outcomes. Examples of the latter included improvements in family functioning and perception of adaptive attitudes (Fox, 1996) and increased parental confidence at post-assessment for influencing their adolescent’s behaviour (Slavet et al., 2005). Keiley (2007) reported improvements in adolescent and caregiver affect regulation from pre-treatment to follow-up. In his comparison of a conjoint and one-person family intervention, Perkins-Dock (2001) found that the conjoint intervention resulted in change of the more family-oriented constructs of cohesion, organisation and home environment, whereas the one-person intervention affected change in the more individually oriented constructs of self-esteem, depression, control and impulsivity.

Important difficulties in the delivery of the family interventions were reported, including problems in providing feedback to offenders and parents (Slavet et al., 2005) and the need to adapt to the prison’s rules (Bayse et al., 1991).

**Randomised controlled trial**

The review yielded only one randomised controlled trial (RCT). This was conducted at two short-term detention facilities in USA, with 154 young men and women (Liddle et al., 2011). The study used an adapted form of multidimensional family therapy (MDFT) (Liddle, 2010) delivered by MDFT-trained clinicians and compared recipients with a group receiving ‘enhanced services as usual’. Eligible participants were aged between 13 and 17 years, incarcerated with known substance misuse problems, and co-resident with at least one parent that was willing to engage with active intervention; 90% of 170 potential participants referred agreed to take part. They were assessed using a combination of dialogue-based diagnostic interviews. Treatment fidelity was measured in terms of the required number of sessions to constitute ‘a dose’, defined *a priori*. The random allocation procedure was not reported. There was superior treatment enrolment and retention in the MDFT arm, with 87% of adolescents and their families retained in treatment for 3 months or more compared with only 23% of adolescents in the enhanced services as usual. Participants reported higher satisfaction with MDFT. Further, clinicians delivering MDFT reported greater collaboration with juvenile justice professionals which, in itself, was associated with decreases
in substance use and delinquency in the community. Ninety-two percent of participants receiving MDFT were identified as having received the full intervention ‘dose’. In the enhanced services as usual group, only 24% completed as intended. There were no measures of reoffending. Difficulties in implementing family interventions in the prison environment were highlighted, including the obstacles in meeting with families in crowded, security conscious settings. The authors highlight the need for further work to outline specific implementation issues.

Discussion

We sought to identify and evaluate studies of the involvement of families in the treatment of prisoners. Specifically, we investigated the type of family intervention undertaken, the professionals delivering these interventions and reported indications of their impact. Twenty-two papers were identified from the review process. All reviewed studies were from the USA and most merely described the intervention implemented. Several different models of family intervention have been tried in prisons, but there are limited data on the specialist skills and training profile of professionals required or involved. Further work reporting on distinctions between manualised and more individually sensitive interventions are indicated.

All included studies pointed to or commented on the beneficial effects of family interventions with prisoners, but only two studies identified reductions in reoffending rates as outcomes amongst prisoners who had engaged in family intervention (Hagan and King, 1992; Keiley, 2007) and observed evidence in support of such work was scarce. Although many papers made recommendations for family services in prison, there appeared to have been minimal advances in the body of research undertaken in the 1970s. It was of interest that several studies referred to themselves as ‘pilot studies’ (e.g. Perkins-Dock, 2001; Keiley, 2002, 2007) or made recommendations for future studies to build on previous research (e.g. Hagan and King, 1992), yet there was no published evidence of these developments having occurred.

The lack of empirical research in this area may reflect the problems in delivering interventions within a prison environment. Common difficulties noted by several studies included limited engagement with families, high participant drop-out rates, prisoner concerns about confidentiality and practical barriers, such as lack of therapeutic room space or geographical distance that families travelled to visit the prison. Prisons are described as low-trust environments, which can negatively impact on prisoner willingness to engage in therapy (Harvey and Smedley, 2010). This is particularly the case if they have had previous negative experiences of working with individuals in perceived positions of authority, which may affect their ability to establish positive and trusting relationships. Shelton (2010) reports that there are potential conflicts in the relationship
between healthcare and custodial staff. The brief time spent in prisons, with prisoners often being dispersed to other institutions at short notice, can also pose a barrier to effective therapeutic relationships.

**Limitations and concluding remarks**

There were serious limitations as to what we could achieve with this review. First, we found little empirical data in the selected papers – and there was little consistency in study methods. The papers were comprised of individual case reports, descriptive and quasi-experimental studies and one RCT. Secondly, no causal relationships could be established as to the efficacy and effectiveness of family interventions within a prison population. Although papers reported on the positive impact of families being involved in treatment, there were several sample, design and reporting limitations that were likely to have impacted on the results and had implications for their generalisability. Thirdly, all studies were undertaken with US samples. Given the differences in criminal systems between the USA and other countries (e.g. Kaufman, 1980), their relevance, applicability and generalisability to prison populations elsewhere remains unclear.

In one sense, the heterogeneity of the studies could be seen as an advantage, since the positive impact of family interventions came through regardless of methods of study. Notwithstanding, the richness and value of different data categories, a greater focus on generating larger datasets employing experimental designs that facilitate hypothesis testing and greater generalisation, are indicated. Too many of the studies offered the evidence of the findings. In this context, Joan McCord’s studies of counselling for young delinquents are telling; the counselled and counsellors were confident about the value of what they were doing, but on empirical measures, including re-offending, the counselled group did less well than the controls (McCord, 2003; McCord and McCord, 1959). In the current financial climate, an economic analysis of delivering the intervention would be essential, as would the inclusion of follow-up data on recidivism rates and service usage, and, of course, ratings of the quality of relationships between the prisoner and his family members.

The recent work from Dodge et al. (2015) and their innovative RCT highlights the likely value of further research, suggesting that there is merit in early intervention and proactive approaches to reducing the risk of future offending and social exclusion amongst high risk groups. Services along these lines are being developed in the voluntary sector, providing help and information on coping with the impact of imprisonment on families and preparing for the release and resettlement of a family member from prison (Action for Prisoners’ Families, 2013), so it is vital to know for sure that this is money well spent. There is a great deal that more works are required not only to ensure that family interventions can play an appropriate role in optimising positive outcomes for prisoners, including those with mental disorders, their families and ultimately wider society.
but also to help provide guidance on which kinds of interventions and which levels of expertise will be required for different subgroups.

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Address correspondence to: Lucia Valmaggia, Department of Psychology, King’s College London, Institute of Psychiatry, De Crespigny Park (PO77), London, SE5 8AF, UK. E-mail: lucia.valmaggia@kcl.ac.uk

†=Joint first author