Psychological Therapy for At Risk Mental State for Psychosis in a Prison Setting: A Case

Study

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Abstract

There is a very high prevalence of psychosis in UK prisons; moreover, a significant number of prisoners meet risk criteria for psychosis. We provide a report of psychological therapy with a client who met risk criteria for psychosis that took place in a prison setting. We applied a self-reflectivity framework when formulating the case, which we believe allowed the flexibility required by the presenting problem and, crucially, the demands of the setting. This approach had two key advantages. Firstly, it enabled the therapist to tailor the work to the according to the level of self-reflectivity demonstrated by the client. We believe this ensured that the therapist interventions were understood by him. Secondly, it helped prepare, and choose a timely juncture, for a move onto more traditional interventions for managing the client's main presenting problem. We believe this work represents progress in working with clients in this complex and demanding setting.

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Introduction

There is a higher prevalence of mental health problems in prison populations compared to the general population (Brugha *et al.*, 2005). Evidence from screening at reception to a UK prison suggests there is also a significant number of cases of undiagnosed first episode psychosis in the prison population, with one estimate being 3% and a larger number of people, estimated at 5%, meeting At Risk Mental State (ARMS) criteria for psychosis (Jarrett *et al.*, 2012). The aim of this paper is to provide an example of psychotherapeutic work with a client meeting criteria for an at risk mental state for psychosis while detained in a prison. The second aim is to illustrate the challenges inherent in delivering psychological therapy in this setting and how they may be overcome.

Once an individual has met ARMS criteria the probability of transition to full-fledged psychosis within a 12 to 36 month period has been estimated to be up to 30% in studies world-wide (Fusar-Poli *et al.*, 2012). These data provide a clear justification for the implementation of an early psychosis detection and intervention service in a prison with the aim of reducing risk, distress, and functional impairment. A further reason for implementing early detection and intervention in this setting is that the prison population, both in the UK and elsewhere, is characterized by a large majority proportion of young men from disadvantaged backgrounds who typically do not engage with mental health services (Rathod, Kingdon,, Phiri, & Gobbi, 2010). Some of the barriers to help seeking in this group include isolation, lack of knowledge about where help is offered, mistrust of mental health services motives, expectations of racism, and stigma (Rathod *et al.*, 2010, Rathod *et al.*, 2013). Early detection screening allows for help acceptance rather than help seeking--a unique route to meet the need for care that otherwise would not be available. Screening provides the context

for the early detection service, which allows for expectations for help to be framed by the clinician; this process may counteract clients' negative expectations of psychotherapeutic services.

Beyond the high prevalence of psychosis in the prison population there are several other reasons for introducing a service of this kind. First, when considering the notion of risk for psychosis in a prison population it is important to remember that prisons are "low trust" (Harvey & Smedley, 2010) and stressful environments. This is evident in the high frequency of events such as tense altercations, unexplained changes in regime, witnessing others self-harm, coercion or bullying between prisoners, and the anticipation of awaiting trial or awaiting the end of a long sentence. This context is therefore highly stressful and is likely to exacerbate emerging anomalous experiences or feelings of interpersonal threat. Within a stress vulnerability framework (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen 1986, Zubin & Spring, 1977), the prison environment may interact with an inherent biological predisposition to psychosis and lead to the emergence of ARMS symptoms for the first time. Psychological therapy for this group has shown benefits in the general population (Hutton & Taylor, 2014) and is warranted in this setting.

There are also clear points of departure in a prison setting from psychological therapy usually offered in the community to help-seeking individuals with an at risk mental state for psychosis. The psychosocial experience of imprisonment is not only one of stress and intrusion but also of deprivation of needs such as romantic and family relationships, materials to meet basic personal needs, information, autonomy, and a range of other similar factors (Harvey & Smedley, 2010). In the UK, these deprivations may occur directly via the standard UK Prison Service IEP (Incentives and Earned Privileges) regime in an attempt to induce appropriate behavior and broader discipline. This reflects the need for prison institutions to promote a security agenda and has consequences for the conditions of psychotherapeutic

work. Clients adopt strategies to cope in this environment that may run counter to the state of mind needed for productive therapy. One strategy is to "get on with it" - keep busy and distract— which may be partially effective at managing distress but also diminishes the opportunities for reflection crucial to psychological therapy (Harvey & Smedley, 2010).

Prisons are intense social environments characterized by constant interaction with others: an average UK Prison Service cell space for two prisoners is 6ft by 8 ft (1m 80cm by 2m 40cm). In UK prisons a typical cell contains a bunk bed, small desk, small storage, small TV, sink and WC. For privacy, a curtain can be drawn when using the WC. Cells are routinely shared with strangers and all services - washing, eating, exercise, education, prayer, and visits from significant others - are communal. A typical prison wing accommodates 200 to 300 prisoners and there is constant background noise (shouting, banging, and alerts).

There has been an effort to increase access to psychological therapies in UK prisons (Forrester et al., 2014). The most commonly used therapy approach in this new initiative - Cognitive Behavioral Therapy (CBT) – assumes that clients are willing or able to reflect on relevant cognitions or emotions associated with key events (Oathamshaw & Haddock, 2006), an aspect of metacognition termed self-reflectivity (Lysaker *et al.*, 2011). However, as noted above, the prison environment is not conducive to self-reflectivity, making conventional CBT a challenge (Harvey & Smedley, 2010). Furthermore, the clients referred to us were at an increased risk for psychosis and there is evidence for disturbance in self-reflectivity from initial onset to more established psychosis (Vohs *et al.*, 2014).

For these reasons the initial approach we took to therapy was informed by a framework for working with clients with psychosis described by Lysaker *et al.* (2011). This framework suggests there are levels of self-reflectivity: at the most basic level, clients understand they have thoughts that are their own; at a higher level, clients are able differentiate between characteristics of thoughts (such as plans, decisions, or desires); at still

higher levels, they are able to understand that these thoughts might be fallible and may contrast with the social world they inhabit. This conceptualization is useful for informing psychological work with prisoners as it allows therapy to naturally find a level of self-reflectivity that the client is willing and able to manage within the challenges of the environment; furthermore, it does not push clients towards acts of self-reflectivity that they are unable to manage.

The case study that follows is an example of the type of complexity that therapists face when working with people with emerging psychosis in this context. It also reflects how our approach was informed, fruitfully we believe, by metacognitive conceptualization of psychological therapy with people with psychosis. The initial stage of therapy involved engaging the client in a discussion that allowed for a degree of self-reflection. The aims of this were to explore the client's experience of imprisonment, attempt to establish how this bisected past experiences, and understand how this knowledge could be used to cope with the distress and deprivations of the environment the client found himself in. This then allowed for targeted work using more conventional CBT techniques to manage outbursts of emotion.

Case Illustration

Max is a white British man in his early 30s who had grown up in a disturbed context. He stated he was not close to his parents as his father had spells in prison and his mother had several other children to care for. He also described frequent fights and tensions between siblings. Following his first custodial sentence for theft in adolescence, Max had gone onto spend much of his adult life in prison for recurrent convictions for theft, including his current spell in prison. The social environment he grew up in outside of family was dominated by gang activity; there were few areas of the city he grew up he could inhabit because of a risk of assault. Nevertheless, Max stated that he had learned to "survive". He described how he

had intimate relationships with women in the past and had one daughter, whom he was estranged from, a situation that appeared to cause him some distress. At assessment, he wasn't able or willing to elaborate on his emotional reactions to this estrangement.

During the initial screening and assessment for the early psychosis detection service at the prison, Max screened positive for an at risk mental state (ARMS). This was established using an initial screening tool for emerging mental health problems (see (Jarrett *et al.*, 2012) which triggered a further assessment using the following tools: Comprehensive Assessment of the At-Risk Mental State (CAARMS; Yung *et al.*, 2005) which screens for psychopathology indicative of the imminent development of a first-episode psychotic disorder ; and the personality module of the Structured Clinical Interview for DSM-IV Disorders (SCID; First, Spitzer, Gibbon & Williams, 2002). Max met criteria for an At Risk Mental State on the attenuated positive symptoms scale of the CAARMS. In response to questions on the Unusual Thought Content scale, he reported referential ideas that he received messages when listening to the radio. He believed these messages were relevant to him because radio programs always mentioned another part of the UK where he used to live and where his children live. Max also felt that those transmitting the messages were intending them specifically for him. He also reported that he felt others knew his thoughts and he responded to this by asking other people how they knew. In response to the Non Bizarre Ideas scale he stated that others were "out to get" him. He stated that officers deliberately disturbed his daily routine and that they changed his pattern of visits so that he would miss seeing family, leaving him feeling tortured by them. These experiences had first emerged whilst in prison in the year prior to contact with the ARMS service.

Therapy Assessment Measures

Max was assessed pre and post therapy using the Patient Health Questionnaire-9 (PHQ9; (Kroenke, Spitzer, & Williams, 2001) and the Generalized Anxiety Disorder Assessment-7 (GAD7; (Spitzer, Kroenke, Williams, & Lowe, 2006)). These brief measures were employed by the service for pragmatic reasons as prisoners in the UK show a reading age in the range 10-12 and completion of long detailed instruments can be time consuming for service users and risk disengagement in this setting.

Initial Case Formulation

As noted above, Max met criteria for ARMS on the attenuated positive symptom criteria of the CAARMS used to assess risk for psychosis. There was, however, greater complexity to his presentation and we considered the possibility of comorbid personality disorder of either a paranoid or schizotypal type. However, at interview it appeared his experiences were relatively recent and did not show the pervasiveness that would be expected in the case of an Axis II disorder. Previous research has found a high level of antisocial personality disorder (ASPD) in incarcerated populations (Singleton & Gatward, 1998); Max showed some features consistent with ASPD, including failure to conform to social norms, impulsivity, and irritability. However, we felt the most significant aspect of his current presentation was ARMS and our initial approach was consistent with this. In addition, we took the view that further structured assessment would compromise the fragile engagement we had established.

It was apparent that Max was highly perplexed by the recent change he had noticed in himself. He attributed this to the actions of others, showing a hostility bias (Combs *et al.*, 2009) and other-blaming attributional style (Bentall *et al.*, 1994). However, at a more fundamental level, Max narrated events on which these appraisals were based as plain perceptions with limited evidence of self-reflectivity. The initial phase of work therefore

aimed to provide Max with an opportunity to tell a story about his life, which initially

focused on how he came to be in prison and what his experience of this was at the time. The

therapist's (VH) primary aims at this point were to encourage Max to tell his story and to

observe the acts of reflectivity that emerged.

Initial Phase of Intervention

The nature of the environment challenged the basic conditions necessary for

psychological therapy to take place. A private space for a confidential conversations is scarce

in prison as a result of demand from a range of agencies – probation , substance misuse,

education, or resettlement services – so we arranged for Max to visit healthcare for planned

weekly appointments. These were somewhat disrupted by unexpected security lockdowns or

a failure to get correct information that the appointment was taking place. It was clear to the

therapists that the short walk from the wing where Max resided to the healthcare block was

challenging for therapy because other prisoners would observe who was going to healthcare

and comment. For example, Max stated that one of his peers just before our session had said,

"you going to one flew over the cuckoo nest," so evidently he was likely to experience stigma

about seeking help. Nonetheless, Max attended six initial sessions where he was able to

elaborate on his experiences of imprisonment and of anomalous experiences that he reported

in the initial assessment.

The most prominent feature of the initial sessions was Max's concrete descriptions of

how he felt others were unfairly treating and persecuting him. Examples of what he perceived

as persecution included the belief that his mail was deliberately lost, that (as noted earlier)

family visits changed so that he could not see family, and that canteen staff were "interfering"

with his food. There was limited time in the session for any other topics to be discussed,

including completion of measures. The experiences he was willing to discuss were narrated as monologues, for example:

> Max: It's too much. Visit times are always changing without any notice. They doing it to wind me up, it happens every time. Letters get lost - they just throw them in the bin. They're trying to break me. They're trying to drive me mad.

Max described his experiences in terms of immediate perceptions with no reference to memories of related experiences or to ambiguity of his, or indeed, other peoples' intentions. Reports from the prison staff indicated that Max was verbally aggressive to them and this led to his being disciplined for verbally abusing a female member of prison staff. Feedback from the staff indicated that these incidents were triggered by minor events, such as an officer looking in Max's direction. Within therapy sessions Max's agitated state of mind was obvious and the therapist was careful to ask questions that encouraged labelling of the experiences as thoughts.

> Therapist: What do you make of having these thoughts?
>
> Max: I'm going to have to do something. Something's gotta happen now. I'm going to lose it man. It can't keep going on like this. They're trying to drive me mad. I'm telling you. They are - it's getting too much now. I'm going to bust - I can't stand it.

The therapist persisted steadily with limited but focused questioning, often allowing extended periods to pass whilst Max talked before continuing with statements that again framed these experiences in the context of thoughts. As the work progressed, examples of greater self-reflectivity became apparent, as can be seen in the following example in response to the same question:

> Therapist: What do you make of having these thoughts?

Max. I think a bit crazy sometimes. I think maybe I am going mad. I can't take it no more.

Therapist: You're having a thought that you might be going mad.

Max: Yeah. It could end up with losing control, smashing someone.

Therapist: You are imagining lashing out - could you tell me a bit more?

Max: I don't want that. I don't want to get days added [to custodial sentence]. I want to see my daughter again.

Max demonstrated some understanding of the consequences of "losing control" in terms of days added to his sentence. The therapist's reflection, "you are imagining lashing out," possibly provided an opportunity for Max to consider the consequences of his actions and may have encouraged a more reflective statement regarding the negative consequences of "smashing someone". Max demonstrated some development from very restricted narratives of persecution by others with a narrow range of retaliatory responses available to him, towards narratives in which he was uncertain how he would respond because of potential consequences.

The therapist also attempted to frame Max's experiences in the context of an environment in which his needs conflicted with the regime's rules. This theme became evident when Max began to talk of moving to a single cell. Single cells are not routinely provided for prisoners because shared cells are viewed as safer as they allow for cellmates to raise an alarm if someone is seemingly at risk. His frustration provided an initial frame for discussions that referred to his emotions. Max begun to note that not having his needs met resulted in "stress". It appeared that term was key to elaborating a richer narrative of emotion for Max, for example:

Max: This place stresses me too much. I can't deal with it. I've got to get shipped out [moved to another prison].

Therapist: How about now? How do you find talking in these sessions?

Max: It helps to get things off my chest, to talk, I feel better afterwards.

Therapist: So you notice a difference in how you feel between the end of a session and the start. How does that work?

Max: Maybe talking here can help me let off steam.

This episode reflected a greater willingness and ability on Max's part to elaborate on his experience of emotion.

The initial phase of intervention encouraged Max to tell his story of his life in prison in order to determine his level of self-reflectivity. The work was successful in these aims. Max was initially highly concrete, delivering monologues emphasizing persecution and discrimination where his actions focused on either escaping from, or even attacking, others whom he perceived had wronged him. As the work progressed, Max began to talk about his experiences of imprisonment together with emotions that accompanied them, namely "stress". Finally, he began to describe changes in his experience of "stress" that allowed for a steadily greater range of intensity of this emotion. Max also became much more settled in the wing of the prison in which he resided and began to establish a routine of activities, such as playing pool or dominoes with other prisoners.

It was at this stage that we believed that Max was capable of acts of reflectivity required by conventional CBT. This enabled us to set the conditions for introducing more structured CBT techniques where work is more explicitly focused on a problem agreed upon with the therapist. At this point, another therapist (LV) took Max on for the second phase of therapy.

At this time, Max felt able complete the standard outcome measures used by the service: he scored a total of 22 on the Patient Health Questionnaire-9 (PHQ9), indicating a severe level of depression. On the Generalized Anxiety Disorder Assessment-7 (GAD7) his score was 21, indicating a severe level of anxiety. Taken together, these results were consistent with the overall high level of emotional disturbance experienced by Max that resulted from his appraisals of threat and danger.

Later Phase of Intervention

As the account above shows, by the end of the first phase of therapy Max was able to better articulate the emotions he experienced in his daily life. With his therapist's help, Max indicated that others were trying to harm him and that this feeling upset him. Further work helped him identify this emotion more specifically as anger. Early in the second phase of treatment Max made clear that anger was something he wanted help with and could be a reasonable goal for therapy. The therapist took a conventional CBT approach to anger management, initially identifying a broad range of the events where Max felt that people were deliberately trying to upset him.

Therapist: We can start by making a list of the situations that get you going and make you angry. You know that push your buttons? What is the first thing that comes to mind?

Max: People always ask me, "how are you?"--that pisses me off. I mean I don't even know them… like prison officers for example… what's it to them how I feel?"

Therapist: Ok, let me write that down, 'people asking, 'how are you?'. Great, good example. Can you think about any other situation?

In the session, Max was able to identify a number of upsetting situations that he and the therapist placed into a hierarchy of situations--from the least to the most upsetting. The rating was made on the degree of "upset" as this is the term Max chose to describe his emotional state across the situations and allowed us to work in his language. The aim of this was to identify a point where Max felt no longer in control of his actions - or a "point of no return". The therapist next asked him to rate each situation on a scale from 0 to 100, where 0 is not upset at all and 100 is extremely upset (see Table 1).

Following this, the therapist asked Max to think about at what score he felt he was at risk of "losing control":

Therapist: Max, I was wondering, you know we all have a point when we feel irritated, but can still control it, and then there is a point when we really lose it, say a 'point of no return.' Where do you think your point of no return is?

Max: Mmm, … I guess around 60, yes after 60 it's gone. It's too late then, all tensed up, and it takes ages for me to calm down again.

Therapist: Ok, 60. So shall we say that we aim to get most situations under 40 so that you have enough room to cool down and not lose it if you do not want to? Also, we can work in finding out what signals you have that show that you are going over 50 so that if you can feel it coming, for example your body tensing up.

Identification of an experience of a "point of no return" was a key act of self-reflection. It enabled the next stage of the work that involved role-playing of specific experiences with the therapist. Given that earlier in therapy Max had stated that he didn't understand why others acted in the way they did towards him, role playing was a particularly powerful technique as it allowed Max to experience, and slow down, the events that had

occurred and discuss these with the therapist. It also allowed the therapist to role-play the various responses to scenarios Max recollected. For example, in the most upsetting scenario he identified a situation where he had used abusive language in an interaction with a prison officer. At this stage very good rapport had been established, and in the context of extensive preparatory work, Max and the therapist were able to role-play parts of this interaction. Max then had the opportunity to observe his actions and acknowledged they could be experienced as hostile by other people. Placing this work in the context of the meta cognitive framework (Lysaker *et al.*, 2011), Max was able to see his reactions to events and the choices he makes as being fallible and open to change. This led to discussions, with the therapist, of alternative actions, such as changing the language he used. At each session the therapist asked Max to re-rate how upset at was during the events. The scores decreased slowly and after 12 sessions Max's ratings, for all levels in the hierarchy, had reduced by at least 50%. This can be seen in Table 1 where ratings early in therapy are shown in the left hand column and after 12 sessions are shown in the right hand column.

Outcome

Before his release into the community, standard assessment measures were repeated. As noted earlier, emotional disturbance – both anxiety and depression – were prominent in Max's presentation at the first time measures were taken. As noted above, Max scored a total of 22 on the Patient Health Questionnaire-9 (PHQ9) at the beginning of the second phase of the intervention. This score had fallen to 11 at the end of the intervention, a reduction of 11 points, which represents a reliable but not clinically significant change (Jacobson & Truax, 1991) based on the upper end of a normative sample (Kroenke *et al.*, 2001). On the Generalized Anxiety Disorder Assessment-7 (GAD7) his end-of-therapy score was 14, representing a reduction of 7 points from the start of therapy. Again, this indicates a reliable

but not clinically significant change with respect to a normative sample (Loewe *et al.*, 2008). In terms of his anger, ratings indicated a reduction in the intensity of anger in response to situations Max had identified as problematic. During the last session he also mentioned another encounter he had prior to his release, with his probation officer, in which he was able to communicate without being hostile. A drawback of this report is we did not employ a standardized measure of anger but, as noted above, our service policy was to place a minimum assessment burden on clients.

The service also administrates a brief "Service Satisfaction questionnaire' ratings (0 to 10) on the following dimensions: "Overall how satisfied are you with the service you received?"; "How much did you feel the service helped you with your problems?"; and "How likely would you be to recommend our service to someone in a similar position to yourself?" Max's overall average rating was 9, indicating a high level of satisfaction.

Follow-up

Four months after release Max came back to prison—he had failed to report to his probation officer according to the required pattern of appointments. When back in prison, Max stopped a member of the team on one of the prison wings to greet him and let him know he was back. When the therapist went to see him, he said he was "still doing well", adding that he did not require any further input from the team and that he would contact us if needed. Although his return to prison was disappointing, it could be construed to be a satisfactory outcome. That is, Max's return was not based on a serious offense involving violence or aggression.

Clinical Practices and Summary

We set out to establish if psychological intervention with a client meeting criteria for risk for psychosis was feasible in a prison setting and how this practice could be tailored to meet the needs of the client. There is an everyday notion that prison provides time to think, one that was memorably articulated by the character Ellis Boyd 'Red' Redding in the classic movie, *Shawshank Redemption*: *"When those bars slam home, that's when you know it's for real, a whole life blown away in the blink of an eye. Nothing left but all the time in the world to think about it."*

This notion is, however, inconsistent with clinical perspectives gained from working with people experiencing mental health problems in prison that instead emphasize an apparent lack of space for thought and reflection. This may partly result from the setting: as noted earlier, prisons are inherently "low trust" environments (Harvey & Smedley, 2010) where sharing thoughts with mental health services or other inmates is fraught with danger as it could reveal vulnerability. The challenge for therapists therefore is to provide a space where self-reflection is possible. The current case study describes how an individual entered psychological therapy describing his experiences as plain perceptions that, to him, seemed to require an extreme response. As therapy progressed, Max began to relate his experiences more often in the first person; he also began to describe experiences of doubt and show some appreciation of others' experience. In this phase of therapy, Max began to make sense of experiences and we believe this necessarily occurred prior to work on regulating emotions. The latter only became feasible when there was sufficiently detailed context of intention and meaning for Max to interweave his emotional responses. We found discussions about emotion without sufficient context yielded only sparse, disjointed, and threatening frames for emotion and this appeared to shut down Max's reflective capacity.

The reflectivity framework we used allowed us to formulate flexible and achievable therapeutic aims—especially important when working with clients who demonstrate limited self-reflectivity. Rather than experiencing Max's initial difficulty with identifying thoughts as a sign the therapy was not going well, we used this information to assess the level of self-reflection Max was capable of. Furthermore, it provided us insight on how specifically to respond at the level at which Max was able to understand and engage with the therapist. Given Max's extremely agitated state of mind during the initial sessions, simple interventions, such as, "you are having a thought that…" framed Max's statements and appeared to foster a better working alliance.

Separating self-reflectivity into stages earlier in therapy also enabled us to monitor signs of progress, such as noticing when Max began to move from descriptions of experiences as plain perceptions towards more subjective characterizations of experience with the possibility of doubt. This was an iterative process because Max moved between levels of self-reflexivity according to the theme he was narrating. Talking about more distressing themes affected his self-reflectivity. The therapist responded accordingly, with appropriate interventions.

Finally, the progress made in the early stages of self-reflectivity allowed Max to identify a goal to work on in his later meetings with the therapist. We were able to use Max's willingness to engage in sessions focused on "telling his story" as a means to identify and experiences that bothered him and that he would like to change. This was a clear sign that he felt that his mind was not as it should be and that, perhaps, therapy might be able to help him with this. This state of mind is essential for productive work in conventional CBT but in this setting is frequently not the state the people first entering therapy in this setting are in.

A drawback of this report is we did not employ a standardized measure of anger, which undermines the interpretation of the anger hierarchy that was used. However, as noted

above, our service policy was to place a minimum assessment burden on clients. In addition, subsequent research and case studies will be needed to determine if this type of therapy can be generalized to people from diverse ethnic backgrounds and/or to women who also make up a substantial proportion of the prison population in the UK. This work should also involve studies using consecutive case designs to further elaborate the practice described here and randomized controlled trials to confirm the effectiveness of this approach for this setting.

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Table 1 Hierarchy of "upsetting" situations rated at therapy session 6 and 12 using a scale of

0 (not upset at all) to 100 (extremely upset)

What happens	Session 6	Session 12
Overfriendly, like they know me and ask for something	10	0
Ask me in a rude way (give me that!)	15	0-5
Look at me, look away and talk	25	0-5
Look at me look away and laugh	35	5
Funny look (Look at me and look away in a shifty way)	50	15
Not doing something they said they would do	70	0-10
Overfriendly (touching me)	80	30
Keep asking me 'are you all right?'	85	0-15
Asking about my Family	90	30
Intimidating attitude (staring me down)	95	20
Women in authority position telling me to do things in a rude way (police, probation, drugs workers, housing officers etc)	100	40