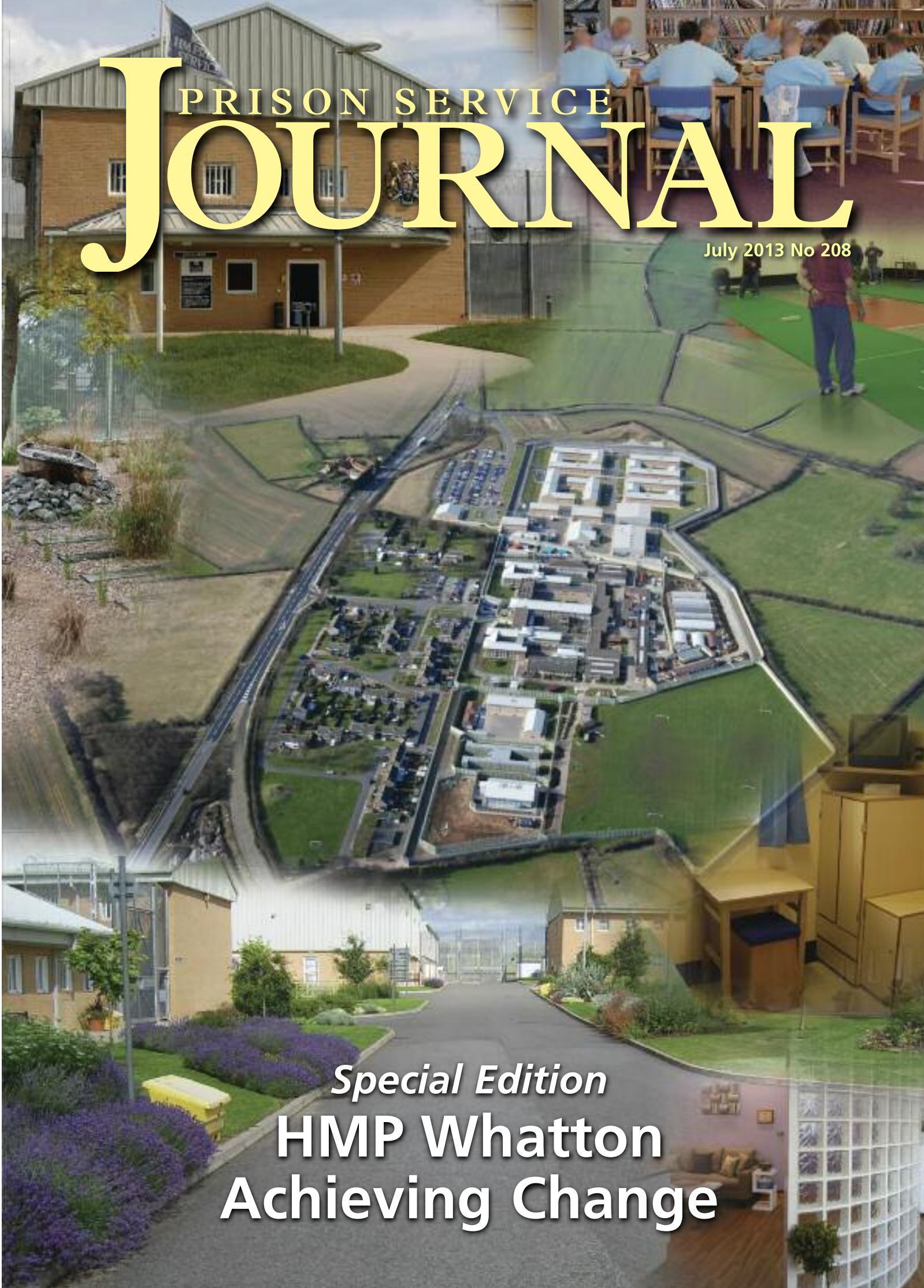

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Special Edition

HMP Whatton Achieving Change

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Editorial Comment

This special edition of *Prison Service Journal* focuses on the work of HMP Whatton, a prison which specialises in the management of men who have committed sexual offences.

There are around 10,500 people in the prison system convicted of sexual offences, almost 15 per cent of the sentenced prisoner population[1]. They are a group who have increasingly been the subject of public and political concern, being characterised as the *'the hate figure of our time'*[2]. This edition details the professional response to the management and treatment of sex offenders, as such eschewing the emotive responses that have characterised much public debate and instead taking a more evidence-based and rational approach to a controversial and challenging subject.

HMP Whatton was originally built in 1966 as a detention centre for boys and for much of its history was a young offender institution. In 1990 it became an adult male category C training prison and over time developed a specialist role for men who have committed sexual offences. Its population more than doubled in early 2006 with a major expansion. It now holds over 800 men, all of whom have committed sexual offences, approximately 70 per cent of the population have child victims and the remainder adult victims.

This special edition provides an in-depth focus on the complex and successful work of HMP Whatton. The edition opens with an article by Dr Nicholas Blagden from Nottingham Trent University and Karen Thorne, a chartered psychologist at HMP Whatton, which reports on a mixed-methods study of the therapeutic and rehabilitative 'climate' in the prison. This study suggests that a progressive and positive culture has been created and maintained that enables change. This is followed by Alison Ievins from the University of Cambridge who offers a sociological study of HMP Whatton highlighting that there are some similarities but also significant differences between the culture of HMP Whatton and that of other prisons. She accounts for these differences not only in the fact that the population of the prison are distinct, but also in the culture and approach of the organisation.

The remaining articles focus on specific issues and groups within HMP Whatton. Rebecca Lievesley, Belinda Winder, Helen Elliott, Adarsh Kaul, Karen Thorne and Kerensa Hocken offer a sober account of the use of medication in the treatment and management of deviant sexual arousal and behaviour. This is an issue that has received salacious and polarised coverage, but this research provides a more balanced, evidence-based account of the innovative work at the prison. A range of specific groups are discussed in greater detail in subsequent articles including a thoughtful descriptive account of the strategic development of a disability strategy by Elizabeth Dunn, Karen Thorne and Kerensa Hocken. This is followed by Kerensa Hocken's detailed and practical discussion of techniques to improve the risk assessment of those with intellectual disability. There is a fascinating description of the development of a sex offender treatment programme for deaf prisoners by Nicola Payne and Helen O'Connor, which reveals the subtlety and complexity of undertaking such a task. Lynn Saunders, Governor of HMP Whatton, discusses the work to provide services to large numbers of older prisoners, including those who will die in prison. She argues that this work is not only important in itself, but also for what it reveals about the wider organisational culture and values. Finally, Dr Ron Harper and Deborah Franks describe how the benefits of counselling psychology can support and enhance the rehabilitative work of HMP Whatton.

Together, these articles illustrate that HMP Whatton has become an innovative, imaginative and leading service in the treatment and management of men who have committed sexual offences. In the most recent HM Inspectorate of Prisons report[3], it was recognised that, *'Whatton is a prison with a clear purpose and function'*, in which *'progress had continued and safety and respect outcomes …were good'*. It went on to say that *'A culture of respect was evident throughout the prison'* and that *'Relationships between staff and prisoners were excellent'*. In relation to its rehabilitative work, it was assessed that, *'The prison's key purpose, the management of sex offenders, was linked directly to the quality and range of its offending behaviour work. Much of this was excellent. Programmes appeared to be well managed and it was clear that the prison was seeking to respond to need'*.

The success of HMP Whatton with a challenging and complex population deserves closer consideration and offers the opportunity for others to learn. It is intended that this edition of *Prison Service Journal* provides exactly that consideration and opportunity.

1. https://www.gov.uk/government/publications/offender-management-statistics-quarterly--2
2. Thomas, T. (2005) *Sex crime: Sex offending and society* Cullompton: Willan.
3. HM Inspectorate of Prisons (2012) *Report on an announced inspection of HMP Whatton 30 January – 3 February 2012 by HM Chief Inspector of Prisons* London: HM Inspectorate of Prisons.

HMP Whatton — A Prison of Change

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Introduction

This paper outlines the context and purpose of HMP Whatton and reports a recent research study that was conducted at the prison which evaluated the prison's climate. The main findings will be discussed, as will potential implications for penal policy.

HMP Whatton is a prison that is focused on rehabilitation, reducing offending behaviour and ultimately reducing recidivism. HMP Whatton delivers all NOMS Sex Offender Treatment Programmes (Core SOTP, Becoming New Me, Rolling SOTP, Extended SOTP, Better Lives Booster, Adapted Better Lives Booster and Healthy Sex Programme) and many of the NOMS Living skills programmes (Healthy Relationships, Controlling Anger and Learning to Manage it, and Thinking Skills Programme). The prison has at its core, a focus on change; providing offenders with a broad range of opportunities to engage in activities to change their lives. So whilst offending behaviour programmes are seen as central rehabilitation opportunities at Whatton, the prison also supports access to other services. This includes offering access to counselling psychologists, mental health provision, educational and vocational skills. Critical to the work of the prison is a generalised ethos that change is possible and achievable. Staff communicate a strong messages about the possibility of change and support offenders to hold high expectations about change. The establishment aims to forge relationships between Staff and Prisoners that are active and participatory on both sides, where people are treated fairly and consistently and practical help is offered.

Research Context

The use of rehabilitative interventions for offenders has expanded over the decades and with it so has evidence of their effectiveness in reducing recidivism[1]. For example research has demonstrated that sex offender treatment programmes can reduce the number of sex offenders that are reconvicted[2,3]. Specifically, programmes which take a risk-need-responsivity approach have been found to be the most successful[4]. HMP Whatton is a prominent prison treatment site, with the highest number of sexual offender treatment completions of any institution. It delivers evidence-based treatment programmes that are focused on reducing recidivism. However, treatment outcomes can be effected by a range of factors including treatment implementation and institutional climate[5].

Whilst it has been found that evidenced-based programmes are effective at reducing recidivism there is increasing concern that the effectiveness of treatment is being comprised by staff drift, organisational resistance and ineffective correctional environments[6,7]. Successful intervention is affected by institutional climate and rehabilitative programmes will only be as effective as the context in which they are delivered. If, for example, there is organisational resistance to offender programmes and a climate which does not foster constructive relationships between prisoners and staff, the good work of programmes is likely to be undone.

The current dominant model of offender rehabilitation is the 'risk, need and responsivity model'[8]. While the areas of 'risk' and 'need' have been extensively

1. Lipton, D. S., Pearson, F. S., Cleland, C. M., Yee, D. (2002)The effects of therapeutic communities and milieu therapy on recidivism: meta-analytic findings from the correctional drug abuse treatment effectiveness (CDATE) study. In McGuire, J. (ed)(2002) *Offender rehabilitation and treatment: effective programmes and policies to reduce re-offending*, pp. 39–77. Chichester, UK: Wiley.
2. Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Quinsey, V.L., & Seto, M. (2002) First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex Offenders. *Sexual Abuse: A Journal of Research and Treatment,* 14(2), 169-194.
3. Losel, F., & Schmucker, M. (2005) The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis, *Journal of Experimental Criminology,* 1, pp.117-146.
4. Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The Principles of Effective Correctional Treatment Also Apply To Sexual Offenders A Meta-Analysis. *Criminal Justice and Behavior*, 36(9), 865-891.
5. Lösel, F. (2011). Offender treatment and rehabilitation: What works?. In M. Maguire, R. Morgan and R. Reiner (Eds.), *The Oxford handbook of criminology*. Oxford, UK: Oxford University Press.
6. Day, A., Casey, S., Vess, J., & Huisy, G. (2011) *Assessing the social climate of Australian prisons*. Canberra: Australian Institute of Criminology Trends and issues in crime and criminal justice, 427, 1- 6.
7. Smith, P., Cullen, F. T., Latessa, E. J. (2009) Can 14,737 women be wrong? A meta-analysis of the LSIR and recidivism for female offenders, *Criminology & Public Policy,* 8, pp 183-208.
8. Andrews, D. A., & Bonta, J. (2010). *The Psychology of Criminal Conduct* (4th ed.). Cincinnati, OH: Anderson.

covered by researchers (and indeed have had a great impact on treatment in terms of focus and assessment) the dimension of 'responsivity' has been neglected in international research. Responsivity is overlooked in terms of appropriate staff-offender relationships, therapy dynamics, motivation and crucially treatment context and setting[9]. These are important for correctional climate, as climate has been linked to positive outcome for offenders[10]. An effective correctional climate may also play a role in crime desistance; many offenders begin their journey towards desistance from prison. Losel[11] argues that while there is no clear evidence on how criminal justice institutions can promote desistence from crime, one thing does seems clear; that encouraging desistance from crime is much more than just requiring offenders to attend offending behaviour programmes alone. The more persistent and serious offenders will have problems across a range of areas, such as mental health, accommodation, education, work and substance misuse. Criminal justice institutions therefore need to enable more individualisation of the offenders' journey through prison, ensuring they are offered a combination of services which meets their individual needs. With sexual offenders this may also include the provision of psycho-pharmacological interventions for a specific subgroup of offenders[12]. The need for individualisation of offenders' paths through prison was recognised and embodied in the 'NOMS pathways to reducing re-offending' model in 2006[13].

Prison, Recidivism and Climate

A focus on the external responsivity issue of correctional climate is necessary and needed given that prison has been found not to reduce recidivism. Evidence suggests that imprisonment itself far from reducing recidivism may actually be criminogenic. Cid[14] offers evidence that those sentenced to prison rather than given a suspended sentence were more likely to be reconvicted. Indeed it has been found that imprisonment was associated with an increase in recidivism and that harsher prison conditions were associated with a 15 per cent increase in post-release criminal behaviour[15]. However, prisons with a rehabilitative focus may be exceptions, as there is strong evidence to suggest that evidence-based rehabilitative programmes reduce recidivism[16,17].

It has been argued that improvements in the institutional climate, programme implementation, evaluation and stronger integration with other services could further improve rehabilitation in prisons[18]. There is some evidence for this in the therapeutic communities (TC) and recidivism literature[19] which found that TC treatment had a significant reduction on reoffending for personality and mentally disordered offenders. While others[20] found that completing a TC had a significant effect on reducing the likelihood of re-arrest for prisoners. These findings may suggest that climate could be useful in helping to facilitate the desistance process. Many crime desisters talk about the powerful effect of having someone else believe that they can and will change, that they are good people, and that they have something to offer society[21]. Research around desistence has helped to generate some ideas about how institutions can 'assist desistance' in offenders to enable them to successfully move away from crime. These include, amongst others, focusing on developing strong and meaningful relationships, giving strong optimistic messages and avoid labelling, focus on strengths not just risk, recognise and mark achievement towards desistence, and working with parents/partners and supporting communities[22].

Day et al have argued that specialist rehabilitation prisons can succeed in providing an environment that is

9. Birgden, A. (2004) Therapeutic jurisprudence and responsivity: Findings the will and the way in offender rehabilitation, *Psychology, Crime and Law,* 10(3), 283-295.
10. Howell, K., Tonkin, M., Milburn, C., Lewis, J., Draycot, S., Cordwell, J., Price, M., Davies, S., Schalast, N. (2009) The EssenCES measure of social climate: A preliminary validation and normative data in UK high secure hospital settings, *Criminal Behaviour and Mental Health*, 19, pp. 308-320.
11. Losel, F (2012) Towards a third phase of what works in offender rehabilitation. In Loeber and B. C Welsh (eds) *The Future of Criminology.* New York : Oxford University Press (pp 196-203).
12. Lievesley et al page 17 this edition.
13. Home Office A Five Year Strategy for Protecting the Public and Reducing Re-offending (2006).
14. Cid, J. (2009) Is imprisonment criminogenic? A comparative study of recidivism rates between prison and suspended prison sanctions, *European Journal of Criminology*, 91, 425-447.
15. Jonson, C. L. (2010). The impact of imprisonment of reoffending: A meta-analysis. Unpublished doctoral dissertation, University of Cincinnati, OH.
16. Cullen, F.T., Jonson, C.L., & Nagin, D.S. (2011) Prisons do not reduce recidivism: The high costs of ignoring science, *The Prison Journal*, 91(3), 485-655.
17. Andrews & Bonta (2010) see n.8.
18. Lösel, F. (2007) Counterblast: The prison overcrowding crisis and some constructive perspectives for crime policy, *Howard Journal of Criminal Justice*, 46(5), 512-519.
19. Lees, J., Manning, N., Rawlings, B. (2004). A culture of enquiry: research evidence and the therapeutic community. *Psychiatric Quarterly*, 75(3), 279-294.
20. Jensen, E.L., & Kane, S.L. (2010)The effect of therapeutic community on time to first re-arrest: A survival analysis, *Journal of Offender Rehabilitation*, 49(3), 200-209.
21. Rex, S. (1999) 'Desistance from Offending: Experiences of Probation', *Howard Journal of Criminal Justice*, 36(4): 366–83.
22. Maruna, S (2011) Re entry as a rite of passage, *Punishment and Society*, 13(3), 3-28.

more conducive to offender rehabilitation than mainstream prisons. It is useful to point out that a prison's rehabilitative climate can be understood as the prison's social climate coupled with the prison's culture, philosophy, and fitness for purpose in relation to reducing reoffending[23]. These critical aspects of a prison are likely to have a direct impact on the effectiveness of rehabilitative measures, behavioural and personal change and the overall effectiveness of the prison.

The Research

This research study was a mixed methods study which investigated the therapeutic and rehabilitative climate of HMP Whatton, a therapeutically-orientated Category C prison. The research was split in two phases; quantitative and qualitative. In the quantitative phase prisoners (n=112) and staff (n=48) completed a series of measures designed to evaluate their perceptions regarding the prison's climate, their beliefs about prisoners and to establish whether there were significant differences between the groups. The measures included the Essen Climate Evaluation Schema[24] (EssenCES); Attitudes Towards Sex Offenders Scale (ATS[25]), Correctional Victoria Readiness for Treatment Scales[26], Implicit Theories of Offending Behaviour[27]. The measures were chosen due to hypothesised links with constructs underlying a rehabilitative environment. For example it has been argued that climate is important for rehabilitative outcome[28], while positive attitudes from staff and beliefs about change by staff and prisoners are vital for fostering effective offender rehabilitation and promoting change in offending behaviour[29]. This phase of the research assessed the therapeutic and rehabilitative climate of the prison from staff and prisoner perspectives. The overarching research aim was to explore prisoner and staff perspectives on the climate of the prison, their attitudes towards prisoners and offending behaviour and their beliefs about change regarding offending behaviour.

In the qualitative phase of the research prisoners (n=15) and staff (n=16) were interviewed in order to capture their experiences of the prison, the prison regime and its climate. The interview focused on the purpose of the prison, prison life, prisoner-staff interactions and the prison regime. It also focused on the rehabilitative ideals/orientation of the prison and opportunities for personal development at the prison. Interviews consisted of semi-structured interviews which lasted between 60-90 minutes. The data were analysed using thematic analysis, which is a method for identifying, analysing and reporting patterns and themes within the data. It aims to capture rich detail and interpret the range and diversity of experience within the data[30].

Research results

Quantitative Phase results

The results found that prisoners and staff evaluated the climate positively, however there were significant differences. The results revealed that staff view the prison's climate as more positive than prisoners. Independent t-tests were conducted to compare EssenCES total and subscales between prisoners and prison staff (see table 1).

Table 1:
Prisoner and staff scores on the EssenCES

Sample	N	Scale/subscale	M	SD
Cat C rehabilitative prison – prisoner	112	Inmates' Cohesion	11.16	4.54
		Experienced Safety	14.59	4.38
		Hold and Support	10.96**	4.71
		EssenCES Total	37.18*	10.30
Cat C rehabilitative prison – prison staff	48	Inmates' Cohesion	12.35	2.89
		Experienced Safety	14.26	3.24
		Hold and Support	14.89**	3.28
		EssenCES Total	41.50*	6.82

Significant results noted with *
*p < .05
**p< .001

23. Blagden, N. J., Winder, B., Hames, C. (under review) Climate change? Investigating the rehabilitative of a therapeutically-orientated prison: A mixed-methods case studies. *Criminal Justice and Behaviour.*
24. Schalast, N., Redies, M., Collins, M., Stacey, J., Howells, K. (2008) EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards, *Criminal Behaviour and Mental Health*, 18, pp. 49-58.
25. Hogue, T. E. (1993). Attitudes towards prisoners and sexual offenders. In Clark, C.N & Stephenson, G. DCLP *Occasional Papers: Sexual Offenders*. Leicester: British Psychological Society.
26. Casey, S., Day, A., Howells, K., Ward, T. (2007) Assessing Suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire, *Criminal Justice and Behaviour,* 34, pp. 1427 –1440.
27. modified version of Gerber, S., & O'Connell, M. (2011) Protective processes: the function of young people's implicit theories of crime in offending behaviour, *Psychology, Crime and Law*, 18(9), 781-795.
28. Day, A., Casey, S., Vess, J., & Huisy, G. (2012).Assessing the therapeutic climate of prisons. *Criminal Justice and Behaviour,* 39(2), 156-168.
29. Kjelsberg, E., & Loos, L. (2008).Conciliation or condemnation? Prison employees' and young peoples' attitudes towards sexual offenders. *International Journal of Forensic Mental Health*, 7(1), 95-103.
30. Braun, V and Clark, V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3:2 77-101.

Table 1 shows that *Hold and support* is a key difference between prisoners and staff and it is also the subscale which measures aspects of prisoner and staff relationships. While prison staff view the relationships as positive it appears that prisoners see them as less favourable. Both prisoners and staff view the prison as having a safe environment, with no significant differences between the two groups. The prison and staff scores on the experienced safety subscales are high scores when compared to the EssenCES norms[31].

Staff attitudes are likely to be a key determinant in a supportive and rehabilitative environment. Likewise prisoners' attitudes towards other prisoners will be important both in terms of prisoners' experience of the prison and beliefs about whether prisoners can be rehabilitated. The Attitudes Towards Sex offenders scale (ATS)[32] was administered to prisoners and staff and was chosen as it reflected the population of the prison.

Table 2:
Showing descriptive statistics for ATS measure for prisoners and staff groups.

Group	Mean	N	SD	Min	Max
Prisoner	103.62	108	14.22	60	132
Staff	92.91	46	18.09	40	139
Total	100.99	149	15.91	40	139

An independent t-test indicated that staff had significantly less positive attitudes to sex offenders than prisoners (t (132)=3.697, p.001). However, these are encouraging data as both prisoners and staff had very high scores and so positive attitudes towards sexual offenders.

The results also highlight that both staff and prisoners viewed prisoners' offending behaviour as incremental i.e. that is they believed they could change their offending behaviour. Table 3 demonstrates that on average prisoner participants viewed their offending behaviour as strongly incremental (changeable).

Table 3:
Implicit Theories of Offending Behaviour (ITOB) — Self Version

Group	Mean	N	SD	Min	Max
ITOB Total Score	32.42	108	4.19	14	36
ITOB Mean Score	5.4	108	0.70	2.33	6

There were also significant correlations between ITOB (self), ATS (r=.303, n=81, p=.004), readiness for treatment (r=.508, n=75, p=.001) and ITOB (other) (r=.637, n=98, p=.001). This suggests and association between believing they can change, believing others can change and readiness.

Summary

In summary both prisoners and staff rated the prison positively. Prison staff, however, held significantly more positive views of the prison's climate and of relationships between staff and prisoners. The measure of prisoner-staff relationships was unexpectedly low particularly given other results in this study. This needs further investigating and may point to areas for improvement for staff-prisoner relationships at the prison. It may also point to limitations in the measure used to capture the quality of prisoner-staff relationships[33]. Prisoners rated the prison as having a very safe environment and this seemed conducive to prisoners wanting to address their offending behaviour. The results also showed that both prisoners and prison staff held positive views towards other prisoners and believed that prisoners could change their offending behaviour. This finding is important in a prison which has a rehabilitative focus.

Qualitative phase results

The qualitative phase of the research utilised prisoner participants (n=15 of whom 9 had completed programmes and 6 were pre-treatment) and staff participants (n=16) in order to qualitatively explore participant's experiences of the prison's climate. Prison staff participants where made up of the governor, senior psychologists, treatment managers, probation officers, prison officers and a prison librarian.

Data were analysed using a thematic analysis which is a method for identifying, analysing and reporting patterns and themes within the data. This approach is not tied to an explicit theoretical position and aims to capture diversity of experience within the data[34]. This qualitative methodology was appropriate for this study because the sample size was too large for a conventional interpretative phenomenological analysis.

The qualitative analysis revealed four main themes (1) *Purpose and purposefulness* (2) *Positive, constructive and safe environment* (3) *Meaningful and constructive relationships* (4) *Growth and development*.

Purpose and purposefulness — There was consensus from all participants, both staff and prisoner,

31. Schalast, N., Redies, M., Collins, M., Stacey, J., Howells, K. (2008) EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards, *Criminal Behaviour and Mental Health*, 18, pp. 49-58.
32. Hogue. (1993) see n.24.
33. Blagden, N. J., Winder, B., Hames, C. (under review) see n.22.
34. Braun, V and Clark, V (2006) see n.29.

as to the purpose of this prison. There was a unanimous belief amongst participants as to the purpose of the prison; it was viewed as a prison that was about rehabilitation, personal change and participation in programmes. Indeed the focus on programmes gave the prison a clear identity with the prison regime largely orientated around that focus.

> *It's about rehabilitation and changing your beliefs erm changing and looking at you offending behaviour so when you get out you don't repeat your mistakes…Programmes has taught me a hell of a lot about myself. (Extract 1 Prisoner participant 11)*

> *I feel clear about what our objective is or what our objectives are and that what we are about really. I think we are very different to other prisons in that our sole purpose here is about helping people who are locked up here to address their offending and reasons for their offending and to try do something about reducing their risk and help them lead constructive lives. I think it's important to have that level of purpose for a prison. (Extract 2 Prison staff participant 16)*

Most participants also felt that the prison allowed for purpose to be constructed in prisoners' lives. Many participants discussed the varied opportunities they had from work, leisure to participation in programmes. This allowed participants to have 'meaningful' lives while in prison, rather than wasteful ones where nothing constructive was done with their day. Prisoner participants discussed how this prison favourably contrasted with other prisons that they had been.

Positive, constructive and safe environment — Participants (treated and untreated prisoners and staff) in this study viewed the environment as positive, constructive and importantly, safe. The feeling of safety was an important and reoccurring theme. All participants felt safe in the prison and this was contributing to them being able to address other aspects of themselves (e.g. those related to their offending behaviour) which previously they did not have the 'headspace' to deal with.

> *You're going from looking over your shoulder, fearful of being attacked like it was in X to just 'morning', it's a big weight lifted off your shoulders being here… [as listeners] we give a talk on the induction wing and I say to them relax, you're in safe hands here. (Extract 3 Prisoner participant 7)*

All participants discussed how this prison cultivated an environment where sexual offenders felt safe and so they did not have to deal with the anxiety or threat of being ousted as a sexual offender. This appeared to relax participants and enabled them to reflect on where they are now and where they want to be in the future. The reductions in anxiety appeared to contribute to prisoners' readiness to engage in treatment.

Meaningful and constructive relationships — The majority of participants felt that the staff and prisoner relationships were positive and how social interaction with officers made participants feel as though they were human beings. This is especially important in this sort of specialist prison where prisoners will be experiencing large amounts of shame and stigma[35] .

> *It comes down to respect, they treat us like human beings. I haven't seen an officer here who thinks of me as just a number, that's Mr X, you're not just a number here you're a person and that's the feeling you get. (Extract 4 Prisoner participant 7)*

> *For me [why I'm here] it's the men, it's the treatment, it's the change…the people are supportive of each other, of prisoners, they're here for the right reasons…staff talk to the prisoners like they would talk to someone on the outside, you wouldn't know what one was the uniform one and which was the stripy shirt one, that's how it feels here, people take time. (Extract 5 Prison staff participant 5)*

Staff were construed as being genuinely interested in the prisoners' lives and their problems. This went beyond any superficial notion of 'pleasant or nice' relationships, but instead had progressed into meaningful relationships. Prison staff were also construed as helpful. The prison climate appears to be important for facilitating constructive prisoner-staff relationships. It has been found that sexual offenders experience local non-specialised prisons as threatening and anxiety provoking which hinders prisoners' engagement in rehabilitative programmes and makes the prisoner more defensive[36].

35. Blagden, N. J., Winder, B., Thorne, K., & Gregson, M. (2011). 'No-one in the world would ever wanna speak to me again': an interpretative phenomenological analysis into convicted sexual offenders' accounts and experiences of maintaining and leaving denial. *Psychology, Crime & Law*, 17(7), 563-585.
36. Schalast et al (2008) See n.31.

Growth and development — Participants believed that this prison allowed for growth and development. This can also be noted in the themes from previous analysis. Prisoner participants articulated how the prison allowed for personal growth and had also led to them witnessing change in others.

> *The change in this lad [since participating on the course] is unbelievable, he's more patient, he talks to you, he even talks about his offence now, he's told me all sorts of things and say he feels so much better now, he can't wait to see his family and tell them, you tell a real weights been lifted off him. (Extract 4 Prisoner participant 7)*

> *There's more of a can do attitude here, whilst, if I'm honest, in some prisons they'd be in the minority, the staff are undoubtedly in the majority here.*
> *(Extract 11 Prison staff participant 16)*

It is interesting how some participants used the same phrase 'can do attitude' when describing the prison and those that work in the prison. Staff appeared actively invested in their work rather than passive or disengaged.

Summary

The qualitative phase of the research found the prison had a clear purpose and that this purpose gave the prison a clear identity. The prison was about rehabilitation, change and providing development opportunities for prisoners. There was a narrative of change which ran through both prisoner and staff responses. There was also symmetry between this narrative of change and staff and prisoners beliefs about change which were captured in the quantitative phase of this research. This finding is potentially important as crime desistance research has consistently found that narratives of change and change in offenders self-identity can promote desistance[37,38]. Prisons that foster change or have offender change at their core may help promote positive practical identities in offenders, which have been linked to crime desistance[39].

The findings from the qualitative phase of the research pointed to positive and constructive prisoner-staff relationships. However, this was not supported by the findings from the quantitative phase of the research. It maybe that there are inherent selection effects for the qualitative phase of the research, though the research did attempted to reach all prisoners and the final sample included both treated and un-treated participants. While this finding needs greater consideration and a more detailed analysis of prisoner-staff relationships at the institution, it may be limited by the quantitative measure of relationships.

Discussion

This research has found that both prisoners and staff believe that the climate of this prison is conducive to rehabilitation. Particularly prisoners reported, both qualitatively and quantitatively, to feeling safe and secure in their prison environment. This seems crucial as often sexual offenders feel threatened, anxious and have to adapt their identities in order to survive prison[40]. These feelings of anxiety will affect whether they feel safe, affect their attitudes towards treatment and have an impact on their view of the prison's climate. Indeed, there are probably numerous limitations for correctional programmes delivering treatment in unsafe environments to sexual offenders.

The study also found that both prisoners and staff held positive attitudes towards other sex offenders and beliefs that they could change. This finding also appears a key determinant in the rehabilitative climate of the prison, and the prison seemed a key driver for personal change. It seems self-evident that for change to be possible, both staff and prisoners need to have positive attitudes about the possibility of change. Indeed if this prison could be characterised as anything it was a prison of change. Some participants reflected on how they have changed while being in this prison and how the treatment programmes had changed them for the better. This finding perhaps points to treatment programme's ability to help participants develop incremental theories about their own offending behaviour and so help foster 'new' positive identities.

HMP Whatton — A prison of change?

Both the quantitative and qualitative analysis (though more notably in the latter) appear to highlight that this prison is a prison of change. Change seems to drive at the heart of this prison and is embedded in the very purpose of this prison. Participants, on the whole, believed in change and believed change was possible in themselves and others. There was also evidence of

37. Maruna, S (2001) *Making Good: How Ex-Convicts Reform and Rebuild Their Lives.* Washington , DC. APA Books.
38. Gobbels, S., Ward, T., & Willis, G.M (2012) An integrative theory of desistance from sex offending, *Aggression and Violent Behaviour*,17, 453-462.
39. Ibid.
40. Schwaebe, C. (2005) Learning to pass: Sex offenders' strategies for establishing a viable identity in the prison general population. *International Journal of Offender Therapy and Comparative Criminology,* 49 (6), 614-625.

reciprocal relationships between staff and prisoners regarding rehabilitation. Prisoners wanted to change, wanted to show that they had changed and staff were keen to recognise and reinforce this change. Such expectations mirror concepts of the looking glass self, where identity formation/transformation is negotiated in appraisals from others, and Pygmalion in offender rehabilitation[41].

The population at the prison had a high readiness for treatment, with participants articulating that the prison helped them grow and develop in personally meaningful ways. However this 'prison of change' appeared to be driven by its climate which participants articulated as 'a therapeutic environment'. One participant also commented that while the prison was not a therapeutic community, it was a form of 'TC lite'. It has been argued that for a prison to be considered a truly therapeutic prison which serves reformative purposes it needs to have clearly articulated goals, evidence-based interventions, qualified staff and core correctional practices[42]. It is argued that such a prison will have three key documents 1) a mandate, 2) clearly articulated goals and 3) a documented code of ethics. This prison has such purpose, its mandate is documented and disseminated to all staff and prisoners 'prevent another victim' and from this it has a clear set of specific goals which are centred on reducing recidivism. A therapeutic prison is then an agent of change and from Smith and Schweitzer 's guidance[43] it would seem this prison fits the criteria of being a therapeutic prison. This is congruent with the qualitative and quantitative findings of this research.

Conclusion

This research investigation, along with previous literature, has pointed to some of the determinants of effective rehabilitative climates for effective rehabilitative prisons. Such environments will foster positive attitudes between prisoners and staff and foster beliefs about change. This research concludes, similarly to Day et al[44], that prisons which are therapeutic and have an explicit rehabilitative climate can provide an environment which is more conducive to offender rehabilitation than mainstream prisons. Environments such as this prison's are ideal for doing sexual offender treatment programmes and behavioural work[45], as the climate is conducive to rehabilitation, to rehabilitative ideals and so perhaps ideally placed to reduce recidivism.

41. Maruna, S., Lebel, T. P., Mitchell, N., & Naples, M. (2004). Pygmalion in the reintegration process: Desistance from crime through the looking glass. *Psychology, Crime & Law*, 10(3), 271-281.
42. Smith, P., & Schweitzer, M. (2012).The therapeutic prison. *Journal of Contemporary Criminal Justice*, 28(1), 7-22.
43. Ibid.
44. See n. 6.
45. Ware, J., Frost, A., & Hoy, A. (2010).A review of the use of therapeutic communities with sexual offenders. *International Journal of Offender Therapy and Comparative Criminology,* 54(5), 721-742.

‘This isn’t a real prison’:

prisoner safety and relationships in HMP Whatton

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There have been many insightful studies into the sociology of prison life. Focusing on areas such as friendship, resistance, staff-prisoner relationships, trust and the attempt to maintain a coherent identity, these studies have illuminated features of the prisoner — and prison officer — experience which would otherwise be invisible to outsiders. It is generally believed that prisoner culture can be influenced by structural causes relating to the nature of imprisonment, by institutional differences and by the values and beliefs imported by prisoners[2]. Sociologists have therefore insisted that, while they may share certain features, all prisons are different, and we should be slow to generalise from claims about one prison to claims about The Prison, or The Prisoner.

Nevertheless, the majority of studies into prison life have been based on the experiences of adult male mainstream prisoners, which are all-too-often assumed to be shared by the rest of the prison population[3] .Much less is known about the experiences of other groups of prisoners or the effects of different types of institution. In particular, very little research has been undertaken into the experiences of sex offenders in prison, despite this group making a significant proportion of the prison population: in September 2012, prisoners convicted of sex offences made up almost fifteen per cent of the total adult male sentenced prison population in England and Wales[4].

The majority of research on the experiences of sex offenders in prison concerns their position at the base of the prisoner hierarchy[5]. It has also been suggested there is a further hierarchy *among* sex offenders, with those convicted of offences against adults receiving more status while those who have offended against children receive more stigma[6]. On the other hand, Mann has argued that child sex offenders invert the terms of the prisoner hierarchy, arguing that they are superior to mainstream prisoners because they are more educated and their offences are, they maintain, less serious[7].

Sex offenders in prison face such danger that they are often isolated for their own protection. In England and Wales, they have traditionally been accommodated on Vulnerable Prisoners’ Units (VPUs) under Rule 45 (previously Rule 43). Even here, however, they have not been safe from abusive behaviour by Vulnerable Prisoners (VPs) who are not sex offenders, and even from staff[8]. Despite this, sex offenders and VPs are considered among the most compliant members of the prison population[9]. Because of the perceived compliance of VPs, as well as their imported vulnerability, Deborah Drake has called for ‘a consideration of the sociology of punishment for vulnerable offenders’[10].

Such a consideration is not just important because sex offenders make up a significant but ignored prison population, but because treatment providers are becoming increasingly aware that ‘the context within which treatment is provided may actually prove to be quite important to the overall effectiveness of treatment’[11]. It was partly for this reason that the HM Prison Service introduced a new strategy for sex offender

1. I am deeply grateful to my MPhil supervisor, Dr Ben Crewe, for his help throughout this project, his assistance with interviewing, and his comments on a draft of this article. I would also like to thank everyone at Whatton, particularly in the Education department, for so graciously hosting this research.
2. Crewe, B. (2007) ‘The Sociology of Imprisonment’, in Y. Jewkes (ed.) *Handbook on Prisons*, Abingdon: Willan Publishing (pp. 123-151).
3. In this article, ‘mainstream prisoners’ refers to those prisoners who have not been convicted of sex offences. The term ‘mainstream prisons’ therefore refers to those establishments which mainly accommodate mainstream prisoners.
4. Ministry of Justice (2012) *Offender Management Statistics Quarterly* [online]. Available at: <http://www.justice.gov.uk/statistics/prisons-and-probation/oms-quarterly> [Accessed 19 February 2013].
5. Åkerström, M. (1986) ‘Outcasts in Prison: The Cases of Informers and Sex Offenders’, *Deviant Behaviour*, 7: 1-12; Winfree, T., Newbold, G. and Tubb III, H. (2002) ‘Prisoner Perspectives on Inmate Culture in New Mexico and New Zealand’, *Prison Journal*, 82: 213-223.
6. Vaughn, M.S. and Sapp, A.D. (1989) ‘Less than Utopian: Sex Offender Treatment in a Milieu of Power Struggles, Status Positioning, and Inmate Manipulation in State Correctional Institutions’, *The Prison Journal*, 69(2): 73-89.
7. Mann, N. (2012) ‘Ageing Child Sex Offenders in Prison: Denial, Manipulation and Community’, *The Howard Journal of Criminal Justice*, 51(4): 345-358.
8. Sparks, R., Bottoms, A.E. and Hay, W. (1996) *Prisons and the Problem of Order*, Oxford: Clarendon Press; O’Donnell, I. and Edgar, K. (1999) ‘Fear in Prison’, *The Prison Journal*, 79(1): 90-99.
9. Ahmad, S. (1996) *Fairness in Prison*, PhD Thesis, University of Cambridge; Sparks, Bottoms and Hay (1996) see n.8; Liebling, A., Muir, G., Rose, G. and Bottoms, A. (1997) *An Evaluation of Incentives and Earned Privileges*, Cambridge: Institute of Criminology.
10. Drake, D.H. (2006) *A Comparison of Quality of Life, Legitimacy, and Order in Two Maximum-Security Prisons*, PhD Thesis, University of Cambridge: 301.
11. Ware, J. (2011) ‘The Importance of Contextual Issues within Sexual Offender Treatment’, in D.P. Boer, R. Eher, L.A. Craig, M.H. Miner and F. Pfäfflin (eds) *International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice and Research*, Chichester: John Wiley & Sons Ltd (pp. 299-312): 300.

imprisonment in 1991, concentrating them in a smaller number of prisons in the hope that this would 'facilitate a consistency of approach in running treatment programmes, cost effective use of resources and skills, and the provision of a safe and supportive environment'[12]. This change in strategy led to HMP Whatton increasingly specialising in the treatment and rehabilitation of sex offenders, and now it only accommodates those who are undertaking or waiting to undertake Sex Offender Treatment Programmes (SOTP). Staff argue that Whatton, a public sector Category C prison, creates a constructive and understanding environment, in which prisoners and staff encourage and support each other through their treatment. Its culture is more commonly compared to that of a Therapeutic Community than a mainstream prison[13].

This article stems from a broader study which began to explore the sociology of prison life for sex offenders. The article will compare the culture of HMP Whatton and that of the mainstream prisons described by sociologists of imprisonment, drawing in particular on recent studies deriving from the experiences of mainstream prisoners in England and Wales[14]. It will outline many differences and similarities between HMP Whatton and mainstream prisons, focusing primarily on experiences of safety and relationships. It will then offer preliminary explanations for these differences and similarities, using Crewe's framework for analysis of the prisoner society, which takes account of structural, institutional and imported factors[15].

Twenty two prisoners were interviewed overall, nineteen by the primary author and three by her supervisor.

The Study

Twenty two prisoners were interviewed overall, nineteen by the primary author and three by her supervisor. In order to reduce the burden on the prison, the research was based in the Education Department, and the sample was selected from its classrooms using an opportunistic selection method. The interviews were semi-structured and qualitative, with a mean length of one hour and 19 minutes. The initial themes and questions were drawn from the sociology of prison life literature, but other issues — concerning, for example, 'grassing' and sexual relationships between prisoners — emerged as significant during the research process. The interviews were then transcribed word-for-word and coded manually.

FINDINGS

Safety

Experiences of safety vary between prisons but, contrary to popular belief, mainstream prisons are not necessarily marked by regular displays of violence. Nevertheless, lack of control and low levels of trust combine to produce an environment in which prisoners rarely feel completely safe and social control is always 'a matter of degree'[16].

Prisoners in HMP Whatton, on the other hand, reported feeling remarkably comfortable and secure. While such feelings may be heightened by comparison with the victimisation they reported in their previous establishments, HMP Whatton certainly seemed to be a much safer establishment than most mainstream prisons. Prisoners reported few violent incidents, and very few prisoners could recall having seen a fight there. One Education staff member reported that an incident alarm bell went off once every six months.

HMP Whatton's safety can be attributed to a number of imported and institutional causes. The average age of its prisoners was forty five, much higher than in most prisons, and younger prisoners are much more likely to be involved in violent incidents[17]. Forty six per cent of prisoners had indeterminate sentences (either life or Imprisonment for Public Protection) and were unwilling to jeopardise their progression through the system, especially as they were in a Category C prison with the outside world in sight. Similarly, HMP Whatton only accommodated prisoners undertaking (or waiting to undertake) the SOTP, who at the very least were likely to be pragmatic regarding their progression through the system, and wary of being moved to establishments with fewer courses.

Drugs

One commonly expressed reason for HMP Whatton's safety was the rarity of illegal drugs there. Crewe argues

12. Guy, E. (1992) 'The Prison Service's Strategy', in Prison Reform Trust (ed.) *Beyond Containment: The Penal Response to Sex Offending*, London: Prison Reform Trust (pp. 1-7): 1.
13. See Blagden, N. and Thorne, K. in this publication.
14. Of particular importance is Ben Crewe's (2009) *The Prisoner Society,* Oxford: Oxford University Press, which describes the social world of HMP Wellingborough, which, like Whatton, was a Category C establishment.
15. Crewe (2009) see n.14.
16. Carrabine, E. (2005) 'Prison Riots, Social Order and the Problem of Legitimacy', *British Journal of Criminology*, 45(6): 896-913 (897).
17. Ditchfield, J. (1990) *Control in Prisons: A Review of the Literature*, London: HMSO.

that drugs — particularly heroin and cannabis — play a central role in prisoner life in the early twenty-first century, structuring or distorting the prisoner hierarchy, increasing individualisation, leading to potentially violent power struggles among prisoners, and increasing levels of debt[18]. According to the prisoners he interviewed, such changes are apparently 'generalisable across establishments', but illegal drugs were noticeable by their absence in HMP Whatton[19].

> *It is safer, because, like, obviously here they act straight, straightaway, where in other places, it's, you've got drugs and that, they're constantly flowing, and [...] you haven't really got that here. So [in other prisons] it's the fine line where it's gonna be kicking off all the time because someone owes someone something or pads [are] getting robbed or whatever (Darren)[20].*

Because there were fewer drugs, there were fewer power struggles, fewer prisoners in debt and fewer occasions to enforce loyalty, through violence or the threat of violence.

It seems likely that the absence of drug culture in HMP Whatton reflected the fact that far fewer of its inhabitants would have been involved in the use or distribution of illegal drugs before being imprisoned. However, prisoners offered other reasons, including the small wing sizes, the fact that many prisoners were on indeterminate sentences, and the apparent frequency of 'grassing' within HMP Whatton.

It is also worth noting that although illegal drugs were rare in HMP Whatton, many prisoners reported that the misuse of prescription medication was common. Medication was present in the prison through legal and legitimate means: prisoners, many of whom were elderly and had health problems, got it from Healthcare. The supply was secure, therefore its presence did not lead to the establishment of a trading network supported by violence. It is also possible that the availability of medication filled the gap in the market which would otherwise have been filled by illegal drugs.

Masculinity and Status

HMP Whatton's apparent calm extended from its lack of violence to its everyday social interactions. Many mainstream prisoners adapt to the pains of imprisonment by presenting a front of 'hypermasculinity', which necessitates a degree of 'controlled aggression' and the ability and readiness to assert oneself through violence[21]. This version of masculinity is partly imported from the lower working-class culture from which many prisoners originate, and is partly a reaction to the structural powerlessness they experience in prison[22]. This version of masculinity was largely absent in HMP Whatton, contributing to its feelings of safety. Most prisoners were not 'chasing after power like in a mains prison' (Anwar), and participants insisted that there was very little need to 'front' (Darren). Those who did were ridiculed as 'plastic gangsters' (Rob).

The relative absence of this culture of masculine aggression was related to the high average age of HMP Whatton's population. Furthermore, many prisoners in HMP Whatton were from a middle-class background, where masculinity is expressed differently[23]. However, it was also related to broader feelings of resignation among prisoners to their predicament. The most common reaction to questions asking whether prisoners felt a sense of power was derisive laughter. Prisoners were aware that they would face stigmatisation on release, but also that they were stigmatised within prison and were at the bottom of the prisoner hierarchy. Sex offenders in prison are often seen as 'the location of "Otherness" ' against which, in the absence of women, mainstream masculinity can define itself[24]. A few participants said that they had sought masculine status in previous establishments, but no longer looked for it in HMP Whatton. Prisoners felt there was no kudos to be earned there; it was considered oxymoronic to be 'big and hard' in 'a sex offenders' jail' (Ed).

The most common reaction to questions asking whether prisoners felt a sense of power was derisive laughter.

This does not mean prisoners in HMP Whatton were unconcerned with issues of status. Rather, their battles were conducted on different territory and used different weapons. Middle-class men often equate status with educational qualifications and economic success[25]. HMP Whatton's inhabitants sometimes complained about the

18. Crewe, B. (2005) 'Prisoner Society in the Era of Hard Drugs', *Punishment and Society*, 7(4): 457-481.
19. Ibid p. 461.
20. In order to ensure anonymity, all participants have been given a pseudonym.
21. Jewkes, Y. (2005) 'Men Behind Bars: Doing Masculinity as an Adaptation to Imprisonment', *Men and Masculinities*, 8(1): 44-63 (61, 52-53).
22. Ibid.
23. Ibid.
24. Thurston, R. (1996) 'Are You Sitting Comfortably? Men's Storytelling, Masculinities, Prison Culture and Violence', in M. Mac an Ghail (ed.) *Understanding Masculinities: Social Relations and Cultural Arenas*, Buckingham: Open University Press (pp. 139-153): 144.
25. Tolson, A. (1977) *The Limits of Masculinity*, London: Tavistock Publications.

low educational standard of other prisoners. As Rob reported:

> *I've heard quite a lot of backstabbing and stuff. That's the main thing [...] between a mains' prison and a sex offenders' prison. I find there's not bullying in the sense of making people feel intimidated, but there's a level of 'We're better than you' kind of thing that can come across.*

Rather than open teasing or violence, they resorted to what Rob called being 'bitchy', conventionally understood as a feminine trait. The emasculation of prisoners in Whatton was such that, even among sex offenders, their status battles could be criticised for being un-masculine.

Sexual Manipulation

Malik claimed that 'you can't feel that proper safe [in Whatton] cos [...] there's a lot of paedophiles in here'. He felt the need to 'watch out' for 'what they call grooming and everything'. While partly deriving from cultural myths about the sex offender as a manipulative predator ('what they call'), Malik's concerns were indicative of a strain of self-conscious anxiety amongst the younger prisoners concerning sexual manipulation, an anxiety which was not without cause. One participant reported personal experience of sexual manipulation, and another expressed apparently reasonable concern about the relationship between his former cellmate, a man in his early seventies, and a younger man of twenty seven. The rarity of overtly violent incidents in HMP Whatton should not, therefore, obscure an undercurrent of sexual manipulation, which may or may not be related to the nature of HMP Whatton's population.

The rarity of overtly violent incidents in HMP Whatton should not, therefore, obscure an undercurrent of sexual manipulation, which may or may not be related to the nature of HMP Whatton's population.

Relationships between Prisoners

Hierarchy

In mainstream prisons, sex offenders are at the base of the prisoner hierarchy, with those convicted of offences against children receiving the most stigma[26]. In HMP Whatton everyone had been labelled as a sex offender, and it was frequently claimed there was no hierarchy because 'we're all sex offenders, no matter what we're in for, we're all exactly the same' (Dave). Rather than passing judgement on people's crimes, prisoners claimed to assess people based on within-prison behaviour: 'you look at the person, not what they did' (Arthur).

Nevertheless, when pushed, it became clear that prisoners struggled to avoid judging those who had committed particularly serious offences, specifically against young children. However, there was not a conventional offence-based hierarchy in HMP Whatton, and these prisoners were not marginalised to the extent that they would be in a mainstream prison:

> *I wouldn't be friends with them, but if they said 'Alright' to me as I was walking by, I would say hello. I'm not a person who's gonna go 'Yeah, fuck off.' (Mitchell)*

> *I talk to anybody, to be honest. If they talk to me, I'll talk to them, but [...] I wouldn't seek them out. (Malik)*

In part this resulted from the involuntary and indiscriminating social interaction imposed by imprisonment. Unlike in mainstream prisons, paedophiles were not a minority, nor were they segregated[27]. It would be almost impossible, and certainly impractical, to avoid associating with people convicted of such offences in HMP Whatton.

There were further institutional inducements to civility and tolerance in HMP Whatton. The prison's therapeutic ideals promoted courteous interactions between prisoners:

> *Everyone sort of clicks in some way, cos obviously, especially when you've gotta go on courses and you've, you've got to be respectful to people that, listening to whatever they've done, you know what I mean? You have to be respectful, otherwise you're just getting bad reports. What's the point? (Darren)*

Psychological reports can determine progression through the system — a fact borne in mind by pragmatic prisoners[28]. In this context, the absence of an obvious

26. Vaughn and Sapp (1989) see n.6.
27. At the time of the research, the Governing Governor said that 692 of HMP Whatton's 838 inhabitants had been convicted of offences against people under the age of sixteen.
28. Crewe (2009) see n.14.

hierarchy can be partly attributed to the coercive power of the institution, and the depth and sincerity of the cordiality promoted should not be exaggerated.

Finally, prisoners had personal reasons for avoiding judging people on the basis of their offences. To put it simply, they did not want to be judged on the same grounds:

> *At the end of the day, [... my conviction is] who I was. That's part of who I was. It's not who I am now. If people are going to judge me on my past, then I'm not going to want to know them. Because that's not who I am. (Evan)*

Prisoners in HMP Whatton tried to protect themselves from stigmatisation by insisting that the offences that they had committed did not accurately represent their current identity, and they tried to retain this principle when evaluating other prisoners. That they did not always succeed can be seen as an indicator of their normality. As Arthur put it, it could be hard to avoid judging people by what they had done because 'you're a human being'.

Trust

Mainstream prisoners often struggle to trust other prisoners. In the five prisons studied by Alison Liebling, fewer than half of those surveyed reported trusting other prisoners[29]. Imprisonment places structural limitations on trust by limiting prisoners' control over their environment and forcing them to live among criminals whose claims they have very little opportunity to test[30].

Given the nature of HMP Whatton's population, it might be expected that its prisoners were more mistrustful than mainstream prisoners. In fact, the majority of participants reported that 'everybody speaks to everybody in here' (Simon), and so the 'wing atmosphere' was 'friendlier' (Owen) than in other establishments — particularly for those prisoners who had been victimised elsewhere. HMP Whatton was certainly unusually trusting when it came to personal property. Most participants left their doors unlocked and very few reported thefts from cells — a marked contrast to most mainstream prisons. Similarly, many participants reported that prisoners in HMP Whatton were more willing to lend tobacco and other goods without demanding double repayment (known as 'double bubble'). These feelings of trust resulted in part from the absence of an illegal drugs economy in HMP Whatton, as well as the fact that far fewer prisoners had been convicted of property offences, and contributed to its sense of safety. Nevertheless, a significant group of prisoners, mainly fathers of young children, were concerned about letting anyone in their cells, fearing that they might look at or steal their family photographs. This is also the case in mainstream prisons, and therefore it arguably reflects the paranoia created by imprisonment itself, and not just imprisonment alongside sex offenders[31].

That said, prisoners in HMP Whatton experienced some specific anxieties relating to the ever-present spectre of their convictions. By inhibiting prisoners' ability to learn more about each other, imprisonment structurally creates mistrust about prisoners' previous lives. All prisoners know about each other is that they have been convicted of a criminal offence. This created particular pressure in HMP Whatton as the offences in question were all sexual, and sexuality is commonly thought to reveal the true identity of an individual[32]. The majority of prisoners interviewed insisted that offences were rarely discussed openly, but they also accepted that rumours, often originating in SOTP courses, spread quickly. Aware that this was the case, some prisoners told others what their offences were, but most participants expressed scepticism concerning other people's claims about their convictions. The belief that 'you can't trust anyone in here, because people lie about why they're here in the first place' led prisoners to listen carefully to people's stories, looking for inconsistencies so they could 'catch people out' (Owen). If a prisoner refused to disclose, this was taken to suggest that he had a 'closet full of skeletons' (Troy). On the other hand, 'if you're always discussing your offence, it's because there's something you're trying to cover up' (Sam). Offences in HMP Whatton were 'floating' (Matthew): although prisoners rarely acknowledged discussing them, they were never forgotten and were the source of significant anxiety.

Given the nature of HMP Whatton's population, it might be expected that its prisoners were more mistrustful than mainstream prisoners.

29. Liebling, A. assisted by Arnold, H. (2004) *Prisons and their Moral Performance: A Study of Values, Quality and Prison Life*, Oxford: Oxford University Press.
30. Crewe (2009) see n.14.
31. Ibid.
32. Foucault, M. (1976/1998) *The Will to Knowledge: The History of Sexuality Volume 1*, translated from the French by R. Hurley, London: Penguin Books.

Friendships

Mainstream prisoners rarely foster meaningful friendships while they are in prison. Limitations on trust, the break with pre-prison life and the risk of transfer combine to prevent their instigation and development[33]. Although relationships do develop in prison, mainstream prisoners tend to stress their situational and superficial nature, referring to people as 'associates', 'acquaintances' and 'prison friends'[34]. This was also the case for most prisoners in HMP Whatton:

> *They're only associates in jail. You're not gonna see them again when you get out. [...] I would probably just stay near with them and that, I won't connect with them. (Ed)*

> *I don't call them friendships in here. I just call them acquaintances, because at the end of the day, there's some people in here you will never ever see again. (Nathan)*

Proper friendships are only possible between mainstream prisoners who know each other from previous sentences or who recognise each other from their local area[35]. Similarly, two of the younger participants in HMP Whatton, both of whom had been on the mains in their previous establishments, claimed that friendships were only possible between people from the same locality because:[36]

> *We know what area we're from, do you understand, we know each other. (Malik)*

These situations provided more information on which to ground judgements about an individual's character, counteracting imprisonment's constraints on trust.

However, very few prisoners in HMP Whatton thought that being from the same area enabled friendships. As it was a specialist establishment, HMP Whatton's inhabitants came from all over the country and were therefore unlikely to see people they knew or recognised. Furthermore, the territorial attachment to locality, and therefore the inclination to form friendships based on sharing it, is a hallmark of mainstream working-class masculinity[37]. As many of HMP Whatton's prisoners came from a middle-class background, they did not import this association.

The class background of many of HMP Whatton's inhabitants also relates to the absence of hypermasculinity in HMP Whatton. Liebling argues that the shallow nature of many relationships in prison results from the protective masks worn by prisoners to help them to survive their sentences[38]. HMP Whatton's relative safety made it much easier to display frailty and express kindness. The differences between this culture and that which develops on the mains are illustrated by Darren's experiences. Darren had developed close and supportive friendships with other prisoners in HMP Whatton. He spoke movingly of the fact that his friends always 'seem to be there to pick the pieces up', for example after emotional phone calls or on the birthdays of his children. He could cry in front of them without worrying about looking like a 'pussy'. This had not been the case in his previous prisons, where he had been on the mains and had felt unable to display such sensitivity:

> *[In Whatton,] if I'm in a vulnerable state, I know no-one's gonna try and come and test me. Where in another jail, someone sees that you're vulnerable or you start letting someone pick on you a little bit, that's it, they'll come and bully you and bully you and bully you until you lash out, and then that's it then. So I think that's probably the reason why [I've been able to develop meaningful friendships in Whatton], you know, cos I know it don't matter what state I get in, no-one's gonna come and try and do anything.*

Experiences like Darren's challenge the conventional argument that meaningful friendships are impossible in prison[39]. Counter-intuitively, sex offenders in establishments like HMP Whatton might find it easier than mainstream prisoners to form meaningful friendships, as they do not need to fit into a culture dominated by masculine aggression.

However, friendships between sex offenders faced particular restrictions. Prison life is almost always temporary as prisoners will be released or transferred, a fact which often impedes relationships between mainstream prisoners[40]. Release constituted a particular problem in HMP Whatton, as the licence

33. Cohen, S. and Taylor, L. (1972) *Psychological Survival: The Experience of Long-Term Imprisonment,* Harmondsworth: Penguin Books; Liebling assisted by Arnold (2004) see n.29; Crewe (2009) see n.14.
34. Crewe (2009) see n.14.
35. Ibid.
36. 'On the mains': in a mainstream prison but not on a VPU.
37. Ibid.
38. Liebling assisted by Arnold (2004) see n.29.
39. See Crewe (2009) n.14; although see Cohen and Taylor (1972) n.33 for descriptions of intense friendships between two mainstream prisoners.
40. Crewe (2009) see n.14.

conditions for people convicted of sex offences often placed restrictions on communicating with other known sex offenders. Many prisoners in HMP Whatton had lost contact with their family and friends as a result of their conviction, and they now faced losing the relationships they made inside. Sam described the loss of these friendships as 'tragic' and 'choking', and attempted to protect himself by not fully committing to relationships with other prisoners:

> *If you have a friend outside, you'll be one hundred per cent friends with them. In here, you can only be about seventy per cent friends with them, because it's like every one of your friends have cancer or something, they're gonna suddenly die one day.*

These methods may or may not be necessary to prevent further sexual offending. However, there is certainly some contradiction between such elements of the public protection agenda and HMP Whatton's attempts to create an environment in which prisoners supported each other through treatment, attempts which were central to HMP Whatton's rehabilitative identity.

Conclusion

This article has shown that, while there are certain similarities between the social world of HMP Whatton and that which develops in mainstream prisons, there are also significant differences. In part, these differences seem to result from imported differences between sex offenders and mainstream prisoners, in particular their differences in age and class background. Sex offenders also have to deal with the stigma created by their offending, and the resulting lack of mistrust they feel about those with whom they are imprisoned.

It is also clear, however, that many of these differences relate to the particular environment of HMP Whatton, for instance its focus on ensuring civility and tolerance between prisoners. One cannot generalize from the social world of one establishment to the social world of all prisons. Similarly one cannot assume that the experiences of a sex offender in HMP Whatton will be shared by a sex offender elsewhere. The next stage in the development of a sociology of prison life for sex offenders should be a comparative study, taking account of prisoners' experiences in different institutions. This would allow greater distinctions to be drawn between the experience of life as an imprisoned sex offender and the experiences of life as a sex offender in a particular prison.

The Use of Medication to Treat Sexual Preoccupation and Hypersexuality in Sexual Offenders

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Context

Research is continually seeking to improve our understanding of factors that increase individuals' risk of reoffending. Findings have identified that sexual preoccupation and/or deviant sexual interests significantly predict sexual, violent and general recidivism[1,2]. Sexual preoccupation is defined as 'an abnormally intense interest in sex that dominates psychological functioning'[3], potentially resulting in individuals engaging in a high frequency of behaviours to relieve sexual urges. A high frequency of sexual behaviours or an excessive sexual appetite is often referred to using a number of terms, including hypersexuality[4].

In the UK interventions with sexual offenders primarily use psychological treatment methods to address different aspects of offending and teach skills to prevent reoffending. Sex Offender Treatment Programmes (SOTP) are the standard treatment methods in UK prisons[5]. However, these programmes cannot always cover the range of deviant sexual fantasies and arousal present in some sexual offenders,[6] or psychological treatment alone might be insufficient[7]. This may result in treatment needs relating to deviant sexual fantasies, sexual preoccupation or hypersexuality being left unmet. Furthermore, if sexual urges or thoughts are particularly intense, this can hinder an individual's ability to focus in treatment programmes and apply management techniques[8].

These limitations with psychological treatment programmes, and the significant public concern about sexual offenders,[9] has encouraged the use of pharmacological treatments employing medication to reduce deviant sexual arousal, fantasies and behaviours, when psychological treatment alone is not enough[10].

Treating sexual offenders with medication to reduce sex drive has been used since the 1940s[11]. In some countries, the use of pharmacological treatment is mandatory, or a condition of release from prison. In California, for example, it is a condition of parole release for repeat sexual offenders with victims under 12 years of age[12]. However, there are ethical implications, particularly when considering side-effects

1. Hanson, R.K., & Morton-Bourgon, K. (2004). Predictors of sexual recidivism : An updated meta-analysis. (Corrections Research User Report No. 2004–02). Ottawa, Ontario, Canada: *Public Safety and Emergency Preparedness Canada*.
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11. Harrison, K. (2008). Legal and ethical issues when using antiandrogenic pharmacotherapy with sex offenders. *Sexual Offender Treatment,* 3(2). Retrieved from http://www.sexual-offender-treatment.org/2-2008_01.html
12. Ibid.

of some medication, and 'there are still problems with maintaining compliance, especially when the treatment is in a pill form and administered by the offender'[13]. While compliance issues may still exist with voluntary treatment, the initial motivation to comply is different, that is to reduce sexual preoccupation and behaviours[14] rather than to secure release. For these reasons, some countries use pharmacological treatment on a voluntary basis.

Since 2007 protocols have been established within the United Kingdom to allow the pharmacological treatment of sexual offenders on a voluntary basis. This is done through referral from prison or probation and thus is currently only available for convicted sexual offenders within the Criminal Justice System[15]. Critics have argued that using medical intervention with sexual offenders diminishes acceptance of responsibility[16]. However, pharmacological treatment is viewed as a supplement to psychological treatment rather than an alternative and 'needs to happen in combination with psychological treatment to help people understand their sexual thoughts and to challenge deviant thought processes'[17]. In 2007, a three-year pilot study was introduced into the prison and probation services[18] whereby individuals could undergo assessment, and if appropriate, access medical treatment. Following this pilot, the Department of Health, HMPS and Nottinghamshire Healthcare NHS Trust have continued to fund ongoing pharmacological treatment of individuals at HMP Whatton.

Critics have argued that using medical intervention with sexual offenders diminishes acceptance of responsibility.

The service at HMP Whatton

Pharmacological medication has been prescribed at HMP Whatton since 2009 with 64 offenders referred for the service to date. Individuals are considered appropriate for referral in cases where mental health issues are identified that contribute to offending or act as a barrier to treatment, or through evidence of one of the following:

- ❒ Hyper-arousal (e.g. sexual rumination, sexual preoccupation, difficulties controlling sexual arousal, high levels of sexual behaviour)
- ❒ Intrusive sexual fantasies or urges
- ❒ Sexual urges that are difficult to control
- ❒ Sexual sadism or other dangerous paraphilias, or repetitive paraphilic offending such as voyeurism or exhibitionism.[19, 20]

Unlike the pilot, which placed emphasis on treatment managers to make referrals, HMP Whatton's scheme is dedicated to educating all staff in this process, ensuring everyone has the understanding and confidence to make a referral where appropriate. Although referrals can be made at any point in an offender's sentence, if the need for medication can be established early it will help to identify and address this as a risk factor earlier. For this to be achieved, the input of staff outside of psychology or programmes is required because offenders may not come into contact with psychology for some time. It will also help prevent any negative impact on later psychological treatment programmes. Behaviours associated with sexual preoccupation or hypersexuality are more likely to be picked up by those in frequent contact with offenders (e.g. wing staff) and it is therefore vital for all staff to have an understanding of this.

Individuals are referred by any member of staff completing a referral form. As the service is voluntary, the referral process requires that individuals have a clear understanding of what they are being referred for and why. As such, information sheets have been developed to ensure understanding, including adapted versions for individuals with intellectual or learning disabilities (ID/LD), and consent is required for each referral. Following referral, all individuals are assessed for suitability by the psychiatrist and if appropriate, this assessment will also determine which medication is most suitable for each individual.

There are two main types of medication used at HMP Whatton: the Selective Serotonin Re-uptake

13. Ibid.
14. Parhar, K.K., Wormith, J.S., Derkzen, D.M., & Beauregard, A.M. (2008). Offender coercion in treatment: A Meta-Analysis of Effectiveness. *Criminal Justice and Behaviour*, 35(9), 1109-1135.
15. See n.11.
16. Meyer, W.J., & Cole, C.M. (1997). Physical and chemical castration of sex offenders: A review. *Journal of Offender Rehabilitation*, 25(3-4), 1-18.
17. Home Office (2007). Review of the protection of children from sex offenders. London: Home Office, p. 14.
18. NOMS (2007). Medical Treatment for Sex Offenders, Probation Circular 35/2000, London: NOMS.
19. HM Prison Service (2008). Psychiatric Assessment for Sexual Offenders. Interventions Group. HM Prison Service.
20. See n.18

Inhibitor (SSRI), such as Fluoxetine, and Anti-androgens, such as Cyproterone Acetate (CPA). SSRIs, more commonly known for their treatment of depression, anxiety and obsessive compulsive disorder (OCD), act by increasing the levels of Serotonin in the brain, which is known to interact with Testosterone in the regulation of sexual behaviour. SSRIs are documented to reduce deviant sexual behaviours in patients with various paraphilias,[21] the intensity of sexual fantasies and obsessions[22] as well as sex drive and deviant sexual behaviour in sexual offenders.[23] This reduction in sex drive is not a predictable effect of SSRIs, instead the aim is to reduce the intensity of the sexual fantasies and urges, allowing individuals to acquire and utilise knowledge and skills developed through psychological treatment[24].

Anti-androgens act by reducing Testosterone levels and moderating sex drive[25] and as such has a well-researched evidence base for treating sexual deviancy[26]

Individuals usually begin on a low daily dose of SSRIs. If no satisfactory results are reported, they can move on to a higher dosage and if, after four-six weeks, there are still no improvements, a low dose of anti-androgen can be added and increased as appropriate[27]. This process is thus tailored to the individual's needs and responsivity to medication. Regular contact is maintained with the psychiatrist to monitor progress, providing the opportunity for individuals to discuss the medication and raise any concerns. Following release into the community, the psychiatrist will make arrangements to allow the individual to continue medication.

Many have criticised this treatment on the basis that it prevents future healthy sexual activity and effectively chemically castrates individuals indefinitely[28]. However, the effects can be reversed and although offenders are encouraged to continue medication on release the aim of this treatment is to reduce deviant thoughts and arousal without ruling out the possibility of future healthy sexual relationships. SSRIs in particular aim only to reduce deviant sexual interest whilst maintaining healthy sexual arousal[29]. While anti-androgens do reduce all sexual arousal, the aim is to decrease dosage over time to allow an individual to promote healthy sexual interests. With the application of skills learned through psychological treatment, which all offenders on medication should receive[30], this should be possible for most individuals.

Many have criticised this treatment on the basis that it prevents future healthy sexual activity and effectively chemically castrates individuals indefinitely.

The evaluation

In order to understand if or how the medication reduces sexual preoccupation, improves responsivity to psychological treatments and reduces consequent sexual reoffending, the impact of the medication is being evaluated. A comprehensive programme of qualitative and quantitative research is being conducted by the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) in the Division of Psychology at Nottingham Trent University. Qualitative research is a method of enquiry which allows for detailed and personal exploration of experiences. Within the research programme this method has been used to explore the experiences and thoughts of offenders on medication and staff working closely with those taking medication.

Quantitative research allows for investigation via statistical, mathematical or computational techniques. It is numerical in nature and is used to produce

21. Kafka, M.P., & Hennen, J. (2000). Psychostimulant augmentation during treatment with selective serotonin reuptake inhibitors in men with paraphilias and paraphilia-related disorders: A case series. *Journal of Clinical Psychiatry*, 61, 664–670.
22. See n.6.
23. Garcia, F.D., & Thibaut, F. (2011). Current concepts in the pharmacotherapy of Paraphilias. *Drugs*, 71(6), 771-790.
24. See n.19.
25. Thibaut, F., De La Barra, F., Gordon, H., Cosyns, P., Bradford, J.M.W., & the WFSBP Task Force on Sexual Disorders. (2010). The world federation of societies of biological psychiatry (WFSBP): Guidelines for the biological treatment of paraphilias. *The World Journal of Biological Psychiatry*, 11, 604-655.
26. See n.23.
27 See n.25.
28 See n.11.
29. Bradford, J.M.W. (2001). The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. *Canadian Journal of Psychiatry*, 46, 26-34.
30. Hill, A., Briken, P., Kraus, C., Strohm, K., & Berner, W. (2003). Differential pharmacological treatment of paraphilia's and sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, 47(4), 407-421.

unbiased results which may be generalised to a wider population. This method has been used to investigate the effects of the medication. While the evaluation is ongoing, some of the preliminary findings to date are discussed below.

Part 1: Analysis of clinical and psychometric measures

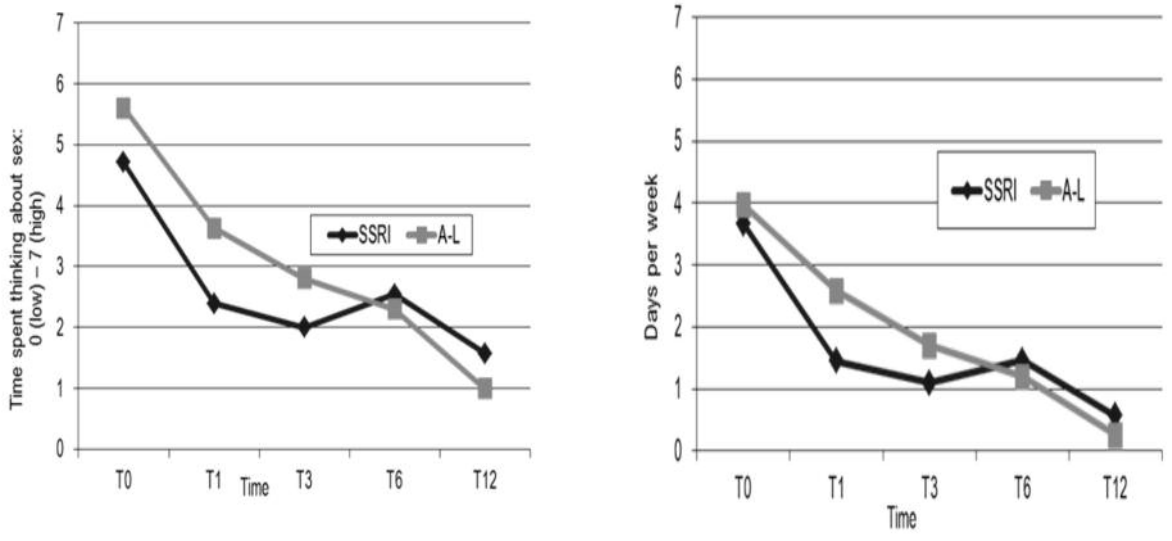
This part of the evaluation primarily focuses on quantitative analysis of individuals who are referred for, and begin to take, medication to reduce their sexual preoccupation (comparisons with those who initially refuse medication, or are non-compliant are also being conducted). Data collated includes: referral information, demographic and offending information, prison file data (e.g. risk levels), and data from participants' medical files (e.g. medication, dosage, health and monitoring information collected on a regular basis). A number of psychometric scales and measures were also collected for individuals referred since August 2011. Psychometric scales are questionnaires or assessments that can be used to measure knowledge, attitudes and personality traits. For this research, the Multi-phasic Sex Inventory (MSI)[31], the Personality Assessment Inventory (PAI)[32], the Sexual Compulsivity Scale (SCS)[33], the Hospital Anxiety and Depression Scale (HADS)[34] and the SIPP-118 (Severity Indices of Personality Problems)[35] are being used.

To date, participants comprise 64 male convicted sexual offenders; average IQ for the sample was 85, a low average score with a range from 63 (extremely low) to 114 (high average). In terms of ethnicity, 56 participants were White British, one was White Other, with data still being sought for seven participants. The average age was 43, within a range of 24-73. In terms of previous offences, over 90 per cent have committed child sexual offences, with an average of five previous contact offences and two previous non-contact offences per offender. The participants had a range of recall, determinate, life and IPP sentences. Of the 64 men referred for the treatment, 36 received SSRIs (Fluoxetine), five received Anti-androgen (CPA), seven received a combination of SSRIs and Anti-androgen, one received a GnRH agonist (Triptorelin), ten did not receive any (refused/not suitable) and five are on hold or under assessment.

Results and discussion

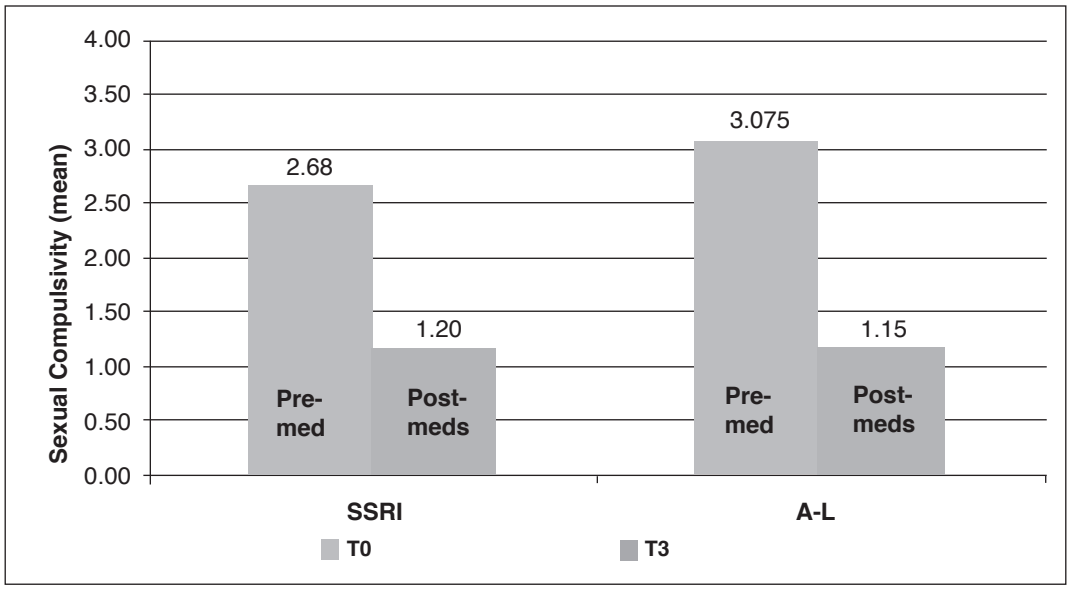
Analysis of the clinical measures demonstrated a reduction across all measures of sexual preoccupation and hypersexuality, including, for example, number of days masturbated per week; strength of sexual urges; time spent thinking about sex and sexual excitability. The graphs below show how participants' sexual preoccupation/hypersexuality reduced between T0

Figures 1 and 2: Time spent thinking about sex and number of days per week masturbated to orgasm for both medication groups, from T0 (prior to medication) to T12 (approximately 12 months after beginning medication)



31. Nichols, H.R., & Molinder, I. (1984). Multiphasic Sex Inventory manual. Tacoma, WA: Author.
32. Morey, L.C.(1991). Personality Assessment Inventory. doi: 10.1037/t03903-000
33. Kalichman, S.C., Johnson, J.R., Adair, V., Rompa, D., Multhauf, K., & Kelly, J.A. (1994). Sexual Compulsivity Scale. doi: 10.1037/t04027-000
34. Zigmond, A.S., Snaith, R.P. (1983). Hospital Anxiety and Depression Scale. doi: 10.1037/t03589-000
35. Verheul, R., Andrea, H., Berghout, C.C., Dolan, C., Busschbach, J.V., van der Kroft, P.A., & Fonagy, P. (2008). Severe Indices of Personality Problems. doi: 10.1037/t03672-000

Figure 3:
Comparison of pre and post sexual compulsivity scores for both medication groups.



(time prior to taking medications), T1 (approximately one month after taking medication), T3 (approximately three months post medication), T6 (approximately six months post medication) and T12 (approximately twelve months post medication).

Psychometric measures

The MSI was specifically developed for adult sexual offenders and consists of 20 scales measuring sexual deviance, atypical sexual behaviours, sexual dysfunction, sexual knowledge and attitudes. The PAI is a self-report measure providing a static screening of the psychopathology of clients. It consists of 22 scales designed to measure clinical, treatment and interpersonal factors related to personality. Preliminary findings show differences in levels of sexual obsessions can be predicted by levels of anxiety, anxiety-related disorders and depression.

The SCS is a ten item scale designed to measure hypersexuality and sexual addiction. Findings demonstrate that a general sample of sexual offenders have significantly lower sexual compulsivity scores than the medication sample prior to beginning medication. Post-medication, the general sample of sexual offenders had significantly higher sexual compulsivity scores than those on medication. Figure 3 highlights the reduction in sexual compulsivity scores for the two medication groups between T0 (prior to medication) and T3 (3 months after starting medication).

Conclusions

These findings show both types of medication significantly reduce hypersexuality and sexual preoccupation in participants to a level lower than that of the average sexual offender at HMP Whatton. The data merits more fine-grained analysis, however the findings are extremely positive and consistent across the different measures. Further analysis is ongoing.

Part 2:
Service user perspectives

This qualitative study involved conducting interviews (23) with 13 offenders at HMP Whatton in order to explore the experiences and understanding of individuals taking SSRIs. Thematic analysis was implemented because it aims to give voice to the service user while allowing the researcher to add a layer of psychological analysis to the account and experiences of participants. Emphasis was placed on clinical themes relevant to the evaluation and three broad themes emerged: Effects; Participant understanding and concerns; Compliance and engagement.

Effects

This theme details the observed effects of the medication across four different areas:

Sexual preoccupation and arousal — When discussing the impact of the medication, all participants reported a decrease in sexual thoughts and fantasies, suggesting it had 'lessened them to almost nothing most of the time' (Joshua). In turn this resulted in a reduction in the frequency of masturbation:

> *Well since taking it I'm erm not so preoccupied with sexual thoughts erm and*

everything else that goes with sexual thoughts has calmed down as well so masturbation and stuff like that and that's all calmed down (Mohammed)

In comparison with sexual thoughts experienced prior to the medication, participants report the current thoughts and fantasies to be less intense and 'a lot more manageable and more controllable' (Mohammed). The data also highlighted the physical effects the medication was having on arousal for the majority of participants (10). The reported effects include: an inability to achieve or maintain an erection: *'I can get a bit of an erection but I can't get a full erection'* (Tom); an inability to ejaculate or difficulty reaching ejaculation: '*…it just goes on and on and on and I won't ejaculate and I'll just give up on it'* (Mohammed); and / or a reduction in the amount of semen if ejaculation occurs: *'There was hardly anything there at all and sometimes there was nothing there at all…although I ejaculated er it was, I suppose you could call it a dry ejaculation'* (Neil). Previous research has also reported similar adverse effects of SSRIs[31]. For some reason these effects were easily accepted while others attempted to counteract these effects through becoming non-compliant or altering the nature of their fantasies.

Depressive symptoms — Participants who reported difficulties with depression reported improvements since beginning medication. This was something they spoke about very positively, often comparing themselves to previous situations: '*I used to get depressed quite a bit erm but now I sort of hardly have at all'* (Joshua); *'I don't get down as much now and I'm always having a laugh and a joke'* (Nathan). As Nathan highlights, some participants felt this reduction in depressive symptoms had allowed them to become generally *'more communicative'* (Barry) and sociable.

Impulse and emotional control — Participants conveyed their need to respond and masturbate to all the sexual thoughts they experienced prior to the medication in order to *'get the thoughts out of my head…relieve it more than anything else'* (Mohammed). In contrast, individuals now reported increased ability to recognise inappropriate sexual thoughts and urges, and deliberately distract from them:

I mean because I'm not fantasising so much that I'm concentrating more and I can think more about the offenses an er so I know that when these come into my mind …I can sort of helps help to push it away (Joshua)

This allows them to 'choose' the stimuli for arousal and masturbation, in turn altering the nature of the fantasies they experience to become more appropriate. Participants often attribute these changes to the general reduction in sexual preoccupation and having more head space to process thoughts and make conscious decisions. In addition, participants also report improved concentration levels and increased ability to manage their emotions when previously they would become angry or frustrated. This is emphasised in descriptions of themselves as 'more patient' (Joshua) and *'more mellowed'* (Nathan).

On the whole participants possessed a good understanding of the medication and why they were taking it. Their knowledge was gained through discussions with staff, the referral process and reading about the medication.

Side-effects — The majority of participants (11) reported at least one adverse effect of the medication, including constipation, sweating, headaches, tiredness and nausea. In a small number of cases participants became distressed or found the effects unmanageable, however the majority reported them to be short-lived.

Participant understanding and concerns

On the whole participants possessed a good understanding of the medication and why they were taking it. Their knowledge was gained through discussions with staff, the referral process and reading about the medication.

Participants appear to have experienced a number of concerns throughout the course of taking the medication. Initially this was regarding the impact of

36. See n.30.

the medication, what to expect and any side-effects they may experience:

> *Erm I always do, I, any treatment we are doing or any medication I always, I suppose get worried about you know, side-effects, you know, is it going to work? Is it going to make things worse? (Scott)*

Other concerns were expressed regarding the impact of medication on their ability to engage in future sexual relationships, a fear of becoming dependant on it or that it will stop working. The therapeutic relationship between individuals and staff appears vital in providing participants with a safe environment to voice and discuss their concerns: *'we discussed the other options so I wasn't afraid to, you know, to come forward and say that's not happening'* (Scott). It also provides the opportunity to ask questions that allow them to make informed decisions about the medication.

Compliance and engagement

Generally, the level of compliance within the sample appeared high, with individuals presenting as engaged and motivated to take medication. However, some non-compliance was apparent as a method of overcoming the effects on arousal, side-effects or believing that the medication was not working or they no longer need it. Interestingly all individuals who stopped the medication for these reasons later requested to resume treatment. In terms of future plans, participants displayed uncertainty regarding their intentions to keep taking the medication after release, based on a lack of motivation, fear of becoming dependant on it or concerns regarding future relationships.

Conclusions

This research supports the view that medical treatment can be effective in aiding the management and treatment of sexual risk factors such as sexual preoccupation when psychological treatments may be problematic. Despite some concerns and side-effects, the use of SSRIs appears to have had a positive effect in reducing the level of sexual preoccupation and associated sexual behaviours. Other apparent positive changes included increased emotional control and mood enhancement. All participants who experienced psychological treatment programmes emphasised that they did not see medical treatment as a replacement for psychological treatment but felt they worked well together. Overall, participants felt positive about the impact the medication is having: *'I think it's one of the best steps I made'* (Nathan).

Despite some concerns and side-effects, the use of SSRIs appears to have had a positive effect in reducing the level of sexual preoccupation and associated sexual behaviours.

Part 3: Staff perspectives

This qualitative study conducted interviews with eight members of a multidisciplinary team working on psychological intervention with sexual offenders, of whom some were voluntarily taking SSRIs or Anti-androgens to reduce sexual preoccupation. Due to their close involvement with offenders treatment progression and the medication procedures, staff were expected to have detailed and insightful views and, therefore, to add a new dimension to the current literature and inform future research and treatment. A thematic analysis was used and five broad themes were identified which are discussed below: Offenders reluctance to take anti-libidinals; Lack of awareness; Pharmacology: 'Just another piece of the puzzle'; Reporting the self-report: effects of and need for anti-libidinals; and Intellectual disabled offenders.

Offenders' reluctance to take anti-libidinals

Participants explained that offenders' reluctance to take medication is often related to concerns about the impact and side-effects, and a lack of awareness of the medication or of their need for it. It appeared that this was due to rumours circulating, possibly as a result of ambiguity and lack of available information. Making information on medication more accessible should prevent the spread of false or exaggerated rumours and reduce anxiety among offenders. In addition, informing offenders of all the possible implications of the medication should help to instil confidence in the treatment. Participants also indicated that some offenders were reluctant to disclose their sexual preoccupation and need for medication because of fear of adverse implications to their perceived risk level. This highlights the importance of focusing on overcoming poor problem recognition and informing offenders of the benefits of revealing their risk.

Lack of awareness

Participants repeatedly expressed concern about their own and others lack of awareness regarding aspects of the medication process. They discussed a desire to have more feedback following referrals, informing them who has gone onto medication to promote information sharing and end-to-end offender management. Participants also discussed a need for those outside psychology to have increased involvement in the pharmacological treatment process, particularly through completing referrals. It was highlighted that members of staff such as officers may identify a need for medication much earlier, due to their daily contact with offenders. This could be through observing behaviours or offenders confiding in them. Thus, this theme highlights the need for more training with officers and others outside psychology to increase confidence and awareness of the processes.

Pharmacology: 'Just another piece of the puzzle'

Participants discussed their positive view of the medication as a treatment option. However, they also strongly emphasised that medication should not be viewed as a 'cure' or something which can work alone as *'it's just another piece of the puzzle really to kind of help the guys make some of the changes that they need to*' (Tony). In light of this, participants emphasised the importance of having psychological treatment alongside, which is widely accepted[37]. They also expressed the importance of offenders taking responsibility for their treatment and sufficient support being provided after release to encourage its continuation, particularly as staff highlighted motivation to continue medication often decreases on release. This requires the collaboration of all those involved in an offender's sentence.

Reporting the self-report: Effects of and need for anti-libidinals

One of the primary aims of this research was to provide a new perspective into the effects of the medication. However, staff's reliance on offenders self-report to identify a need for medication, or understand how the medication was working became clear very early on. Nevertheless, this in itself is an interesting finding and is possibly a consequence of staff's lack of awareness of who is on medication, emphasising the importance of providing feedback by increasing communication between departments. Despite the reports being secondary, they were largely positive, describing offenders improvements since being on medication, for example: *'He basically would say he could still see the triggers, he just didn't have that sexual desire towards them anymore'* (Tony)', 'One of them referred to it as like a volume button being turned down a little bit' (Jo).

. . . staff's reliance on offenders self-report to identify a need for medication, or understand how the medication was working became clear very early on. Nevertheless, this in itself is an interesting finding . . .

Intellectually disabled offenders

This final theme highlighted participants' discussion of Intellectually Disabled (ID) offenders. They felt that ID offenders *'are overrepresented in the anti-libidinal population'* (Ashley). Participants expressed concern over some of the ethical issues of gaining consent and monitoring progress with this population. They suggest more training for staff, and adapted information and support for offenders, would be useful. Nevertheless, there was still a positive view from participants about ID offenders on medication: *'they had a good awareness of what it's [medication] doing for them'* (Ashley).

Conclusions

The findings of this research highlighted areas for improvement as well as of good practice in the pharmacological intervention. An over-arching theme within the data was the need for more information sharing and collaboration, to encourage end-to-end offender management. Adopting this multidisciplinary approach will contribute to a more successful delivery of the pharmacological treatment, which adheres to NOMS aims of crime reduction, public protection and offender reform[38]. However, there was a positive attitude towards the pharmacological treatment among all staff involved

37. Guay, D.R.P. (2009). Drug treatment of paraphilic and nonparaphilic sexual disorders. *Clinical Therapeutics*, 31(1), 1-31.
38. Turley, C., Ludford, H., Callanan, M., & Barnard, M. (2011). Delivering the NOMS offender management model: Practitioner views from the offender management community cohort study. *Ministry of Justice Research Series 7/11*.

in this research, which demonstrated a general desire to continue to promote it.

Conclusions

The implementation of this service at HMP Whatton appears to have been successful, with 49 prisoners having received treatment to date and more being referred on a regular basis. Furthermore, the qualitative research highlights that the treatment is being received positively by both offenders/service users and staff.

In terms of the treatment's success, preliminary findings are extremely encouraging in that the medication (both SSRIs and anti-androgens) has been shown to significantly reduce sexual compulsivity, preoccupation and hypersexuality based on the quantitative findings. The accounts of both service users and staff support these findings. One of the strengths of the evaluation is that it combines a numerical analysis of sexual and psychometric measures with a broader analysis of the 'big picture' through exploring the thoughts and experiences of service users and staff. The two qualitative studies presented complimentary data highlighting similar findings from different perspectives, for example service user concerns and how to overcome these, which strengthens the validity of the points being made.

In response to some of these findings, HMP Whatton is developing training packages on this service for various staff groups. The prison is dedicated to increasing knowledge and confidence among staff to provide a high quality service of offender rehabilitation. This is just one example of how Whatton strives to achieve offender reform by focusing on individual needs of staff and offenders, and by responding to the complicated risk factors associated with sexual offenders.

A brief report on the provision of services for hearing impaired, Intellectually Disabled, ADHD and autistic spectrum offenders at HMP Whatton

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Background

This report introduces a project currently running at HMP Whatton to identify and address service gaps for a minority group of offenders with specific disabilities. The project was commissioned by the Governor following a legal challenge to the prison over the management of an Intellectually Disabled (ID) prisoner. The challenge highlighted a failure to support an ID offender appropriately during an investigation and drew attention to a general failure within the Prison Service to make reasonable adjustments for those with disabilities. NOMS policy requires staff to 'identify prisoners with particular needs and to make reasonable adjustments'[1] and before the challenge, HMP Whatton had some existing procedures which aimed to meet this requirement, for example by offering a sex offender treatment programme to hearing impaired prisoners. However, a lack of formal strategy meant that not all disability groups were being recognised, and when they were, the information was not being communicated to key staff in the prison.

The legal challenge at HMP Whatton brought into focus the high numbers of intellectually disabled offenders held in the establishment. Consistent with previous findings[2], approximately 25 per cent of offenders who are assessed for Offending Behaviour Programmes at HMP Whatton have some degree of Intellectual Disability. These offenders may have a history of placement in high secure Learning Disabilities services or have been frequently referred to such services. Demands on secure service provision mean that many offenders who might benefit from the additional services offered by specialised Learning Disability service fail to secure a place in such facilities and are often managed within prison settings. An investigation by the Prison Reform Trust[3] has done much to raise awareness of this group of prisoners and identified a national gap in prison to meet their specific need. The costs of places in specialised learning disability services and the national gap in prison provision prompted consideration of how HMP Whatton could work with offender health commissioners to deliver the additional services usually associated with specialised environments in the prison context.

Although the initial legal challenge dealt with ID, the initial scoping process of the project identified four key target groups whose needs are not currently met and allowed for specification of different needs between and within these groups:

- Intellectually Disability (ID) — This is also referred to a learning disability, and means that a person has an intellectual functioning level below 70 on an IQ test, and that they also have difficulty with independent living. However there are also a group who do not meet the criteria for ID because their IQ is above 70, but is still below the level considered average (80 and above). This is sometimes referred to as the 'borderline' range. In NOMS offenders whose intellectual abilities fall below 80 are treated as 'ID' and are recommended to complete adapted Offending Behaviour Programmes. However, to access support services from Healthcare (service provided by the NHS), offenders need to meet the NHS criteria, which usually falls around an IQ of 64 and below. Therefore the scoping procedure proposed a 3 tiered model to identify and streamline access to services for offenders that fall into each of the IQ categories (e,g 80+, 64-79, and below 64). The lower the IQ, the greater the support required.

1. Ensuring Equality and PSI75/2011.
2. White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century (Department of Health 2001).
3. Talbot, J., & Riley, C. (2007) *No One Knows: Offenders with learning difficulties and learning disabilities*. Prison Reform Trust, British Journal of Learning Disabilities, 35, 154-161.

- Autistic Spectrum Disorder — (ASD) — ASDs include Autism and Aspergers. Both are characterised by difficulties in language and communication, interaction and imagination (flexibility of thought).
- Hearing Impaired — This includes profound or partial deafness to a degree that would prevent access to services.
- Attention Deficit Hyperactivity Disorder (ADHD) — ADHD describes a group of behaviour symptoms which result in inattentiveness, hyperactivity and impulsiveness.

The aim of the project was to explore the unique needs of these prisoners at HMP Whatton and make recommendations about how the establishment could improve their experience and environment in custody and the services they can access. These services needed to include both risk reduction activities and also services targeting social and welfare needs of the offender.

Method

In order to meet the outlined aims, a variety of methods were chosen with the intention of capturing the personal experiences of the target groups, current research evidence, and existing policies and procedure both within and external to NOMS. Five methods were utilised:

Multidisciplinary Steering Group: A multidisciplinary steering group was established to provide a clear strategic steer for the development of a specialist needs strategy and to ensure that the outcomes could be operationalised. The steering group represented the key stakeholders and consisted of the Governor of HMP Whatton, Forensic Psychologists, Consultant Forensic Psychiatrist (Clinical Director, Offender Health), Healthcare manager, Learning and Skills manager, Disabilities Liaison and Equalities managers and Residential managers. Additionally, external expertise was provided by Nurse Consultants from the Nottingham city Aspergers service[4]. The steering group convened every three months.

In order to meet the outlined aims, a variety of methods were chosen with the intention of capturing the personal experiences of the target groups, current research evidence, and existing policies and procedure both within and external to NOMS.

Literature review: A review of research literature was undertaken to identify recommended practice for the target groups. This provided an empirically sound evidence base for development of a service model.

Review of services in public and private sector providers: A survey was completed with other public sector prisons and public sector and private sector organisations working in the disabilities field to establish the services offered within each environment. In some cases, these services were visited by members of the project team and examples of best practice with service provision were identified and used to compliment the findings from the literature review.

Mapping existing provision in HMP Whatton: Services provided to all offenders at HMP Whatton were mapped out. These were then reviewed to consider accessibility and appropriateness of the service for users from any of the identified target groups.

Focus groups with Service Users: Two Focus groups were conducted at HMP Whatton with prisoners from some of the target groups. One group was undertaken with men who had accessed and completed Adapted Offending Behaviour Programmes. The other was undertaken with men who had 'moderate level'[5] ID and had not yet accessed offending behaviour programmes. The focus groups explored the offenders' experience of navigating their way through prison life and the custodial sentence.

Findings

The investigation process found that there were many services already in existence at Whatton which met some needs of the target groups. It also identified specific existing gaps in the provision of services, falling across six areas:

- Assessment — A lack of consistent, timely and targeted screening and assessment procedures which could identity prisoners who fall into the target groups.

4. The authors would like to thank Jacqueline Dziewanowska and Lynsey Regan, from Nottingham City Aspergers Service for their invaluable advice and support during this project.
5. Moderate/severe needs were defined as an IQ of between 50-64.

- Information Sharing — Some of the identified needs were being assessed independently by departments across the prison (such as learning and skills, psychology and healthcare) but there was no mechanism in place for sharing this with others departments, and needs were not consistently understood across the prison.
- Understanding of needs — There was a lack of understanding amongst the staff group generally about the identified disabilities and the associated needs of a prisoner with these difficulties.
- Treatment and intervention provision — Access to offending behaviour programmes, learning and skills, activities, counselling and other psychological services was not consistently available for all the groups. Additionally some areas of social and personal care interventions were not facilitated at all within the prison.
- Environment — The prison environment did not cater for needs, for example materials, such as application forms, notices and menus, and systems such as induction, were not accessible for those unable to read or hear.
- Throughcare — There was a lack of involvement with specialist agencies who might provide services and consultancy to meet the target groups needs. On leaving Whatton, there was also an absence of appropriate referrals to these services.

These gaps showed that HMP Whatton could do more to achieve the appropriate level of provision recommended in current policy (for example the Equality Act 2010). The findings, along with recommendations were fed back to the Steering Group via a consultancy report and visual presentation. The steering group were then able to explore a variety of alternatives to fulfilling the needs outlined and generate an action plan.

These gaps showed that HMP Whatton could do more to achieve the appropriate level of provision recommended in current policy . . .

Recommendations

Various recommendations emerged from the identified gaps. A number of these were achievable in a relatively short time frame while others required systemic change, taking longer to achieve.

Assessment — Screening to identify needs of prisoner needs should be completed as soon as possible on arrival to the establishment. Ideally within 48 hours. Those indicating a specific need at the screening stage to be referred on for in-depth assessment. The assessment process should be multi-disciplinary.

Information sharing — A communication system should be in place between Psychology, Programmes, Learning and Skills, Offender Management Unit and Healthcare, which collates information on individual prisoner needs and clearly outlines what treatment/provisions they are accessing (for example a multi-disciplinary care plan) to streamline a prisoners pathway through HMP Whatton.

Understanding of needs — Staff awareness training is an essential need around the establishment. Induction/reception and healthcare staff should be prioritised, and then rolled out to all staff groups. The training should include practical guidance on what behaviours and indicators of need to look out for, and how to respond and cater for specific difficulties. Personal Officer training should also stress the value in providing essential support, communication and services to prisoners.

Advice on the practical management of individual offenders needs should be provided to wing staff and instructional officers. This should be routinely provided in addition to the general staff awareness training. Feedback/information should then be shared by wing staff/instructional officers to the multi-disciplinary team involved in an offenders' sentence and care plan.

Environment — Offenders who require significant support should be allocated a case co-ordinator and a care plan should be created. This should be completed with a multi-disciplinary team and the offender. Regular multi-disciplinary reviews should be held to offer continuity of care and allow offenders regular input into their care plan.

Use of accessible materials to improve understanding of key aspects of prison life. Examples include Sentence Planning and OASys documentation, Induction paperwork, and key communication paperwork (such as notices to prisoners, canteen menus, wing applications). There are numerous materials already available from NOMS which should be reviewed and rolled out as a priority. Following this, signs around the establishment would benefit from being written in lower case as a minimum adjustment.

Use of an advocacy system for support. This could be done in a variety of ways. For example, an elected representative chosen by them to accompany them to

their Sentence Planning Board (a member of staff), or links with organisations who provide legal advocacy support to offenders. However, there is also a need for less formal advocacy for such offenders e.g. for example in assisting them to complete application and complaints forms. It was therefore recommended that an appropriate peer support scheme be implemented to achieve this.

A follow up visit by a member of staff after the first induction talk. This should check they have understood the information given. A recap over the induction information should also be provided.

Interventions and treatment — It was recommended that all existing Learning and skills courses be made available for offenders at Entry level 1. Improved social care/living skills support; the current programme of courses could be developed to offer a wider range of programmes to support social care and independent living needs. Interventions and psychological services should be made available to address offending behaviour needs that are not currently met through existing accredited adapted provision. This could include use of interpreters for hearing impaired offenders, adapted materials and delivery methods and provision of offence focused work where an accredited programme is not available.

Throughcare — Better links with community services would streamline services. To begin with those who fall in scope for NHS/healthcare services should be referred onwards. This would be more challenging for those who fall outside this scope, although still beneficial. They would qualify for minimal services in the community through the NHS. However, a relationship with charities and independent organisations could be of benefit (e.g. Autism West Midlands).

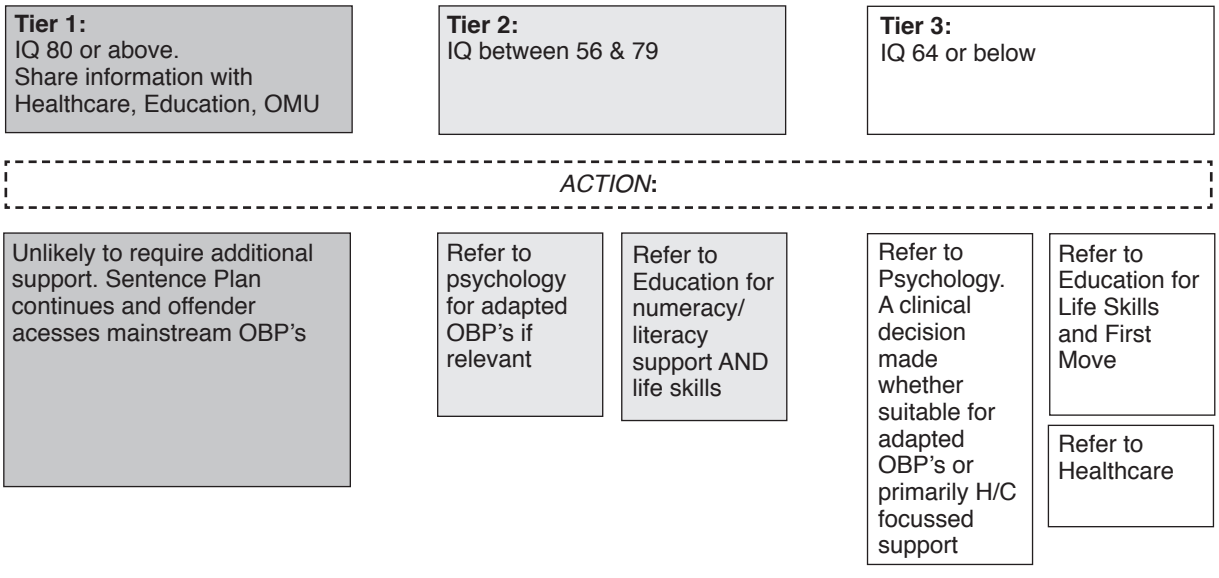
Actions

The multi-disciplinary steering group reviewed the recommendations and developed an action plan to deliver them. The action plan proved valuable in initiating and monitoring the implementation of the recommendations. Some recommendations were not implemented in the original form because they were deemed to provide little additional value to service delivery. In these cases, alternative means of meeting the aims of those recommendations was explored. For example, provision of speech and language therapy for highest need cases could be met through the addition of a specialised Learning disabilities nurse.

A priority task was to identify and respond appropriately to need. In order to do this, a care pathway model was adopted (see figure 1). This has three core functions: time bound identification of need (screening, and assessment), referral to appropriate service and case management (via a case worker and multidisciplinary team meetings). In order to streamline resourcing and in line with commissioning intentions, services are related to need and risk. To respond to the varying needs of ID prisoners, a three-tier system has been introduced which sees the most intensive services matched to prisoners with an IQ below 64. The highest risk offenders would be prioritised for interventions provided by other service providers (e.g. Psychological services or Learning and skills) if they do not qualify for Offender Health based provision.

Additional specialist services for those with ID were recommended, particularly to manage prisoners with the

Fig 1:
3 Tier Model



most need. A bid has been submitted to offender health to secure funding for a full time ID nurse, and some input from an ID specialist Psychiatrist and ID specialist Clinical Psychologist. Offender health commissioners have been keen to engage with the bid recognising the cost effectiveness of providing these services in prison rather than more costly secure health environments. The bid aims to ensure specialised staff provide services to the offenders who would be considered to have a moderate to severe ID.

Key staff in the establishment have formed a working group to provide support to other departments in HMP Whatton to review and amend all the existing documents that prisoners rely on to access information and services. This includes changes to canteen sheets, complaints forms and general applications. The project has also highlighted the wide range of documents and resources which exist within NOMS to assist ID offenders in navigating their way through prison, e.g. for example Easy Read version of the OASys sentence plan. Sadly the existence of these documents is not widely known about and consequently do not seem to be used. Work has been undertaken to ensure managers of the relevant departments are provided with these resources and tasked to ensure that they are used with the appropriate group.

The review highlighted the presence of a wealth of information about offenders needs within the establishment, with several detailed assessments being available for individuals. However these were rarely accessible to all interested departments and so work has been undertaken to establish a central database for recording the outcome of reception health screening, education assessments and any available IQ assessments that have been undertaken within the establishment. This presents some complex challenges for relevant professionals. Ensuring informed consent for information sharing is gained has formed a key aspect of the delivery of this work. However, it is work that has been worthwhile in ensuring valuable data on an offenders needs is identified early and shared with those who can best assist them in addressing these needs.

A staff training programme, delivered by a multi-disciplinary team, has begun to raise awareness of the specialist need groups, their needs and how best to work with them.

Future directions

A next step is the introduction of a 'passport' system; small booklets which each prisoner from a target group will carry with him to make sure his needs are communicated to all departments in the prison. This will also allow him to access specific services.

Staff training will continue, providing specific training packages to different groups. For example, training with Offender Management Unit on risk assessment and interview techniques with specialist need groups. A formal, prison wide launch of the care pathway model is also planned.

We are currently exploring the possibility of a verbal complaints procedure for prisoners who are unable to write.

Conclusion

Whilst there are clearly still challenges to deliver more accessible services for these specialist need groups the project has revealed that there are many things that can be done to improve this within existing resourcing. Implementation does not need to be costly but does take time and there are accessible existing resources that prisons can draw on. It is likely that most prisons will be able to review and improve service provision to specialist need groups without significant resource implication. A multi-disciplinary steering group representing key prison departments is essential to the success of such a project.

Resources

The following is a list of resources available that were used by the steering group:

A variety of Easy Read guidance and documentation is available from www.changepeople.co.uk. These include a range of picture banks, accessible materials and Easy Read guides (How to Make Information Accessible).

The learning disabilities mailing list is a monthly email circulation containing packages and links to ID resources and a means of communicating with professionals about ID. This is available from the UK Forensic and Learning Disabilities Network run by Janet Cobb at www.jan-net.co.uk.

Crossing the Communication Divide is a toolkit for Prison and Probation staff working with offenders who experience communication difficulties (including learning and literacy difficulties, autism and aspergers, ADHD, sensory difficulties, dyslexia and dyspraxia). It was commissioned by NOMS to produce guidance for practitioners involved in Offender Management. This includes accessible versions of the OASys self assessment form and prison general application. Available from the Knowledge Library (Reference number 200943 November 2009) on the Prison Service Intranet.

The Prison Reform Trust have undertaken substantial amounts of research and produced a number of documents specifically designed to provide information and support to prisoners with additional needs: www.prisonreformtrust.org.uk.

Positive Practice, Positive Outcomes: a handbook for professionals in the criminal justice system working with offenders with learning disabilities: http://tinyurl.com/4pcwat4

Doing Good Risk Assessment With Intellectually Disabled Offenders

Kerensa Hocken *is a registered forensic psychologist and the clinical lead for the Sex Offender Treatment Programme at HMP Whatton. She is currently studying for a PhD in the risk assesment of intellectually disabled sexual offenders.*[1]

Background

Intellectually Disabled (ID) offenders are perhaps one of the most forgotten groups in the prison system. Even though key research by the Prison Reform Trust[2] has done much to highlight the size of this population and raise awareness about what should be done to meet their needs, change is slow.

Reports such as those by the prison reform trust prompt us to think about how the daily prison life of an intellectually disabled prisoner may be disadvantaged and this consideration must also extend to their experience of treatment and assessment for offending behaviour. There are currently very few accredited programmes for intellectually disabled prisoners. The Becoming New Me and Adapted Better Lives Booster programmes exist for sexual offenders, little else is available, although this is starting to change with the welcome pilot of the Adapted Thinking Skills Programme and the learning disability Therapeutic Community at HMP Gartree. However, the process of risk assessment for ID offenders has not received the same level of consideration. Risk assessment in prison can vary, but all prisoners will have an OASys (Offender Assessment System) report and many will have other structured risk assessments such as the Historical Clinical Risk 20 (HCR-20) or Structured Assessment for Risk and Need (SARN). An essential element to completing these assessments is the prisoner interview. This allows for the exploration and clarification of their history, and any progress made in reducing or managing their risk. However, recent research[3] suggests that how we conduct these interviews may result in inaccurate risk assessments.

Charactertistics of intellectual disability

In order to understand the difficulties of doing risk assessment with ID offenders it is helpful to clarify what an ID is and some of the difficulties people with ID may experience. The severity of an intellectual disability is classified across four levels:

- Profound — this is where a person will have marked physical difficulties and need intensive specialist care.
- Severe — a person can acquire some limited reading skills but will require supported accommodation and assistance with daily living.
- Moderate — individuals are unlikely to be able to live independently but can acquire limited vocational and educational skills.
- Mild — individuals are more likely to be able to acquire some vocational and educational skills and live independently but may need support at times of change.

Most (approximately 85 per cent of people) with an ID will fall into the mild range. It is estimated that approximately 7 per cent of prisoners have an ID[4]. Although the exact breakdown is unknown, most of these will fall into the mild range, however there will be some prisoners who do fall within the moderate range. It is highly unlikely that there are any prisoners falling into the severe and profound ranges. There is also a 'borderline' range. Although not meeting the classification for ID, this group are below the average range of intellectual functioning, often have difficulty securing stable employment and tend not to do well educationally. Due to these difficulties, prisoners falling into the borderline range are accommodated on the offending behaviour programmes adapted for those with an intellectual disability. Approximately 25 per cent of prisoners are expected to fall within the borderline range[3]. Although we commonly don't think of ID as being something we encounter routinely in prison, these figures suggest it is much more prevalent than expected and it is likely that most of us will come into contact with prisoners who have mild ID or are in the borderline range on a weekly basis.

1. A very special thank you to Fiona Williams from Operational Support and Interventions Group, National Offender Management Service, many of the suggestions for interviewing IDSOs outlined in this paper are based on techniques used on the Becoming New Me Programme run in prisons and the national probation service by NOMS, for which she is responsible. Thank you to Mike Dean at HMP Whatton for the pictures.

2. Talbot, J. (2008) *No One Knows* report. London. Prison Reform Trust.
3. Hocken, K.E.L, Winder, B., Grayson, A. & Andrews, M. (2013) *An Investigation into the Relationship Between IQ and Dynamic Risk Factors for Sexual Offending Using the Structured Assessment For Risk and Need for Sexual Offenders*. Manuscript under preparation.
4. Mottram, P. G. (2007) HMP Liverpool, Styal and Hindley Study Report. Liverpool: University of Liverpool.

Difficulties commonly encountered by those with an ID can be broadly categorised into five main areas: language, memory, abstract thinking, processing speed, and managing life and relationships. Each of these will be described in more detail below.

First, in relation to language, people with ID can have difficulties with using language (known as expressive language) and understanding language used by others (known as receptive language). Sometimes a person will have problems in both areas, but often people are better at one than the other. In prison this may result in staff assuming that prisoners understand more than they actually can because they have good expressive language. Problems with expressive language include not knowing a large range of words and not understanding unfamiliar, or long words (three syllables or more as a general rule). As a result they do not have the range of words to use and may use words incorrectly. A good way to think about this difficulty is imagining you are trying to use a foreign language. You only know a limited amount of words and pick from those to get your point across, but the meaning is not exact. Sometimes however, the meaning can be way off target, for example; I recently interviewed an ID prisoner who used the word 'commitment' instead of 'situation'.

Second, memory, which refers to the fact that people with ID can have difficulties learning new information because they have problems with memory. Although they may actively engage in learning, there may be problems with committing information to long-term memory, so it will be forgotten. Sometimes the brain tries to account for the gaps in the memory by automatically trying to fill in the missing information, known as 'confabulation'. Because this process tends to be automatic, the person is typically unaware that it is happening and believes the memories are accurate. This can result in incorrect recollection of events and inconsistent reporting of events. In prison a failure to recall a detailed and consistent offence account is often mistaken as being risky, resistant or manipulative. People with ID may also have problems learning new information and using it straight away. For example, they may not be able to incorporate feedback into their behaviour immediately because the brain gets overloaded.

Third, abstract thinking involves non-verbal problem-solving skills, such as those needed for solving picture puzzles and understanding time and sequences. It includes the skill of using imagination to think about future situations and being able to predict consequences of actions in those situations. Having an ID can make these things more difficult and as such, those with ID may get the order of events wrong and struggle with hypothetical situations[5]. So, questions commonly asked of prisoners such as, 'imagine you are in this situation, what would you do?' can be difficult for those with ID.

Difficulties commonly encountered by those with an ID can be broadly categorised into five main areas: language, memory, abstract thinking, processing speed, and managing life and relationships.

Fourth, processing speed encompasses a common difficulty for those with ID have with the speed at which the brain can process information. Often it takes a little longer for an ID person to follow what is being said because their brain needs longer to find meaning to the information. This can cause them to fall behind in conversations and they may answer a question asked ten minutes previously.

Finally, managing life and relationships addresses that people with ID may not be able to live independently, because they have difficulties with self-care, managing finances, hygiene and health, literacy, numeracy and telling the time. It is also common for them to have problems in communication, such as eye contact, and understanding social cues, sometimes resulting in them saying or doing the wrong things. They can also be suggestible and easily influenced.

Having an ID can put people at a disadvantage in life that can affect their self-esteem and self-concept. In order to fit in, it is common for those with an ID to learn how to 'mask' their difficulties, so some of the problems above are not immediately obvious unless you really know them or they have had in-depth assessments. This is also why we may underestimate the number of prisoners with an ID.

In order to account for these difficulties it is necessary for adjustments to be made to the environment and services. In prison this means offering offending behaviour programmes tailored to meeting

5. Dulaney, C. L., & Ellis, N. R. (1997). Rigidity in the behavior of mentally retarded persons. In . E. MacLean (Ed.), *Ellis' Handbook of Mental Deficiency, Psychological Theory and Research* (3rd ed). Erlbaum: Mahwah, NJ. pp. 175–195.

these needs so that prisoners with an ID can have the best learning opportunities. However, a significant part of the prison process, risk assessment of offending behaviour, has not yet begun to take account of the needs of ID prisoners. This is an area that needs immediate attention, since risk assessment outcomes impact upon treatment opportunities, potentially delay or facilitate possible release dates, and influence the level of restrictions in place once a prisoner is released.

Problems with risk assessment of ID prisoners

Traditionally, interviews take a verbal style of communication (normally a question and answer format) and rely on the recall ability of the offender (what they can remember about their offence and from treatment). It is possible that by using this style of interview for ID clients we may be measuring memory and communication skills, rather than risk, because the skills required to recall and verbalise past events and learning are often those that ID people struggle with, as discussed above.

In risk assessment interviews prisoners are often asked to think of risk scenarios and discuss how they would manage them. This requires abstract thinking skills because it demands the ability to think hypothetically, something which ID people find difficult to do because they tend to think in more rigid and concrete terms. Therefore, ID offenders might not be able to identify risk scenarios or explain how they would manage them in an interview situation, but this may have nothing to do with their actual understanding of their own risk and ability to manage it. The assumption that a prisoner must be able, hypothetically, to identify risk situations to indicate risk reduction may be flawed. In real life offenders need to be able to *recognise* risk situations as they arise, which requires a different set of skills to those that are needed for imagining one.

Staff presented with a prisoner who is vague and inconsistent, who does not describe risk factors, risk situations or relapse prevention strategies beyond very concrete ones, would be forgiven for thinking that person is risky. However, it seems we may be working on assumptions about the indicators of risk and progress, and failing to draw upon the wide evidence base about learning and memory. For example, we know from the early research on memory[6] that an inability to recall information does not necessarily mean it is not available, but that it may not *accessible*, and therefore requires other methods to help access it. The adaptations made to the way treatment is delivered to ID sex offenders are based on the literature relating to working with ID populations and it is generally accepted that treatment must be adapted in this way to make it learning accessible and useful for ID offenders[7]. If we know that learning methods must be adapted for ID offenders, it should then follow that we adapt methods for accessing that learning accordingly, however there is nothing in the literature on risk assessment that identifies this need. It is possible we could improve risk assessments with ID prisoners by making changes to the way in which we do the risk assessment interview, using our knowledge from treatment with ID offenders and drawing on the memory and learning literature.

. . . a significant part of the prison process, risk assessment of offending behaviour, has not yet begun to take account of the needs of ID prisoners.

Suggestions for interviewing

To compensate for the difficulties described above, treatment for ID sex offenders in the National Offender Management Service (NOMS) is based on the VAK principles[8] (Visual, Auditory, Kinaesthetic). These VAK principles highlight three communication styles that should be consistently adopted when working with ID offenders (sometimes referred to as 'VAKing up' your style!). This means communication should include visual, auditory and kinaesthetic elements. Currently, we rely almost exclusively on an auditory style, using spoken language. The challenge facing us is to expand our skill set to use the other two styles of communication in interview. In reality this means:

Visual — Using visual elements in your communication style helps to make concepts more concrete and avoids problems ID people might have understanding language. A good way to do this is to

6. Tulving, E. & Pearlstone, Z. (1966) Availability versus accessibility of information in memory for words. *Journal of Verbal Learning and Verbal Behaviour*. V 4, No 5, 381-391
7. Hurley, A., DesNoyers, T, Daniel, J., Pfadt, A.G. (1998) Individual and group psychotherapy approaches for persons with mental retardation and developmental disabilities. *Journal of Developmental and Physical Disabilities*. Vol. 10, No.4, pp. 365-386.
8 . Ministry of Justice (2009) *The Adapted Sex Offender Treatment Programmes: Theory Manual*. Interventions and Substance Misuse group, National Offender Management Service, London.

use simple drawings or pictures. If both people can see what is meant, it reduces the chances of misunderstanding. You can use drawings in any way you want, but they work well when you want to ask about a hypothetical situation because you can draw it, either as a single situation or a story board in which you can narrate the sequence of events (see figure 1). It is advisable to put the prisoner into the story rather than drawing a situation about other people and asking the prisoner what they should do. Research suggests that ID people are often able to give the right answer about what others should do, but when asked what they would do, tend to give a completely different response which seems to better reflect their behaviour[9]. Drawing an offence account can also help to get a more accurate and detailed description. This is because ID prisoners cannot always describe events very well but they can draw them, or explain enough for you to draw it. (The benefits of doing this are very similar to those described by Helen O'Conner and Nicola Payne in their article about working with deaf offenders elsewhere in this issue). Another good visual technique is a timeline (see figure 2). A timeline can be used to represent a lifetime or just a few hours, but it is important to clearly mark the timeline with key events and dates because this helps the person to remember the order of things much better than if only using verbal recall. You can also encourage them to elaborate the timeline with pictures or memorabilia such as photos.

Visual reminders are also good to prompt memory, especially when asking about what has been learned in treatment, because recognition is easier for ID people. Therefore, treatment materials should be taken into interview and used as a focal point to ask about certain things. To assess sexual interests, showing pictures from magazines or media and asking an ID prisoner to pick out preferences provides a more concrete method than simply asking them for a description.

Auditory — Although this is the method we use most commonly, there are several changes needed to the way we use language when working with ID prisoners to account for problems with expressive and receptive language skills. The key change is to use simple language. This means avoiding long words (typically three syllables or longer) or jargon, something very common in prison. Try to ensure you only ask one question at a time and leave plenty of thinking of time. A common misconception is that prisoners are being avoidant or resistant when they do not answer questions immediately, but ID prisoners need much more time because of their slow processing speed.

When interviewing a prisoner about progress on a treatment programme it is really important to try to use the type of language used on the programme, because ID prisoners probably will not recognise what they are being asked unless the question is in familiar language. For example, on Becoming New Me we use the concept of 'old me' (to describe the person they were when they offended) and 'new me' (the person they are when they don't offend). So an ID person may have trouble

Figure 1
Story board of an offence

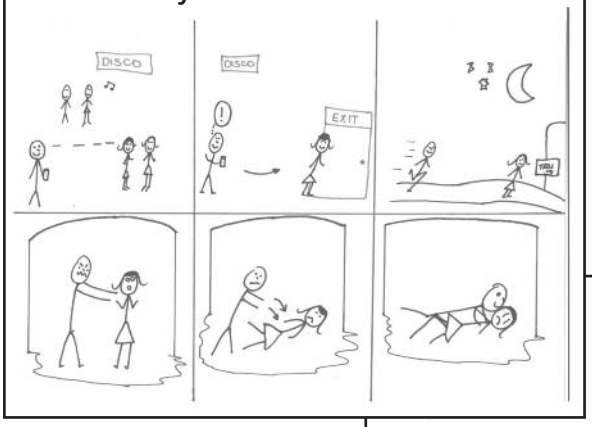
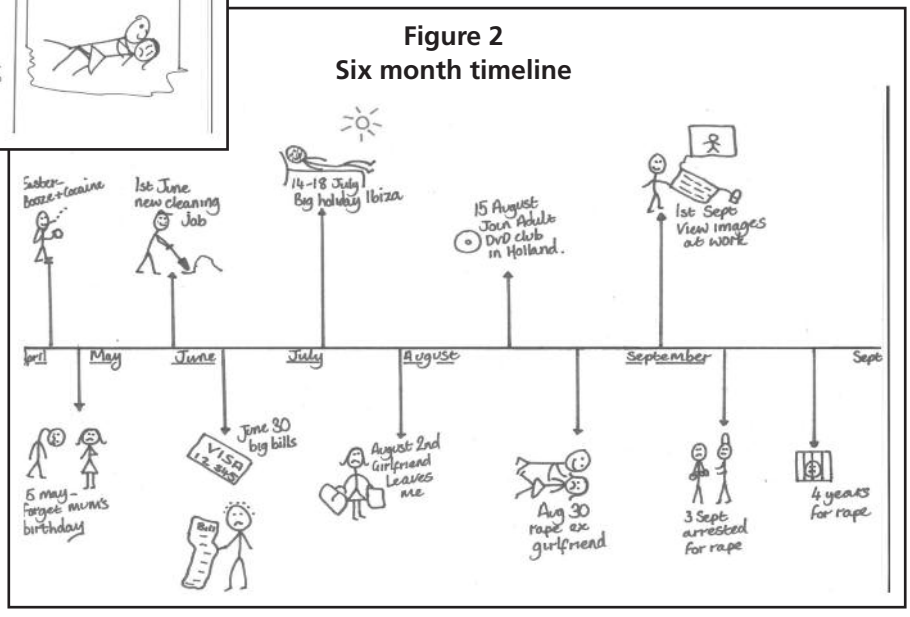


Figure 2
Six month timeline



9. Mayes, D. (2013) *Assessing the Role of Sexual Knowledge, Beliefs and Attitudes in Sexual Offending by Intellectually Disabled Men*. PhD Thesis under preparation. Nottingham Trent University.

with the question 'what are your risk factors?', but are likely to understand: 'what are your old me risky things?' If possible, it is good to speak to a facilitator of the programme to find out what type of language they will recognise, or better still take the facilitator along to the interview with you. A final tip is to avoid clichés, dry humour or sarcasm because ID people might not understand it and could misinterpret it. Avoid the trap of thinking they understand this use of language because they appear to use it themselves. ID people often use these forms of expression without fully understanding their meaning, and they commonly get sayings wrong or mixed up (e.g. I was like a bull in a haystack).

Although some of these suggestions sound quite simple they do require a lot of concentration because we tend to be unaware we are doing things such as asking more than one question at a time.

Kinaesthetic — This refers to a communication style that is about 'doing', for example demonstrating a concept through role-play. This style tends to be one that is most unfamiliar to us and feels very much out of our comfort zone. However, it is valuable because ID offenders may be able to use the skills taught, but not explain them. A good way to understand this is to think about doing sports. As you practice you get better, but you are not always able to explain what it is about the way you play that has improved, you just know you can do it. Therefore, role-play is a great way of checking out learning and relapse prevention plans. For example, you could ask an offender to show how they might respond in a certain situation, rather than just describe it. This might require you to simply set up the situation, either through description or through use of drawing, and possibly take on a role (e.g. 'lets imagine we are in a pub, I am your friend and I say: 'go on have a drink', show me what you would do?). This technique works even better when you ask the person to tell you what the friend would say that could be particularly tempting. It is also important to say the line directly ('go on have a drink') rather than only describing what you are saying ('I'm persuading you to drink') because it needs to be as realistic as possible. This technique can be easier with another person involved, such as a programme facilitator.

You can also use these techniques to get an offence account by asking an offender to 'walk and talk' the offence. This is done on a very basic level, not using touch, by having the offender slowly walk through what they did. One of the reasons this may be effective is the concept of 'body memory'[10]. Although not a proven phenomena, it is thought to be independent from our conscious verbal memory, and people may remember more through reinstating the body movements than if they only verbalise it. A simple example is when you have to retrace your steps after losing something to help prompt memory.

Other tips

ID offenders tend to have a reduced ability to concentrate[11], therefore interviews need to be kept short, ideally no more than an hour. Long interviews are likely to have several negative effects on the quality of the information gained because fatigue reduces the ability to remember and to use language correctly. From the ID offender's point of view, this may increase their perception of failure and low self-worth, resulting in them giving up or becoming frustrated.

ID people can be suggestible and they may agree with you or say what they think you want to hear.

To explore their ability to spot a risk situation it is better to give them a selection of situations and ask them to tell you which is the risky one, rather than simply asking them to tell you what their risk situations are. It can be helpful to get them to rate the risk situations on a traffic light system: green for no risk, amber for some risk and red for very risky. This allows you to test their ability to recognise risk.

ID people can be suggestible and they may agree with you or say what they think you want to hear. This tendency should not be mistaken for manipulativeness, because it is not generally intended to be deliberately deceptive or misleading. There are several reasons why ID people are suggestible, including a need to please and fit in and because they do not understand what is being asked of them. In order to minimise this, try to avoid asking too many closed questions (e.g. 'have you had a risky thought this week?' is worded better as 'when was the last time you had a risky thought?'). Of course in prison we are working with an anti-social group, and ID people can be manipulative and deliberately deceptive, but it is important to bear in mind that there may be other explanations for what you are seeing.

10. Rothschild, B. (2000). *The Body Remembers: The psychophysiology of trauma and trauma treatment*. London. Norton.
11. Keeling, J., and Rose, J. (2006) The adaptation of a cognitive behavioural treatment programme for special needs sexual offenders relapse prevention with intellectually disabled sexual offenders. *British Journal of Learning Disabilities*, 34, 110-116.

Many offenders, and particularly ID offenders are likely to be nervous when entering an interview situation, especially when they know it is about their offending and can impact on their release. These feelings can hinder their already limited communication skills, so helping them to relax and feel comfortable can make a big difference to the way they perform. Building rapport through general conversation first is done by most staff and is essential with ID offenders, but you should also consider doing some simple icebreakers as well. These help to relieve tension and build trust. There are lots of free ideas on the Internet for icebreakers.

The suggestions offered above are suitable for use with prisoners who fall into the borderline range as well as those with an ID. However, the greater the difficulty they have, the more need there will be to use these techniques. Be flexible with these techniques and use them together in combination for best effect. Not all these techniques will be helpful to everyone, you will need to try out various different ones with a prisoner before finding out which ones work best for them.

Behaviour observation

Behaviour observation, from a range of sources, has been highlighted as particularly important with ID offenders because of their difficulties in communicating change and behavioural intention[12]. It is helpful to talk to others who know and work with the prisoner. It is important to consider in advance how risk behaviour may show itself and ask specific questions about it. A behavioural observation checklist might also be given to staff who know the prisoner to facilitate this process.

Structured clinical judgment risk assessments

Many offenders require specialist risk assessment, completed by a psychologist or probation officer. For anyone completing one of these for an ID prisoner it is important to consider the validity of that assessment for this group. Risk assessments are usually developed on research samples that do not include ID offenders and therefore the risk factors that the tool assesses may not easily apply to ID offenders. Specialist guidance for the adaptation of the tool for ID offenders exists for some risk assessments, such as the Psychopathy Checklist-Revised, Historical Clinical Risk — 20 and Sexual Violence Risk-20[13]. This additional guidance should always be used when doing a risk assessment with in ID offender. If assessing sexual offending, it be helpful to consider using the Assessment of Risk Manageability for Intellectually Disabled Individuals who Offend- Sexually (ARMIDILO-S). This risk assessment has been developed especially for ID sexual offenders and initial research on UK samples shows good predictive validity[14].

Future directions

Research on risk assessment with ID offenders is a new area and we know relatively little about it. Further research is needed to explore if the same factors are relevant to risk, the difficulties associated with assessing risk and developing risk tools specifically for ID offenders. The Structured Assessment for Risk and Need (SARN) has been subject to such research and specialist guidelines for assessors are under preparation. Further research is needed on the UK prison population, since much of the research on ID offenders tends to focus on UK community offenders or those from different countries.

Conclusions

Thanks to investigative research done by those such as the prison reform trust, we are more aware of the presence of ID offenders in the prison system. Many changes to the prison environment are necessary in order to accommodate their needs and provide equality of access to services such as offending behaviour programmes and, importantly, risk assessment. While change will be inevitably slow, it is within our capabilities to improve the way we conduct risk assessment interviews with ID offenders immediately. This can lead to better quality risk assessments for this group because of the more detailed and accurate information that offenders can give us through using these techniques. The challenge is to reflect on what we implicitly value as signs of risk and progress in intellectually disabled offenders, and to rethink those assumptions. Many of the changes needed to our interviewing style may feel uncomfortable and take practice. However, it is essential that we move towards this change in order to make sure that ID offenders are afforded equal opportunities within the risk assessment process.

12. Boer, D.P., Haaven, J., Lambrick, F., Lindsay, W.R., McVilly, K., Sakdalan, J. & Frize, M. (2012) *Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend Sexually* http://www.armidilo.net/# accessed on 04 June 012.
13. Craig, L.A., Lindsay, W.R. & Browne, K.D. (Eds) (2010) *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities*, A Handbook. Chichester, Wiley-Blackwell.
14. Blacker,J., Beech, A.R., Wilcox, D.T. & Boer, D.P. (2011) The assessment of dynamic risk and recidivism in a sample of special needs sexual offenders. *Psychology, Crime & Law*, Vol. 17, No. 1, 75-92.

Treating Deaf Sexual Offenders:

Theory, Practice and Effectiveness

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Background

According to the Royal National Institute for the Deaf more than 100,000 adults can be categorised as having severe to profound deafness. The extent of the hearing loss, along with the age at which a person becomes deaf have a significant effect on the way they communicate, which ranges from lip reading to using British Sign Language, (BSL)[1].

A lack of systematic recording means that the number of deaf offenders in prisons is unknown. In 2003[2] there were estimated to be 100 deaf offenders in custody and deaf offenders were said to be over represented in prisons compared to hearing offenders[3]. Gerrard[4] identified that over 75 per cent of deaf offenders regarded BSL as their first language and found the written word a restrictive and frustrating activity. One-in-four deaf prisoners do not have an interpreter in court hearings and so enter prison without fully understanding the charges they have received. Prisons are not designed to accommodate people with hearing loss[5], meaning deaf offenders are often denied the same opportunities and access to services as hearing prisoners.

The number of deaf *sexual* offenders in the prison service is equally unknown[6], this is partly because many deaf sexual offenders receive probation orders and do not enter into the prison system unless they have committed a serious or repeated sexual offence. One explanation for this is that judges are more lenient in their sentencing due to their 'condition' of being deaf[7].

Treating deaf sexual offenders

Some argue that, for treatment programmes to be accessible to deaf sexual offenders they require interpreters for communication between facilitators and group members. However, other researchers[8] suggest the use of interpreters raises a number of issues, including the effect on the therapeutic relationship of the triadic relationship of interpreter, facilitator and group members.

Despite these difficulties, interpreters are recognised as being the appropriate way to communicate with deaf offenders in a treatment setting[9]. Only a small number of prisons pay for interpreters[10] therefore, lack of access to this support, makes it more difficult for deaf sexual offenders on indeterminate sentences to demonstrate that they have lowered their risk. This implies that many are refused parole as they have not attended treatment, when in fact there is insufficient provision to enable them to access the help they need[11]. As a consequence, deaf sexual offenders can spend longer in prison, which impacts on their feelings of isolation and mental health[12].

At present, forensic services for deaf sexual offenders are inadequate[13] and only psychiatric services in the UK provide assessments and treatment for deaf sexual offenders with mental health conditions. These include a high secure and medium secure unit which both offer treatment for deaf sexual offenders. The treatment processes are found to be effective despite the use of BSL trained staff rather than interpreters[14]. However, measuring the effectiveness of such programmes relies on psychometric testing, which

1. Austen, S., & Coleman, E. (2004). Controversy in deafness: Animal Farm meets brave new world. In: Austen, S., Crocker, S, eds. 2004. *Deafness in Mind – Working Psychologically with Deaf People across the lifespan*. London: Whurr.
2. Department of Health, (2005). *Mental Health and Deafness, Towards Equity and Access*, NIMHE. HMSO.
3. Miller, K. (2003). Deaf Sex Offenders in a Prison Population. *Journal of Deaf Studies and Deaf Education*, 8, 3: 357–361.
4. Gerrard, H. (2000). *A double sentence: Deaf prisoners in the UK*. London: Deaf Prison Project.
5. Gibbs, A., & Ackerman, N. (1999). Deaf prisoners: Needs, services and training issues. *Prison Service Journal*, 22, 32: 31–32.
6. Berry, M., & Brown, J. (2006). Some aspects of possible vulnerability of Deaf people in the forensic world. *Forensic Update*, 85: 27–33.
7. Ibid.
8. Marshall, W. L., Fernandez, Y. M., Hudson, S. M., & Ward, T. (1998). *Sourcebook of Treatment Programmes for Sexual Offenders*. New York/London: Plenum Press.
9. Bramley, S. (2007). Working with deaf people who have committed sexual offences against children: The need for an increased awareness. *Journal of Sexual Aggression*, 13, 1: 59–69.
10. Ireland, J. (2005). Personal communications in response to an earlier draft. UK.
11. Gerrard, H. (2000). *A double sentence: Deaf prisoners in the UK*. London: Deaf Prison Project.
12. See n11.
13. Department of Health, (2002). *A sign of the times: Modernising Mental Health Services for People who are Deaf*. London. Department of Health.
14. Young, A., Howarth, P., Ridgeway, S., & Monteiro, B. (2001). Forensic referrals to the three specialist psychiatric units for deaf people in the UK. *Journal of Forensic Psychiatry*, 12: 19–35.

typically involves a large verbal component. As deaf language skills are extremely varied, this impacts on the internal validity of the measure if questions are posed differently and lose meaning. That has an impact on the level of standardisation and highlights that measures of effectiveness based on psychometric testing are only as reliable as the assessors administering them[15].

There are currently no services within prisons for deaf sexual offenders. Little is known about recidivism among this group as the number of deaf sexual offenders in custody is unclear. However, recidivism is estimated at 30 per cent, so the need to develop better service provisions for deaf sexual offenders is clear[16].

HMP Whatton is developing a new Sexual Offender Treatment Programme (SOTP) for deaf sexual offenders. In trying to address such obstacles, provisions were put in place. These provisions will be discussed as part of an evaluation of the effectiveness of this model of treatment.

Group Information

The Deaf SOTP was delivered to four group members. Three experienced and BSL trained facilitators delivered the programme, working on a rotational basis with two being present in each session. There was a team of four BSL interpreters, also working on a rotational basis with two interpreters per session. There were two supervisors to ensure availability given the additional needs of the client group.

There are currently no services within prisons for deaf sexual offenders.

Treatment Format

The SOTP used was a pilot of the new Becoming New Me (BNM) programme. BNM is designed for offenders with Intellectual Disabilities (ID). The deaf offenders attending the programme did not have ID but they communicated using BSL. BSL differs from English in that it has a separate grammar, syntax and social context. Therefore, it cannot be assumed that deaf offenders can read English. The group members had varying literacy skills but none could write more than a few words of English. One advantage of the BNM programme is that it does not rely on written English but uses a variety of methods of communication. It has a pictorial basis with visual prompts displayed around the room. It also uses more interactive techniques, which particularly helps offenders with sequencing problems. This is important when working with deaf offenders. When communicating in BSL, the topic and context have to be set up in BSL in order for communication to make sense. The interactive techniques used help to focus offenders at a point in time thereby setting the time and context for them.

A further advantage of BNM is that it uses limited vocabulary. Although deaf offenders may not have ID, they may be considered language-deprived because BSL has a limited vocabulary. There are simply not as many signs compared to English words. The BNM programme also relies on more concrete concepts compared with other SOTPs which often use abstract concepts. One challenge of working with deaf offenders is that they have limited abstract reasoning[17]. Therefore, the use of concrete concepts in BNM works better with this client group. Deaf offenders also have limited inner dialogue and introspection and may also have difficulties with perspective taking[18]. The BNM programme does not focus on these skills so is deemed a more appropriate form of treatment. The pace of the BNM programme is much slower compared with other SOTPs. It was expected that this would work well with deaf offenders as the interpretation process creates a slower pace throughout treatment. Finally, the pilot of the new BNM programme incorporates aspects of the Adapted Better Lives Booster programme (ABLB). Given the amount of the funding needed for interpreters, it was unlikely that the group members would be able to access further treatment following this programme. The combination of BNM and ABLB in the programme meant that offenders accessed secondary relapse prevention treatment as well.

Interpreters

There is some debate about the use of interpreters in a therapeutic setting. As stated earlier, it has been suggested that the triadic relationship between offenders, interpreters and facilitators might be detrimental to the treatment process[19]. This involves offenders having to disclose personal details with many people in the room which could impact on their ability to be open and honest. However, because of the lack of facilitators with sufficient BSL qualifications (level six), it

15. O'Rourke, S., & Grewer, G. (2005). Assessment of deaf people in forensic mental health settings: A risky business! *Journal of Forensic Psychiatry & Psychology*, 16, 4: 671–684.
16. Iqbal, S., Dolan, M., & Monterio, B. (2004). Characteristics of deaf sexual offenders referred to a specialist mental health unit in the UK. *Journal of Forensic Psychiatry & Psychology*, 15, 3: 494–510.
17. BSL interpreters, personal communication, 2012.
18. Ibid.
19. Marshall et al (1998) see n.8.

was decided at HMP Whatton to use interpreters. There were a number of challenges involved in this. It was not possible to simply translate material into BSL because it is such a different language to English[20]. There was a greater need to prepare sessions in advance with interpreters to ensure exercises were placed in the correct context and set up correctly with the aims of the session in mind. Much of the material had to be adapted further to take into account deaf culture and work responsively with the group members. There was also a need for facilitators and interpreters to debrief together after each session. This ensured interpreters had an opportunity to discuss concerns and seek support with any difficulties brought about by working with sexual offenders. It also allowed communication about how well learning points had been understood by group members and what further changes might be needed. Despite the challenges, the use of interpreters brought great treatment gains. It ensured that information was translated accurately and reduced misunderstandings and misinterpretations. The risks of such confusions are clear given the treatment subject. The interpreters also provided a wealth of knowledge regarding deaf culture. This was important when considering treatment needs. For example, whether a deaf offender had a treatment need relating to anger or simply communication frustration given the limited opportunities to communicate in a prison setting. Deaf people often have to rely on external agencies to support them with daily living issues in a hearing world. This could be deemed a treatment need in terms of poor problem solving or another aspect of their culture.

Despite the challenges, the use of interpreters brought great treatment gains.

Challenges

All group members were inexperienced in group environments. They had received varying levels of schooling and this was reflected in their processing of the group environment. As their focus was on the interpreters they would often sign over each other which had to be managed by facilitators. Some group members had residual hearing which caused them to be easily distracted by background noise. Each distraction necessitated a conversation about what the noise was, which resulted in frequent loss of focus in session.

Deaf offenders experience a high degree of isolation in prison caused by difficulties with communication. They lack knowledge about the prison regime, probation and programmes information and are not privy to general prison gossip. They also cannot access much of the prison literature because it is written in English. This isolation impacted on treatment in two main ways. First, the group members would not challenge each other regarding their offending and permission-giving thought patterns. This is because challenging each other risked being exiled from the small deaf community in prison. As they have no one else with whom they can communicate, no one would risk losing that. The second impact of isolation was misuse of group time. The first 15 minutes of a group programme is dedicated to group members discussing any current issues they have which may impact on their participation during session. Previously deaf group members had not had this forum where they could talk easily with staff through interpreters. This resulted in them wanting to use this time to discuss a range of issues including letters they had received but could not read, problems on the wing and at home, feeling unwell, concerns about their future, probation etc. As they were not privy to overhearing others talking, they were often unaware that other people also experienced such problems. They appeared to be quite self-centred because they would talk at length about their problems but show little empathy to the problems of others. It generally seemed they were following the conversation not to show support, but to gauge when they would be able to join the conversation and discuss their own issues. However, given the lack of empathy and emotional support deaf people often grow up with[21] resulting from the difficulties with communication, it is perhaps understandable they have difficulty with those skills themselves.

The process of translation was a further challenge when working with this client group. Since BSL does not have the range of vocabulary of English, many of the social niceties of conversation are lost. BSL translates the meaning of what is said rather than each word which results in BSL appearing much more direct. This impacts on the ability to build a therapeutic alliance. For example, translating the comment: 'That's a really good point and thanks for raising it. It's something that we'll be discussing in the next section so hold on to that because its important and we'll come back to it then'; becomes: 'Stop. Remember it. Talk later'. Issues with translation were apparent throughout the programme. Another example is that, risk factors had to be reworded, so the item 'preferring sex to include violence or force' was

20. For example, this group had no knowledge of the word 'prefer' as this is based on an English concept not a BSL concept. Therefore, the risk factor 'preferring sex with children' had to be changed to 'fancy children'.
21. BSL interpreters, personal communication, 2012.

changed to 'feel sexy — hit, punch, kick, hold'. In BSL there is no sign for violence as an all encompassing term, so individual actions are used. Furthermore, some signs are based on English concepts and so require knowledge of the hearing world which deaf offenders might not have. An example of this is this concept of responsibility. The deaf offenders had no concept of this in terms of taking responsibility for themselves and their behaviour. They only understood it within the context of other people having a responsibility to look after them, such as doctors, social workers, the Royal National Institute for the Deaf (RNID) and their local council.

Facilitator experience of delivering Deaf SOTP

Facilitators enjoyed the opportunity to deliver this unique programme and recognised the pioneering nature of the work. However, the experience also had a number of less positive aspects. The pace of sessions could be extremely slow because everything went through the translation process. This required a greater degree of patience than other SOTPs. There were many misunderstandings, frequent need for repetition and confusion because of facilitators' lack of experience of the deaf world and group members' lack of experience of the hearing world. Although all facilitators were trained to at least BSL level two, the need for translation left facilitators feeling deskilled because they did not know exactly how their words were being translated. The subtle meaning of carefully selected statements designed for maximum impact was often lost in translation.

Group members' learning was more easily recognised by this point and they were very proud of their achievements, particularly because they did not feel they had achieved much in other aspects of their lives.

Facilitators noticed some difficulty building a therapeutic alliance with group members. Much of this resulted from the triadic relationship highlighted by Marshall et al[22] which made the process feel disjointed. The directness of BSL meant much of the language used to build a therapeutic relationship is lost in translation. Deaf group members were unaware of tone of voice or specific words facilitators used so facial expression was emphasised to build warmth instead. However, this was often missed by group members because they were watching interpreters. The result was a lack of rapport compared with hearing groups, which is of particular concern given that research has highlighted the power of the therapeutic alliance in promoting change[23].

Facilitators also found it difficult to manage their feelings regarding the lack of empathy displayed by the group. Although this is not uncommon on this type of work, it is rare for an entire group to show this degree of lack of empathy. This is a consequence of having such a small group, because facilitators are unable to look to other group members to recognise change or the impact their work is having. However, it would not be feasible to deliver deaf SOTP to a larger group given the responsivity needs of this client group.

These aspects of facilitating on the programme had a negative effect on the resilience of facilitators, resulting in them questioning their abilities and finding it hard to empathise with their group members. This lack of empathy was compounded by the use of interpreters, which reduced rapport and added distance when working with offenders. In addition, group members' preoccupation with their own problems also contributed to this drop in empathy for facilitators. As this was a pilot programme, facilitators did not have a clear end date for the programme. There were also only two facilitators delivering at key parts of the programme, which impacted on their individual workloads. These factors worked in combination to lower resilience at points during the programme.

However, the ending of the programme was extremely positive for facilitators and group members alike. Group members' learning was more easily recognised by this point and they were very proud of their achievements, particularly because they did not feel they had achieved much in other aspects of their lives. There were many positives to delivering this programme, such as the ability to be creative, learning new skills to be responsive, working with interpreters, learning to manage difficult group dynamics and learning new communication skills.

Treatment effect

- In order to evaluate the effectiveness of the programme, research was conducted to answer two specific questions:

22. See n.8.
23. Prescott, D. (2012). Therapeutic Communication: Motivation, Feedback and Beyond. Paper presented at Sexual Offender: Essential Therapy – Coercive Therapy? 12th Conference of the International association for the Treatment of Sexual Offenders (IATSO), Berlin, Germany. Lengerich, Germany: PABST Science Publishers.

- ❒ Has the intervention enabled group members to develop insight into their risk and develop strategies for risk management?
- ❒ Has the intervention enabled group members to develop protective factors to offending through treatment?

Four measures of change were used for the three group members who completed the Deaf SOTP. These measures included:

Psychometric assessments

The DSOTP used the Reduced Adapted NOTA 1, including: Self esteem questionnaire, Impulsivity scale, Ruminations scale, Relationship style questionnaire, openness to women scale/openness to men scale, sex offender opinion test and my private interests measure. These measures have been adapted to suit lower functioning individuals and as such, use simplified language. These psychometric assessments use dynamic items and are therefore able to detect post treatment change.

Offence accounts

The pre and post course offence accounts were completed by the facilitators in order to explore whether group members could describe their offending, explain why they offended and take responsibility for it. These were compared pre and post course.

Treatment needs and protective factors

The treatment needs and protective factors[24] for each group member were included with a treatment needs analysis grid (TNA). These grids identify risk areas which are relevant to offending. These were compared pre and post course which helped to determine any changes in risk areas post treatment.

Results

Has the intervention enabled group members to develop insight into their risk and develop strategies for risk management?

Insight into offending

The DSOTP treatment programme has proven effective in developing the group member's understanding and awareness of their offending.

In contrast to the opinion that exploring offence accounts with deaf sexual offenders can result in a lack of information about emotions and thoughts, because of the largely verbal component[25], this was not found to be the case with this group. This might have been the result of the treatment using pictures rather than words, which allowed the group members to explore their offending in a more visual way. As noted by O'Rourke and Grewer[26] BSL involves a large visual component, suggesting that the visual element of the deaf SOTP helped group members to explore their offending.

Targeting risk areas

Findings from the treatment needs analysis grids (TNA) suggest that the appropriate risk areas have been identified in treatment to a large extent. In some instances, other relevant risk areas remained untreated. This was particularly relevant to Participant three where risk relating to sexual interests had not been explored. There are several possible explanations for this. First, exploring offending with deaf individuals is vulnerable to inaccuracies because of the limitations of vocabulary[27]. This conclusion supports research by Steinberg[28] who proposed that when using interpreters the pace of therapy with a deaf client is much slower given the nature of the communication and interpreting languages. Second, each group member had a high number of dynamic risk factors with varying sexual interests, and this was a piloted programme, so insufficient time was allowed to explore all areas of risk. However is also noted that hearing offenders with high dynamic risk would usually complete more extensive treatment to address specific risk areas. Forthcoming programmes for hearing offenders will adopt a rolling method by which additional modules are included for higher risk offenders in need of more specific work — such as exploring attitudes, or sexually deviant behaviours. In line with this method, the Deaf SOTP would benefit from the inclusion of core elements of treatment that are mandatory for all group members,

24. Protective factors are considered to be individual characteristics or environmental conditions that could help to counteract the risks to which the individual is exposed (Richman & Fraser, 2001). These are introduced into treatment in order to focus on the positive aspects of an individual's life and to prevent treatment from being deficit-focused.
25. Brennan, M., & Brown, G. (1997). *Equality before the law: Deaf people's access to justice*. Durham, UK: Deaf studies Research Unit.
26. O'Rourke & Grewer (2005) See n.14.
27. Hoyt, M. F., Siegalman, E. Y., & Schlesinger, H. S. (1981). Special issues regarding psychotherapy with the deaf. *American Journal of Psychiatry*, 138, 807 – 811.
28. Steinberg, A. (1991). Issues in providing mental health services to hearing impaired persons. *Hospital and Community Psychiatry,* 42, 380 – 389.

with optional elements personalised to those individuals in need of more extensive work.

Rationalising offending

One of the questions raised by the research is whether deaf sexual offenders rationalise their offending in the same way as hearing offenders[29]. Although Dennis and Baker[30] propose that they blame their deafness for the offending, the group members in the Whatton pilot project did not follow this trend. They were able to identify lifestyle factors and thoughts they experienced during their offending. An interesting finding relates to the level of responsibility that group members took for their offending. While they did not blame their deafness for the offending, responsibility was placed on the victim by all three group members. Dolnick,[31] proposed that the deaf community's attitude can influence offending by supporting denial or minimization. Given three group members formed their own community within the prison, it is possible that minimisation is being reinforced by the group. Possible challenges to this minimisation could risk an individual being isolated from the community. Another possible explanation is that deaf offenders are no different in this type of minimisation than hearing offenders who are completing treatment for the first time. Schneider and Wright[32] argue that a high proportion of sexual offenders deny or minimise their offences.

Has the intervention enabled group members to develop protective factors to offending through treatment?

Developing protective factors

Findings from the treatment needs analysis grids suggest all three group members developed protective factors through treatment. In particular, areas relating to getting on with other people and being a responsible member of society improved. It is possible that the experience of being able to communicate in a group setting via an interpreter has improved relationships with professionals. This is supported by Schneider and Sales[33], who found that developing social contacts is difficult for deaf offenders due to obvious language barriers. This can lead to frustrations because of the amount of time it takes to write information back and forth to individuals such as Offender Managers if telephone devices to support deaf offenders are not available. There was also evidence that group members had started to establish a more active life in prison. The development of this protective factor in particular is encouraging given all group members had treatment needs relating to self management.

Future research

Interpreters

The use of interpreters has widely been acknowledged as the appropriate way to work with deaf offenders[34]. However, as previously discussed, this triadic relationship can impact on the therapeutic relationship between group members and facilitators[35].

The use of interpreters might have influenced the pace of the programme. This suggests future research would benefit from exploring the experiences of individuals involved in this treatment. This could be completed by interviewing these individuals. Such investigation could also identify other difficulties that have been observed with using interpreters, such as ensuring professional objectivity and boundaries[36].

Conclusion

What has been established from the research is that in order to work effectively with deaf offenders, treatment techniques need to be modified. The research goal was to evaluate the effectiveness of the pilot Deaf Sex Offender Treatment Programme based on changes in dynamic risk. All three group members who engaged in the treatment were high risk. Measures identified noticeable shifts in identifying and developing insight into risk areas. Less impact was found with regards to more specific areas such as sexually deviant behaviour. However, as it is unlikely that one treatment programme will ever be developed to address all treatment areas, progress in risk areas that were addressed have been comparable with mainstream treatment for hearing offenders. The Deaf SOTP would benefit from additional modules being included within its design. This would allow the option for high risk deaf sex offenders with more specific needs to complete mandatory modules, followed by additional modules. This would replicate forthcoming treatment programmes currently being developed for hearing offenders.

29. O'Rourke & Grewer (2005) see n.14
30. Dennis, M. J. P., & Baker, K. A. (1998). Evaluation and treatment of deaf sexual offenders. A multicultural perspective . In W. L. Marshall, Y. M. Fernandez, S. M, Hudson., & T. Ward, (Eds), *Sourcebook of treatment programmes for sexual offenders*. New York: Plenum Press.
31. Dolnick, E. (1993), Deaf as culture. *The Atlantic*, 3, 37.
32. Schneider. S., & Wright, R. (2004). Understanding denial in sexual offenders. *Trauma, Violence and Abuse*, 5, 1: 3–20.
33. Schneider, N. R., & Sales, B. D. (2004). Deaf or hard of hearing inmates in prison. *Disability & Society*, 19, 1: 77– 89.
34. Bramley. (2007). see n.9.
35. Marshall, et al (1998) see n.8.
36. Dennis & Baker(1998) see n.29.

Older offenders:

the challenge of providing services to those aging in prison

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Prisoners over 60 are the fastest growing age group in prison, increasing by 103 per cent between 2002 and 2011[1]. There are a number of reasons for this development. Partly it is a collateral consequence of a more general growth in the use of imprisonment and the length of prison sentences, but is also specifically related to changes in the policing, prosecution, sentencing and post-release supervision of sex offenders, including those who have committed 'historical' sex offences[2]. Nationally forty two per cent of the 9913 prisoners over fifty in prison in England and Wales have been convicted of sex offences[3].

The imprisonment of older prisoners creates a complex challenge for a prison system 'primarily designed for, and inhabited by, young and able-bodied people'[4]. Assumptions about age, ability and mobility are integral to the architecture and regime of prisons. As has been noted by Elaine Crawley:

> *'There are…some evident respects in which prisons have never been designed with older people and their needs in mind. Their very fabric (the stairs and steps and walkways, the distances, the gates, the football pitches and gymnasia, the serveries and queues, the communal showers, the incessant background noise) is, in general, constructed in blithe unconsciousness of the needs and sensibilities of the old'*[5]

It is therefore in some deeply embedded and fundamental ways that prisons are unsuited to older prisoners. However, it has been illustrated that historically, the management of older prisoners has been lacking in many other ways, including the provision of activities, healthcare and preparation for release[6]. The general approach of prisons to older people has been described as being characterised by 'institutional thoughlessness'[7]. This concept attempts to encapsulate how prisons, managers and prison staff do not set out intentionally to provide a poorer service to older prisoners but do so by being unaware and insensitive to the nature of those needs and ways in which they might be met.

This has been compounded by older prisoners themselves, who have been characterised as 'old and quiet'[8] and have not assertively pushed for improvements in services or greater attention to their needs. In addition, from a staff and organisational perspective, older prisoners, and in particular aspects of social care, have been devalued as not 'proper work' for prisons and prison staff[9]. The interests and needs of older prisoners therefore have had a low level of visibility.

As the population of older people in prison has started to rise, so the Inspectorate of Prisons has highlighted the issues that this raises and attempted, with some success, to inform policy and practice development[10]. However, there remains no overall national strategy for older people in prisons and instead individual establishments have to 'innovate' or 'improvise' in order to meet the needs of the populations they hold[11].

This article is specifically concerned with the innovations and improvisations made at HMP Whatton in order to meet the needs of an expanding population of older men, who pose special problems in relation to custodial management, healthcare and preparation for release. The prison is as a treatment centre for 841 sex offenders. The main focus of the prison is the delivery of ten accredited cognitive behavioural programmes and 173 prisoners completed a programme in 2011/12. At peak operation 120 prisoners will be engaged in a

1. Ministry of Justice (2012) *Offender Management case load statistics 2011* London Ministry of Justice.
2. Crawley, E. (2005) *Surviving the prison experience?: Imprisonment and elderly men* in *Prison Service Journal* No. 160 p.3-8.
3. Ministry of Justice (2012) *Offender Management Statistics quarterly bulletin April to June 2012* London: Ministry of Justice.
4. HM Inspectorate of Prisons (2004) *'No problems – old and quiet': Older prisoners in England and Wales. A thematic review by HM Chief Inspector of Prisons* London: HMCIP p.v.
5. Crawley, E. (2007) *Imprisonment in old age* in Jewkes, Y. (ed) *Handbook on prisons* Cullompton: Willan p.224-244 (p.231).
6. HM Inspectorate of Prisons (2004) see n.4 and HM Inspectorate of Prisons (2008) *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons* London: HMCIP.
7. Crawley, E. and Sparks, R. (2005) *Hidden injuries?: Researching the experiences of older men in English prisons* in *The Howard Journal of Criminal Justice* Vol.44 No.4 p.345-56 p. 352.
8. See n.4.
9. Crawley, E. and Sparks, R. (2005) *Older men in prison: survival, coping and identity* in Liebling, A. and Maruna, S. (eds) *The effects of imprisonment* Cullompton: Willan p.343-365.
10. HM Inspectorate of Prisons (2004) see n.4 and HM Inspectorate of Prisons (2008) see n.6.
11. Crawley (2005) see n.2.

programme on any weekday. The establishment has applied for accreditation as an 'enabling environment'[12] an approved scheme supported by the Institute of Psychiatry and aims to provide a 'whole prison approach' to reducing reoffending. Staff prisoner relationships are good and the prison has a clear focus and direction on public protection[13]. Given HMP Whatton's specialisation in sex offender treatment, it is unsurprising that there are a disproportionately high number of older men being detained: thirty seven per cent are over the age of 50, fifty four individual prisoners are over seventy and the oldest is 82.

This article will focus on the ways in which HMP Whatton has responded to the needs of its older prisoners in three important areas: regimes and activties; health care, social care and dying inside; and preparation for release. The article will also close by commenting on the outcomes for prisoners and discussing how this reflects the wider culture of the establishment.

Regimes and activities: Making the prison survivable

For many older people entering prison can feel like a catastrophe with which they struggle to cope and adapt. Part of their response can be to isolate themselves from contact with family and friends outside so as to numb the shame, stigma and pain[14]. Inside of prison they may also keep their distance from other prisoners both because they lack trust but also because the activities on offer are unsuitable or inaccessible[15]. Without proper stimulation and activity, mental and physical decline can start to set in. It is therefore essential that the activities and services available at HMP Whatton are adapted and developed so as to support the health and well-being of the older population.

A large part of the residential accommodation at HMP Whatton is at ground floor level. This is extremely helpful when accommodating large numbers of elderly or less mobile prisoners. Several areas of the prison are designated for the older prisoners. This ensures that staff can be trained to deal with their needs and that appropriate services can be developed in this area. The accommodation is generally quieter than the rest of the prison so prisoners feel safer and supported. By offering both segregated and integrated living spaces, older prisoners have open to them choices about their living arrangements.

Many older men have worked throughout their lives and continue to do so within the prison. Indeed, many voluntarily continue even beyond the national retirement age (currently 65). For those who do not work, other opportunities have been developed that enable men to socialize and engage in activities with people in a similar situation so as to 'share commonality, mutual support and alleviate the loneliness experienced'[16].

Given HMP Whatton's specialisation in sex offender treatment, it is unsurprising that there are a disproportionately high number of older men being detained . . .

In 2008, a partnership was established with Age UK, which led to the development of the 'Older Prisoners Active Living Group' (OPAL), funded through the Lankelly Trust. The project included the employment of support worker who was allocated a designated area in order to develop activities for older prisoners. Age UK also provided wider advice and support to staff in their dealings with older prisoners.

The OPAL group operates on four afternoons per week and provides a number of activities for older prisoners. This includes speakers on a range of subjects, from healthcare matters, resettlement matters such as debt and housing advice and activities promoting the constructive use of leisure time, quizzes, community singing and concerts feature regularly. Fifty of the retired group regularly attend sessions. Since 2010 a representative of the Soldiers Sailors and Air force Families Association (SSAFA) has attended the prison on two afternoons per week as part of the OPAL group to engage with elderly ex-service personnel and to help organise suitable age related activities. This has enhanced the range of activities provided and ensured that a greater number of prisoners can attend the sessions.

Physical activity in prisons is often geared toward team activities largely for younger people with rugby and football dominating the curriculum. The

12. http://enablingenvironments.com/ accessed on 11 April 2013
13. HM Inspectorate of Prisons (2012) *Report on an announced inspection of HMP Whatton 30 January – 3 February 2012 by HM Chief Inspector of Prisons* London: HM Inspectorate of Prisons.
14. Crawley and Sparks (2005) see n.9.
15. Mann, N. (2012) *Ageing prisoners* in Crewe, B. and Bennett, J. (eds) *The Prisoner* London: Routledge p.92-102.
16. Ibid p.99.

gymnasium team, in order to meet the needs of the older prisoners, have provided modified exercise programmes and activities suitable for the over 50s. These include a supervised walking group on the sports field and specifically modified gym sessions and activities such as bowls, badminton and modified cardio vascular (CV) sessions.

New regime activities currently being developed include the provision of support for the development of leisure time activities in conjunction with Workers Educational Initiative (WEA) These activities will include history, archaeology, music, Italian art and crafts. This initiative was pursued as education funding was reduced at HMP Whatton in 2012/13. The reason for this was that the Skills Funding Agency had targeted resources at developing employability skills for release. As many men will not be leaving prison to take up employment, as they will be beyond state retirement age, they will need to possess skills to use their leisure time constructively. Discussions are also underway with the local University of the Third Age Group to further develop activities and interests for the older prisoners and to utilise the skills knowledge and experience of prisoners to form there own group.

The core activity at HMP Whatton is offending behaviour programmes. All of these programmes are accessible to elderly prisoners. There is a requirement that they are willing to participate in programmes to be accepted at the prison. All group work rooms are wheelchair accessible and adaptations can be made for prisoners who have specific individual mobility issues or other physical needs met such as paperwork produced in large font for those with poor eyesight. A team of programme support volunteers, comprised of other prisoners who have undertaken programmes, also offer support to those who are concerned or fearful about participation in the group work programmes.

The development of a range of activities to meet the needs of older prisoners is important in enabling them to maintain their well-being in prison. There is ongoing discussion and review of the services provided directly with older prisoners or their peer representatives at OPAL focus groups and the Equality Action Team, and the monthly prisoners' forum. The aim of these services and the process of review and refresh is to ensure that older prisoners survive imprisonment not only physically but also that they have lives that are socially and emotionally meaningful.

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Health care, social care and dying inside

Managing older prisoners brings with it a complex set of health and social care needs. It has been estimated that prison healthcare costs for those over 50 is 250 per cent of the average, and that on average they will have three chronic conditions that require ongoing treatment[17]. One of the outcomes of this is that lifestyle prior to custody and the nature of incarceration itself is thought to reduce life expectancy by ten years compared with the wider population[18].

A prisoners' personal care and health needs are assessed upon arrival during the induction process at HMP Whatton by the healthcare staff and the prison disability liaison officer. Specialist chairs, shower seats and mobility aids are provided where necessary to ensure that prisoners are able to function as independently as possible in the prison.

A paid peer support scheme has been developed, in line with recommendations of the Inspectorate of Prisons[19]. Day to day Disability Awareness Coordinators (DACs) are risk assessed and selected to work with other prisoners to assist them with their basic social care needs. These prisoners are based on units where prisoners need extra support with day-t-day social care such as carrying meals, laundry and assisting with mobility. However, the DAC's are not permitted to provide intimate care for safeguarding reasons. These services, when a prisoner is no longer able to care for himself, are currently provided by healthcare assistants. Discussions are underway with the local authority to develop the service further, whereby they will take responsibility for funding paid carers when there is a need for intimate care to be provided. This is particularly important when prisoners are not in need of healthcare services but require help with toileting and bathing.

A team of paid prisoner wheelchair 'pushers' are trained by gym staff in manual handling and a 'taxi' service operates in the prison to allow wheelchair users movement around the prison, The team is called upon

17. Wahidin, A. and Aday, R. (2005) *The needs of older men and women in the criminal justice system: An international perspective* in *Prison Service Journal* No. 160 p.13-22.
18. Cooney, F. and Braggins, J. (2010) *Doing time: the experiences and needs of older people in prison* London: Prison Reform Trust.
19. HM Inspectorate of Prisons (2004) see n.4 and HM Inspectorate of Prisons (2008) see n.6.

to allow prisoners with mobility issues access to a range of activities including the gym, library healthcare, chapel and OPAL, counselling, group work rooms, workshops and the education building.

There are some older prisoners with more intensive needs. As a response to concerns from staff about a number of elderly prisoners experiencing symptoms of Alzheimer's, a bid was made in 2012 to the Kings Fund to adapt a dormitory into a specialist suite for prisoners suffering with Alzheimer's and dementia. Adaptations to lighting and sound proofing have been made to enhance the living environment and care for prisoners suffering from these conditions. This facility was completed in April 2013 and provides a useful resource for the growing number of prisoners needing this care. The implementation of this project also included staff training to ensure that is was supported by a skilled and committed team.

Inevitably, some older prisoners die in prison. HMP Whatton has had 27 natural cause deaths in prison custody since 2006. In general, many older prisoners have a dread of 'a prison death' with its cold mechanistic quality lacking proper mental and spiritual preparation, contrasting this with the ideal of final hours spent at home surrounded by family and friends[20]. Indeed, many of those who have died in HMP Whatton have had little family contact due to a number of factors; the length of time they have been in custody, the nature of their offences, the age and/or ill health of their own family networks, or simply, their distance from their home area.

In general, many older prisoners have a dread of 'a prison death' with its cold mechanistic quality lacking proper mental and spiritual preparation, contrasting this with the ideal of final hours spent at home surrounded by family and friends.

Prior to 2008 prisoners requiring palliative care were provided with access to a hospice or the opportunity for compassionate release in their final few days. However, some prisoners and staff expressed concern about the appropriateness of this move. In the absence of family support, a move to a hospice, away from people the dying prisoner knew, and away from the support of other prisoners and familiar prison staff, the experience was lonely and isolating. As a result of this concern prisoners were given the option to remain in the prison to die if they chose to do so, providing the appropriate care and pain relief could be made available. This was a challenging development for the prison, not least because of the impact of a death in custody has on both staff and prisoners and because of the cultural change necessary to ensure that appropriate care and support was provided to dying prisoners. The prison does not have a staffed 24 hour healthcare facility. Nursing staff are available in the prison from 07.30 hours until 18.30 hours on a Monday to Friday and on Saturday and Sunday mornings. Therefore arrangements to provide healthcare staff outside these times were made with healthcare commissioners when a prisoner was in need of more intensive care at the end of his life, particularly overnight. This was an acceptable arrangement because of the potential savings in bed watch costs and the costs of taking up scarce secondary care facilities. Protocols were agreed with the staff associations about the use of the facility, the security of pain relief medication and the safety of care staff. Risk assessments to allow the prisoner's cell to be unlocked to allow staff access during the night, and procedures were put in place to allow family or friends if they were available and wished to visit, to take place on the residential unit.

These arrangements proved to be very successful. However, the staff team felt that improvements could be made by the development of a purpose built unit designed for the last few days of life, as this was frequently the most challenging time on a residential unit. This was In part due to the impact on other prisoners of the physical decline of one of their neighbours and also because of the need to retain the deceased on the wing until the police had attended in accordance with the law in respect of deaths in custody. As a result, in 2010 an application was made to the Kings Fund to develop a palliative care suite for the final few days of a prisoner's life. The plan was for the prisoner to remain on a residential wing as long as possible in order that he could retain the contact and support of his peers, moving to a specialist suite away from the main prison wing for his final few days. The suite was opened in 2011; five prisoners have passed away there to date[21]. The development of the 'Retreat' has resulted in a much improved service to the

20. Crawley and Sparks (2005) see n.9.
21. As at 4.3.2012.

families of the dying prisoners. Visits can be longer and not so constrained by the routines of the prison. Staff can ensure that the prisoner achieves a 'good death' surrounded by familiar staff and with visits from peers (if the prisoner requests this). This innovative programme is comparable with international examples of best practice[22].

Managing older prisoners entails complex and emotionally demanding work including meeting health and social care needs as well as planning for dying inside. Responding to these challenges has required sensitive and thoughtful consideration of what could and should be done within the prison setting. The solutions have required careful engagement with staff and prisoners as well as the support of health and charitable funders.

Resettlement

Many older men are concerned about the potential of release into the community. Many lost their material possessions and social networks on conviction and feel that they are facing a hostile and bewildering world without the resources to cope[23]. They are often concerned about gaining housing, accessing social and health support and those who have committed sexual offences are also concerned about the risk of violence from others[24]. Historically there has been little tailored resettlement support for older men, who have often been simply given the same advice designed for younger men and does not address their specific needs[25]. Older men themselves have also been often unable to assert their interests and needs and so have been overlooked in planning and preparation for release in favour of those groups and individuals that are more vocal[26].

In response to this, HMP Whatton established a pre-release group for older prisoners within 6 months of release, known as Training and Information for Prisoners in their Senior Years (TIPSY). This group meets around six times a year and provides resettlement support and advice to assist older prisoners when preparing for the transition from custody to the community.

The resettlement of elderly prisoners who have been convicted of a sex offence is often more problematic. On many occasions prisoners will not be permitted to return to their home area because of their offending and the need to protect victims. They may also have licence conditions that are restrictive and prevent participation in previous employment, religious activities or interests — attendance at church groups or religious worship is often either prohibited or seriously curtailed as an example. This means that they will often be resettled in an unfamiliar area, and will often be without the support of positive and familiar role models and activities. This together with the stigma and public concern about the return of sex offenders to the community means that the elderly are often fearful of their release and anxious about their ability to cope outside of the confines of the prison.

Managing older prisoners entails complex and emotionally demanding work including meeting health and social care needs as well as planning for dying inside.

In order to respond to this particular challenge, HMP Whatton is in the process of setting up a support programme for elderly prisoners who are likely to be at risk of reoffending upon their return to the community. This programme is based on the model of Circles of Support and Accountability (COSA)[27]. This initiative was developed in Canada and combines both help and support for released prisoners but also monitoring, surveillance and accountability for their actions. It has been described that

> *'The goal of COSA is to promote successful integration of released men into the community by providing support, advocacy, and a way to be meaningfully accountable in exchange for living safely in the community'.*[28]

It is therefore an approach that validates both the needs of victims and those of ex-offenders.

The Circles are comprised of trained volunteers and supported by professionals. HMP Whatton is working

22. Crawley (2007) see n.5 .
23. Crawley, E (2004) Resettlement and the older prisoner in Criminal justice matters no.56 p.19-22.
24. Ibid.
25. HM Inspectorate of Prisons (2004) see n.4 and HM Inspectorate of Prisons (2008) see n.6.
26. Crawley (2004) see n.23.
27. Wilson, R., McWhinnie, A., Picheca, J., Prinzo, M., and Cortoni, F. (2007) Circles of support and accountability: Engaging community volunteersin the management of high-risk sexual offenders in *The Howard Journal of Criminal Justice* Vol.46 No.1 p.1-15.
28. Ibid p.8 italics in original.

with a national organisation known as Circles of Support as well as Nottingham Trent University, the Quakers and Nottinghamshire Probation Trust amongst others in developing Circles to support older men released into the community. The support will start in prison in order that participants are able to begin to develop relationships with the volunteers before moving into approved premises and then into the wider community.

The development of COSA has been demonstrated to be successful. In Canada, research studies have highlighted benefits for staff and community stakeholders involved[29], and has also had a significant impact on re-offending, with a 70 per cent reduction in sexual offending reported[30]. By improving the resettlement of older men from HMP Whatton, it is the ambition to achieve similar levels of benefit for the community and ex-offenders.

Conclusion

As a national leader in the management and treatment of sex offenders, HMP Whatton has also had to learn to manage an ageing population. This article has attempted to describe the innovations and improvisations made in order to do this. The outcome of this has been positive, with HM Inspectorate of Prisons recognising the high quality of services provided and older prisoners themselves reporting that they felt respected[31]. Although there is more that can and must be done in the future, this highlights the solid foundation that has been built.

The responsiveness of HMP Whatton to this group of people also illuminates some wider issues regarding organisational culture and values. As has been noted previously, older men are generally less assertive and vocal about their needs than other prisoners[32]. It has been argued by Elaine Crawley and Richard Sparks that this raises important questions about order and legitimacy in prisons[33]. It has been previously suggested that order is created in prisons through a process of negotiation, a 'dialectic of control' between those in power and those are the subjects of that power[34]. However, that relies upon the exercise of active agency in this particular field struggle by prisoners. What has emerged from the study of older prisoners is that they do not engage in this negotiation and struggle, but instead they are 'old and quiet'[35]. All too often this has meant that their needs have been ignored, but why have HMP Whatton responded more actively and what does this reveal about the wider organisational culture? There has been some external pressure, brought to bear by organisations such as HM Inspectorate of Prisons and Prison Reform Trust, who have highlighted the problem of older prisoners nationally[36]. However, much of the pressure for change and the ideas for innovation have come from within, being generated from the staff at HMP Whatton themselves. They have sought to improve the services not in order to maintain a precarious order against potential resistance or in order to comply with managerial requirements, but instead to some degree this has been taken forward because staff and managers see this as worthwhile *in itself*. Whilst it is important not to overplay or exaggerate this, the development of services for older prisoners at HMP Whatton does, at least in part, reflect a wider culture of compassion, care and humanity.

29. Wilson, R., Picheca, J., and Prinzo, M. (2007) *Evaluating the effectiveness of professionally-facilitated volunteerism in the community-based management of high-risk sexual offenders: Part one – effects on participants and stakeholders* in *The Howard journal of criminal justice* Vol.46 No.3 p.289-302.
30. Wilson, R., Picheca, J., and Prinzo, M. (2007) *Evaluating the effectiveness of professionally-facilitated volunteerism in the community-based management of high-risk sexual offenders: Part two – a comparison of recidivism rates* in *The Howard journal of criminal justice* Vol.46 No.4 p.327-337.
31. HM Inspectorate of Prisons (2012) see n.13.
32. HM Inspectorate of Prisons (2004) see n.4.
33. Crawley and Sparks (2005) see n.7.
34. Sparks, R., Bottoms, A. & Hay, W. (1996) *Prisons and the Problem of Order* Oxford: Clarendon Press.
35. HM Inspectorate of Prisons (2004) see n.4.
36. HM Inspectorate of Prisons (2004) see n.4, HM Inspectorate of Prisons (2008) see n.6 and, Cooney, and Braggins (2010) see n.18.

Treating the person not the prisoner:

How dynamic talking therapy interventions support Sex Offender Programmes and risk reduction at HMP Whatton

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Talking therapies help people to learn how to deal with negative thoughts and feelings and make positive changes in their lives. There are a wide variety of treatment types, each designed to deal with different sorts of problems, but they all have the potential to help those with mental illnesses or those distressed as a result of difficult life events. Talking therapies are known by a confusing mix of names depending on the theoretical approach they take to treatment. Some look at how thoughts and feelings affect behaviour, others assist people to increase understanding of how their personality and early life experiences influence current thoughts, feelings, relationships and behaviour.

Delivering talking therapy treatments in a setting exclusively devoted to the detention and rehabilitation of male sex offenders presents complex and diverse clinical challenges, as well as raising serious ethical issues. Yet individual and group psychological interventions of this type can offer valuable opportunities for increased self-reflection, development of empathy with others and emotional growth. Such personal growth can considerably enhance offenders' participation in, and co-operation with, the rehabilitation process and effectively contribute to reducing the risk of re-offending. In addition to the disturbing experience of incarceration, many prisoners arriving at HMP Whatton will have suffered some form of trauma or abuse at some stage in their lives, be it physical, mental, emotional or sexual. As Durcan[1] states:

> *Not only is prison itself a risk factor for emotional distress, but the prison population is comprised disproportionately of people from disadvantaged backgrounds with a history of trauma, loss and low resilience to distress.*

These people have frequently adopted unhelpful and unhealthy strategies over time to help them tolerate the intense residual psychological pain from their experiences. Such maladaptive coping strategies can include drugs and/or alcohol abuse, emotional detachment, denial, displacement of anger through high risk-taking or initiating violent confrontations, anti-social behaviour to reflect and support their damaged self-image, or behaviour emulating their abuser in order to gain a false sense of control over their experiences. Some will have fallen into patterns of learned helplessness and passive thinking that help to support and perpetuate offending behaviour by encouraging them to believe they cannot change.

The prospect of revisiting these emotionally distressing experiences as part of Sex Offender Treatment Programmes can lead to some individuals refusing to engage in treatment for fear of becoming re-traumatised or because they are unwilling to face the psychological pain involved. There are those who become defensively resistant to the point where they disengage part-way through a programme, severely disrupting the group dynamics and their own chances of progression. Others may have inflicted the same type of abuse they experienced on their victims, adding to the complexity of separating out their own abuse experiences from the role they played and the decisions they took in perpetrating their crimes. Some may be carrying burdens of post-traumatic stress, unresolved grief and loss, anxiety or phobias that prevent them effectively engaging in programmes work even though they desperately wish to do so. In more serious cases, individuals may be locked into repetitive cycles of emotional instability, suicidal or self-harming behaviour; or they may be suffering from clinical depression, obsessive compulsions, schizophrenia, bipolar disorder or other forms of mental illness, singly or in combination.

1. Durcan, G (2008) From the inside: Experiences of prison mental health care, London: Centre for Mental Health, cited in Appleby, L, May, P, Meiklejohn, C, Edgar, K and Cummins, I (2010) *Prison Mental Health: Vision and Reality*, London: Royal College of Nursing.

A significant proportion of prisoners will also have a personality disorder diagnosis, a type of illness which causes the person to think, perceive things, feel things or relate to others in ways that can be distressing. Studies suggest that personality disorders, which are a recognised form of mental disorder, are common among adult prisoners[2]. It is estimated that between 60 and 70 per cent of the UK prisoner population is affected by some form of personality disorder, the most common being the anti-social and borderline types[3], as defined by the Diagnostic and Statistical Manual of Mental Disorders[4].

It is against this background that the Counselling Psychology Service at HMP Whatton was launched in July 2006 to offer treatment to sex offenders suffering from a wide range of mental illnesses and psychological problems as they faced the challenge of programmes work to address their offending behaviour. Since its inception demand for the service has been consistently heavily over-subscribed, reflecting the widely acknowledged unmet high level of need for psychotherapeutic support across the prison estate, again, as stated by Durcan[5]:

> *The need for better mental health care in prisons has been evident for some time. Reports throughout the last two decades have shown that prisoners have dramatically higher rates of the whole range of mental health problems compared to the general population.*

More than 70 per cent of people in the UK prison population have two or more mental health disorders[6].

Male prisoners are 14 times more likely to have multiple problems than men in the general population, while for females the ratio is 35 times more[7]. Furthermore, the suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared with nine per 100,000 in the general population[8].

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Between 2007 and 2012, the six full years that the Counselling Psychology Service has been in operation at HMP Whatton, 1073 referrals were made by prison staff, all of which required explicit prisoner consent[9]. This represents an average of 21.3 per cent, or roughly a fifth, of the prison's population referred for individual or group interventions each year. During the same period 469 people received individual therapy and 197 undertook group therapy, an overall total of 666 people, or an average of 13.2 per cent of the prison population treated each year. The figures include 210 repeat referrals for further treatment — an average of 35 clients a year. These were people requiring repeat blocks of individual work to address more complex problems, or who wanted individual work after attending a therapy group, or those wishing to repeat group work. Some prisoners have multiple treatment needs and repeat interventions are often required in those cases. However, there is considerable practice-based evidence to suggest individuals with multiple presentations can benefit from repeated blocks of short-term intervention with experienced therapists.

The service currently employs two Counselling Psychologists, who are both HPC-registered and chartered by the British Psychological Society. As well as treating the full range of psychological problems and mental disorders, one practitioner is trained to deliver therapy in sign language for deaf clients.

They also supervise the work of two volunteer counsellors registered with the British Association of Counselling and Psychotherapy (BACP) delivering Transactional Analysis and Person-Centred Counselling on behalf of the service, and offer placement practice

2. Fazel, S. and Danesh, J. (2002) Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys, Lancet, 359, 545–550, cited in Howells, K, Krishnan, G, and Daffern, M (2007) Challenges in the treatment of dangerous and severe personality disorder, *Advances in Psychiatric Treatment*, vol. 13, 325–332 accessed at http://apt.rcpsych.org/
3. www.justice.gov.uk/...disordered.../working-with-personality-disordered-offenders.pdf -
4. American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* 4th ed., text revision, Washington DC: American Psychiatric Association.
5. See n.1
6. Social Exclusion Unit (2004) quoting *Psychiatric Morbidity Among Prisoners in England and Wales*, (1998), cited at http://www.mentalhealth.org.uk/help-information/mental-health-statistics/prisons/
7. Ibid.
8. The National Service Framework For Mental Health: Five Years On, Department of Health, (2004) citing *Samaritans Information Resource Pack* (2004) cited at http://www.mentalhealth.org.uk/help-information/mental-health-statistics/prisons/
9. Harper, R, and Franks D, (2013) *East Midlands Counselling Psychology Service Annual Report and Needs Analysis: A snapshot of the service taken on 31st December 2012*. East Midlands Counselling Psychology Service: HMP Whatton.

opportunities to Counselling Psychology doctoral students.

The service operates independently, but it works closely with Programmes and other departments to support the multi-agency approach to providing care for prisoners in crisis, or those with short and longer-term mental health needs. Consistent and regular feedback received since its inception demonstrates that the professionalism, efficiency and reliability of the service, and the quality and effectiveness of its treatments, are generally highly regarded by prisoners and operational and non-operational staff. The service is trusted and seen as a transparent, accessible and valuable resource for staff seeking information on psychological or mental health issues. Nevertheless, continuous efforts are made to build on this reputation by improving the quality and level of help it provides. Negotiations are currently being held with senior Healthcare staff at HMP Whatton to establish closer co-operation between the two services in order to help to ease waiting list pressures and maximise the efficient use of valuable and limited resources.

The service is trusted and seen as a transparent, accessible and valuable resource for staff seeking information on psychological or mental health issues.

Individual therapy varies according to the type of problem requiring treatment, but in each case the primary focus is on the working alliance between therapist and prisoner, and that person's preferred mode of working. This integrated-relational, client-led approach to therapy often requires a dynamic mix of treatments using cognitive-behavioural, systemic, psychodynamic and humanistic theoretical approaches. As a result, the therapists' skills base incorporates elements including Cognitive Behavioural Therapies (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), Brief Solution-Focused Therapy, Transactional Analysis, Systemic Therapy, Schema Therapy, Object Relations Therapy, Personal Construct Therapy, Self Psychology, Attachment work and Mindfulness.

The service's group work also incorporates many of these different therapeutic approaches. The two main treatment groups currently offered to prisoners at HMP Whatton are COPE (Coping with Problem Emotions), which is a 14-session group developed to help people learn how to manage powerful emotions appropriately, and an eight-session Self-Harm Group, which helps people to break their cycle of self-harm and find safer and more positive ways to communicate and process their negative feelings and thoughts. In addition to these groups, the service provides occasional Bereavement and Loss groups for those who are struggling to come to terms with powerful emotions connected with grief and loss. A treatment group for those prisoners suffering from low to moderate depression has also been developed by the service and was launched last year.

The service provided just over 794 hours of clinical contact with prisoners in 2012[10], involving delivery of six groups and completion of 60 individual cases. A Clinical Outcome Routine Evaluation (CORE) questionnaire is used before and after treatments to evaluate the effectiveness of the intervention work. The CORE is a popular general measure of change with widely recognised validity. It looks at four broad areas: general well-being, problems and symptoms, life and social functioning, and risk of harm to self or others.

Over the six years since the launch of the Counselling Psychology Service CORE averages for people receiving individual treatments have consistently shown significant improvements across all sectors. In the well-being category, which relates to individuals' sense of positivity, hopes and aspirations, an average 43.3 per cent improvement has been recorded. Meanwhile, an average reduction of 42.4 per cent has been indicated in problems and symptoms, consisting of elements including panic, anxiety and somatisation (psychological distress experienced as real physical pain), intrusive or irrational thoughts, insomnia, flashbacks, and obsessive behaviour.

Clients reported on average a 40.9 per cent improvement in functioning, related to the ability to problem-solve, communicate concerns to others, feel warmth towards others, build relationships, cope with criticism, acknowledge achievements and develop an appropriate level of self-esteem. But most significantly, a reduction of 60.6 per cent on average was recorded in individuals' risk of causing harm or injury to self or others.

These improvements were achieved with an average block of only eight standard 50-minute therapy sessions per individual, extended at the therapist's discretion to ten sessions in some instances to obtain effective closure. Data from the CORE returns showed a

10. Ibid.

general improvement of 43.2 per cent, suggesting those people completing a single individual course of treatment were generally left more emotionally resilient, more self-reliant and more stable psychologically as a result of the experience.

Group CORE results mirrored the individual therapy results, with CORE averages for people engaging in groups also consistently showing significant improvements across all sectors. This was demonstrated for all groups, particularly the COPE and Self-Harm groups.

Research suggests some humanistic and psychodynamic talking therapy interventions have been effective in helping to reduce anger[11], an intense emotional response which frequently features in and influences offender behaviour. However, much of the research in this area has tended to come from the cognitive behavioural therapy (CBT) perspective. The Whatton COPE Group model takes a more integrative and holistic approach to treatment, looking at both the origins and focus of anger, as well as helping people identify triggers to their behaviour and manage responses in a more effective way. Deffenbacher et al. suggest anger management treatment outcomes should take into account general life functioning[12].

The Whatton COPE Group model takes a more integrative and holistic approach to treatment, looking at both the origins and focus of anger, as well as helping people identify triggers to their behaviour and manage responses in a more effective way.

CORE returns for the two COPE groups completed since 2011 showed an average 46 per cent improvement in wellbeing after the 14 sessions. Symptoms reduced by an average 47.5 per cent, general functioning was enhanced by 52.2 per cent and risk of harm to self and others lowered by an average of 69.7 per cent.

As previously stated, an estimated 60 to 70 per cent of the UK prisoner population have a personality disorder[13], and statistics also suggest 70 to 80 per cent of people who suffer from a Borderline Personality Disorder self-harm[14]. Because anti-social and borderline personality disorders are the most common types seen in custodial settings, acts of self-injury are a frequent occurrence in prisons.

Self-harm can be described as the urge to inflict physical wounds on your own body, motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance. The act is usually carried out without suicidal or sexual intent. Some people use self-harm as a way of stepping back from suicide, others as a trade-off, swapping physical pain they can tolerate for emotional pain they cannot. Some use it to express feelings in the only way they know how. So self-harm can be seen as having three general functions: coping, control and validation[15]. Such behaviour can be extremely debilitating and damaging to the self-harming individuals, but also distressing and stressful for prison and other staff who have to deal with them.

Ten self-harm groups have been run at HMP Whatton since 2009, with 76 potential clients being assessed and 65 people actively engaging in the eight-session treatment plan.

Of those people, ten were on an ACCT document at the start of the group and 24 had self-harmed in the month prior to the group starting. In total, 40 people had engaged in self-harming behaviour within the three months prior to starting a group. There was a significant drop-out rate, with some people withdrawing and others choosing to switch to individual therapy, so only 45 people completed the groups. Of those who completed the course, only five reported actively self-harming at closure, but at minor levels. The figure was the same at the review session a month later. It should be noted that these figures include one individual who attended two groups.

Averaged CORE returns for the eight-session self-harm groups run since 2009 report a 23.5 per cent improvement in well-being, a general reduction in symptoms of 32.4 per cent, functioning enhanced by 32 per cent and risk of harm to self and others reduced by an average of 46.5 per cent. Overall CORE scores

11. Deffenbacher, J, Oetting, E, and DiGuiseppe, R, (2002) Principles of Empirically Supported Interventions Applied to Anger Management, *The Counselling Psychologist*, Vol. 30, No. 2, 262-280
12. Ibid.
13. Fazel and Danesh (2002) see n.2.
14. Ministry of Justice (2011) *Working with Personality Disordered Offenders — A Practitioners Guide*, www.justice.gov.uk/guidance/docs/working-with-personality-disordered-offenders.pdf
15. Adams, J, Rodham, K and Gavin, J (2005) Investigating the 'Self' in Deliberate Self-Harm, *Qualitative Health Research*, Vol. 15, No. 10, 1293-1309.

showed a general overall improvement of 32 per cent in mental state based on the criteria listed.

Practice-based evidence from working with repeat-referral clients suggest these individual and group treatment outcomes have positive implications not only for general offender management, but also for prisoners' potential engagement in offender treatment programmes and possible progress on release, as illustrated by the reduction in risk factors and symptoms of psychological distress recorded. For longer and indeterminate sentence prisoners, where multiple repeat referrals are possible, the opportunity for extended assimilation and extension of psychological insight and self-reflection is frequently reported by inmates as being valued and life-enhancing.

General reflections and observations obtained in feedback from prisoners after their therapy experiences often share the theme that much earlier access to therapeutic support or intervention could have put them on a more positive life path or even played a role in preventing their offending.

Other common observations indicate that prisoners feel they have enhanced their learning from Sex Offender Programmes, or they have been able to make better sense of their experiences in them, as a result of undergoing personal therapy processing either before or after programmes work.

. . . the opportunity for extended assimilation and extension of psychological insight and self-reflection is frequently reported by inmates as being valued and life-enhancing.

It is clearly acknowledged that these types of statements may be seen as grooming or compliance strategies designed to ingratiate or influence parole or sentence planning outcomes. However, referrals to the Counselling Psychology Service are made with the explicit agreement of the individual, in the full knowledge that the work has no influence on parole or offender management reports. Throughout the process it is stressed to prisoners that therapy treatments are in no way directly concerned with assessing or reducing risk of reoffending because this is the remit of the forensic psychology department. Prisoners do not have to engage, they choose to engage knowing there are no potential benefits or losses in terms of influencing parole. Therefore it can be argued that the feedback obtained is not as influenced by pressure or expectancy to 'say the right things' or please the therapist as it may be in other intervention settings or environments.

There is good reason to avoid including talking therapy treatments in sentence plans. Individuals need to be ready and able to engage in psychological therapy. This is not simply related to the individual's desire to do the work, but to the scale and extent of the problems to be dealt with, and that person's current capacity to engage openly and non-defensively with the process. There is no point in asking someone to confront a repressed trauma or dismantle a psychological defence mechanism if he simply does not have the resilience or capacity to do so at the time of asking, or is not in a place where he feels secure and strong enough to face the challenge. In this regard talking therapies are not an off-the-shelf, one-size-fits-all cure for prisoners' psychological and behavioural distress. The process is as unpredictable and varied as the individuals who come for treatment.

One common factor for a positive outcome is that people tend to get out of the process what they put in, so the better they are able to engage the more they are likely to benefit. The second and more important factor is the strength of the working relationship — the therapeutic alliance — between therapist and client. Given these two factors, talking therapies can have powerful influences on individuals' perception of self and their patterns of interaction, and be an agent for change through a variety of psychological mechanisms.

There is some evidence that lack of security in childhood attachment patterns has a significance in the development of sex offending behaviour[16]. For a child, attachment to a consistent and effective caregiver establishes a sense of security, safety and well-being that enables the healthy development of individual identity in a predictable and secure environment. The absence of this security can be influential in the development of personality disorders, particularly borderline personality disorder[17].

16. Bogaerts, S, Vanheule, S, and Desmet, M (2006) Personality Disorders and Romantic Adult Attachment: A Comparison of Secure and Insecure Attached Child Molesters, *International Journal of Offender Therapy and Comparative Criminology*, Vol.50, No.2, 139-147.
17. Fonagy, P (2000) Attachment and Borderline Personality Disorder, *Journal of the American Psychoanalytic Association,* Vol. 48, No. 4, 1129-1146.

It has been argued that custodial sentences have a negative impact on prisoners' development of sense of self[18]. Talking therapies depend on the establishment of a strong working attachment between therapist and client. Providing a positive attachment experience for the individual, possibly for the first time in his life, and activating the client's ability to find meaning in their own and other people's behaviour[19], offers pro-social modelling with an added bonus of giving the individual a positive experience interacting with a psychologist. As stated by Bogaerts et al[20]:

> *By experiencing an inter-subjective relationship with a therapist, a patient can be enabled to develop a deeper understanding of his or her own attachment and abusive history.*

Mann suggests the majority of sex offenders feel psychologists should deliver Sex Offender Treatment Programmes, but that many do not trust psychologists[21]. Providing a positive attachment alliance with a psychologist in a relaxed and supportive talking therapy setting, where the client is encouraged to be in control at all times without the pressure of having to progress through a programme that has an influence on his release date, can encourage prisoners to develop that trust. It can also help to redress the negative influence of rumour and inmate disinformation that generates distrust and resistance to engagement in programmes. As Mann argues:[22]

> *Sexual offenders in prison are heavily influenced by the attitudes of those around them about the efficacy of treatment. They are influenced by non-treatment staff, by other prisoners, and by their families and friends.*

So to improve and encourage engagement in Sex Offender Treatment Programmes we must acknowledge the tensions between prisoners and their view of psychologists, and work to alleviate them by improving the context in which treatment is delivered and trying to change prisoners' adversarial perceptions of the prison environment[23]. As part of this process it is important to provide pro-social modelling and a supportive environment for those being treated, which is where ethical dilemmas can often manifest for the therapist.

Therapeutic treatments need to be holistic and take account of human rights, ethical practice and the well-being of those undergoing treatment[24].

In a prison environment such as HMP Whatton this means the Counselling Psychology Service must balance duty of care to those being treated with the ethical demands of professional governing bodies, including the Health Professions Council and British Psychological Society. It must also meet the expectations of the National Offender Management Service (NOMS) as service provider, the judicial system and the wider public. Holding clear and firm boundaries is essential to avoid this balancing act distorting or negatively influencing the relationship between therapist and client. One way of achieving this is through openness and transparency of the treatment process and explicit acknowledgment of the limitations that each service partner imposes on the service. The strict confidentiality boundaries of therapy inevitably can cause tension between therapist and client, but in a prison they can also create problems because of expectations about sharing information.

Talking therapies depend on the establishment of a strong working attachment between therapist and client.

The issue of consent to referral for treatment and disclosure of information is complex in a prison setting because of the inevitable power imbalance between prisoners and staff. This places an onus on Counselling Psychologists to make appropriate challenges and monitor the issue on their clients' behalf, but requires careful management to avoid generating conflict between the various interest groups involved.

It is clear from the experience of the Counselling Psychology Service at HMP Whatton that talking

18. Greve. W, Enzmann, D, and Hosser, D (2001) The Stablization of Self-Esteem Among Incarcerated Adolescents: Accommodative and Immunizing Processes, *International Journal of Offender Therapy and Comparative Criminology*, Vol. 45, No. 6, 749-768.
19. Ibid.
20. See n.16.
21. Mann, R (2009) Getting the context right for sex offender treatment, in Prescott, D (ed) *Building Motivation for Change in Sexual Offenders*, Brandon, VA, US, Safer Society Press.
22. Ibid.
23. Ibid.
24. Mandikate, P, and Akerman, G (2012) Can Convicted Offenders Be Classed as 'Volunteering' for Therapy? Working with Men Who Have Committed Sexual Offences and Volunteered for Treatment in a Prison-based Therapeutic Community, *Sexual Offender Treatment*, Vol. 7, No. 2.

therapies have a valuable and special role to play in establishing a structured and integrated approach to the psychological engagement and treatment of offenders. This places a demand on service providers to ensure they adapt to meet the needs of treatment through the continuous review of services and consistent investment in the clinical development of practitioners, in order to implement the most modern and effective therapeutic interventions available.

An example of this is the growing reputation of Eye Movement Desensitisation and Reprocessing (EMDR) for treatment of post-traumatic stress disorder, phobias and anxiety. The Whatton service already has a growing practice evidence base for the effectiveness of this technique for a variety of clinical problems. But there are also interesting, albeit limited research studies that highlight the potential of EMDR to effectively treat people with personality disorders[25] and sexual abusers of children who have themselves been abuse victims[26].

More generally it has been widely recognised that there is:

> *A lack of adequate expertise and resources in prisons in the treatment of primary mental health problems, especially in relation to counselling and psychological therapies[27].*

Therapy and counselling services in our prisons are currently provided on an ad hoc basis by means of a number of disparate organisations, some, but not all, of which are linked to various charities and quasi-professional bodies. Services are not standardised or co-ordinated. Treatments are often delivered without any structured approach to the effective co-ordination of interventions with psychology or healthcare departments. Treatment provision varies widely, as do the skills base of practitioners and the level of supervision.

The Whatton Counselling Psychology Service model demonstrates how talking therapy services can be provided effectively and safely in prisons, employing a combination of qualified mental health practitioners such as Counselling Psychologists and Counsellors.

The co-ordinated structure provides a broad range of treatments and sets appropriate standards of care and intervention. It also provides effective, high-quality supervision and support for practitioners in a very challenging environment. Applied to other general and specialist establishments on a wider basis, such a model offers a number of advantages. These include providing a coherent link between psychological offender treatment programmes and the clinical needs of prisoners, and putting talking therapy interventions across the prison estate onto a more ethical, standardised and properly supervised footing. Such a model has the potential to contribute significantly to the ultimate goal of the prison regime, to help prisoners become more effective citizens and break repeat patterns of offending behaviour for good.

25. Brown, S, and Shapiro, F (2006) EMDR in the Treatment of Borderline Personality Disorder, *Clinical Case Studies*, Vol. 5, No. 5, 403-420.
26. Ricci, R, Clayton, C, and Shapiro, F (2006) Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings, *The Journal of Forensic Psychiatry and Psychology*, Vol. 17, No. 4, 538-562.
27. Nottinghamshire Healthcare NHS Trust, Offender Health Directorate *Primary Mental Healthcare Service Model*, October 2012.

Reviews

Book Review

The Wiley-Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management

Edited by Karen Harrison and Bernadette Rainey
Wiley-Blackwell (2013)
ISBN: 978-1-1199-4555-0 (hardback)
Price: £120 (hardback)

The ethical dimension of assessing, treating and managing sex offenders has gained greater prominence over recent years, although concerns in relation to an overly and inappropriately confrontative approach to this work and concerns that it is effectively 'legitimised nonce bashing'[1] an be tracked back to the early 1990s. However, more recently the work of Marshall, Ward, Gannon and others has really sharpened the focus on the way in which we treat and work with sex offenders and the fact that treating the offender with respect and offering him hope of a 'Good Life'[2] does seem to correlate well to improved outcomes and importantly, reduced risk.

This comprehensive collection of chapters from a stellar cast of contributors clearly fills a gap in the literature and brings together some genuinely international thinking.

The legal and ethical core focus of the book weaves well through three sections; Treating and Managing Sexual Offender Risk in Context, Offender Treatment and finally Risk Management.

In the first section important issues of offenders' rights, dignity, consent to treatment, culturally appropriate treatment and mandatory reporting are dealt with in an accessible manner that mixes fact and law well with discussions of morality and ethics.

The second section poses some important questions about the state of evidence in relation to treatment efficacy and the importance of high quality outcome research. The crucial importance of the quality of the therapist/client relationship is discussed as is the extent to which offender treatment is punishment (and) or rehabilitation and potential resolutions of this dichotomy. Welcome inclusions in this section are chapters on the place of drug treatment for certain sex offenders and what we know and still need to know in relation to the assessment and treatment of female offenders.

Part three covers an impressive sweep of risk management approaches with sex offenders, something which has moved centre stage in many nations and jurisdictions. It is helpful to be reminded how far the field has come over the last two decades or so in relation to risk assessment and how rapidly sex offender registration has developed, particularly in the UK and the USA. Circles of Support and Accountability presents such an important and optimistic, community based approach to risk management and containment and it, rightly has its own chapter in this collection.

Other areas that could have usefully had a greater emphasis in what is an impressive contribution to the field include the legal and ethical aspects of working with young people with harmful sexual behaviour, primary prevention and community engagement, the assessment and treatment of those who view and distribute online child abuse imagery and of the impact of societal sexualisation and legal hard core adult pornography (a particular concern for the UK government).

Finally, this book is of course explicitly about sex offenders. The voice of the child and adult victim/survivor must inform the way we construe the legal and ethical aspects of their assessment, treatment and management in the same way that offender behaviour and cognitions should inform our work with those who suffer the impacts of their actions.

Jon Brown *is Head of Strategy and Development (Disabled Children, Sexual Abuse) at NSPCC.*

Book Review

Offender rehabilitation and therapeutic communities: Enabling change the TC way

By Alisa Stevens
Publisher: Routledge (2012)
Price: £80.00 (hardback) £24.99 (paperback)
ISBN: 978-0-415-67018-0 (hardback) 978-0-415-63527-1 (paperback)

Forensic therapeutic communities have often faced a charge of having a limited evidence base. However, in the 50 years since their first appearing to the now well established place

1. Sheath, M. 'Confrontative' Work with Sex Offenders: Legitimised Nonce Bashing? Probation Journal December 1990 37: 159-162,
2. Ward, T and Gannon, T.A. (2006) '*The Comprehensive Good Lives Model of Treatment for Sexual Offenders' Aggression and Violent Behaviour* 11, 77-94.

they occupy within offender rehabilitation, they have attracted a vast amount of academic and research interest. Given their roots in social psychiatry, and the social and political influences which have often formed the backdrop to their being established, it is probably not surprising that the attention they have attracted has been from unusually diverse backgrounds. Interests ranging from ethnography, prison security, forensic psychology, outcome research, personal narrative and psychotherapy have seen an unrivalled number of texts devoted to trying to define, understand and evaluate forensic therapeutic communities. Perhaps what has been neglected however have been sociological and criminological perspectives and Alisa Stevens' book provides a welcome and thought provoking contribution to the role which therapeutic communities have in offender rehabilitation. Based on observations and in-depth interviews the author conducted across a number of prison-based democratic therapeutic communities, Stevens provides an analysis, not only of relevance to therapeutic communities, but which also contributes to a wider understanding of rehabilitation and offender desistance.

For those wishing to gain an understanding of the development and origins of therapeutic communities, and an overview of their treatment model and efficacy, Stevens begins by providing a succinct summary of the moral, social and 'anti' psychiatry beliefs and principles on which the therapeutic community treatment model was based. The comprehensive account of the evidence base should also go some way to disavow the belief that prison-based therapeutic communities have survived despite an ill-informed evidence and lack of research interest. An area which Stevens then goes on to approach with a significance degree of candour is the challenges faced by researchers when attempting to undertake their research in prisons. Questions of particular importance for researchers conducting field work in prisons, such as researcher/participant boundaries, organisational dynamics, emotional impact and ethical dilemmas are all addressed with a refreshing sense of openness and reflection. Stevens eloquently articulates the precarious place researchers can find themselves using the metaphor of the 'tight-rope walk' this frequently entails.

Stevens continues, providing an interesting account of what leads prisoners to invest considerable time and emotional energy into their experiences within a therapeutic community. Whilst she identifies the multi-faceted motivational drives which offenders possess, she also identifies the considerable hope and genuine desire for change which participants carry with them into and throughout their time in treatment. After reading this chapter, it would seem hard to maintain a view that what drives offenders' participation is a predominantly cynical and self-serving motive. The book also offers some interesting observations into often neglected areas such as how prisoners are able to form supportive, non-exploitative and genuine relationships amongst themselves. It also comments very usefully on how powerful and significant relationships can be formed with members of staff and how a culture can develop and survive typified by mutual concern and respect. The book also provides some interesting observations into how the salient factors behind a 'decent' regime can be fostered within the culture of a therapeutic community. This theme is expanded in an important chapter addressing themes of responsibility, accountability and safety; Stevens charts how a social environment can be created where prisoners have a genuine sense of pride, develop a healthy attachment to and ownership of their community and how, within the culture of high expectations, prisons respond with integrity.

Stevens devotes one section of her book into an analysis of one of the enduring aspects of the therapeutic community treatment culture; the collective belief held by prisoners that a feature central to both their offending and the personal flaws often exposed in their history of failed relationships, is their hiding behind a 'mask' of masculinity; or as Stevens put it, a hyper-masculinity which needs to be unmasked. This perspective is not regularly found in textbooks in forensic psychology but interestingly is an enduring feature of prisoner self-narratives. She offers a valuable perspective on how aggresivity and hyper-masculine values are unnecessary and counter-productive within the therapeutic community culture. She also identifies how this provides offenders with one of the first steps towards a change in self-identity and this introduces one of the most important contributions of the book: providing an account of therapeutic communities which is firmly placed within the framework of offender desistance.

Stevens argues how therapeutic communities provide a catalyst for a change in self-concept and a more adaptive 'self-narrative' which allows offenders to see themselves as having an identity less aligned to crime and more towards pro-social goals and values. From a forensic psychological perspective I find this to be interesting take on how therapeutic communities impact upon change which has theoretical overlaps with the concept of 'treatment readiness'; this suggests

that to be in position to engage in and benefit from treatment, having values and an identity which are linked into the goals of treatment is a perquisite. Stevens offers a useful sociological perspective on how therapeutic communities provide an environment rich with the conditions necessary for personal change.

Stevens offers some original, thought-provoking perspectives on the role of therapeutic communities in rehabilitation and has developed some unique observations aligned with contemporary thinking about the importance of desistance. Whilst some of the quotes from participants can at times reflect a rather insular view, which can appear to over-idealise their experiences as the expense of being dismissive of other therapeutic approaches and this may not help to engage a wider audience, this is noted by the author, and Stevens' book provides a very important and valuable contribution into the role therapeutic communities have in creating and fostering the conditions for offender change.

Richard Shuker *is Head of Psychology at HMP Grendon.*

Book Review:
Prison violence: Causes, consequences and solutions
By Kristine Levan
Publisher: Ashgate (2012)
ISBN: 978-1-4094-3390-3 (hardback)
Price: £35.00 (hardback)

Maintaining safety and order are amongst the most fundamental requirements of prisons and the responsibilities of those who operate them. Not only are they reflections of good organisation, they are also a mark of the moral climate and underpin the prospects for rehabilitation. Without order and safety, the prison experience is a debilitating battle for survival.

This book, written by Kristine Levan of Plymouth State University in USA, attempts to provide a 'comprehensive look at prison violence'. It focuses on individual, interpersonal violence and gang conflict rather than institutional disorder such as riots. The book attempts to draw upon international evidence and reflects debates and practices relevant across a wide range of countries and jurisdictions. It is part of a series concerned with 'Solving social problems', which 'provides a forum for the description and measurement of social problems, with a keen focus on the concrete remedies proposed for their solution'.

The book is admirably concise at a little over 100 pages and in that short space manages to cover a good range of topics. This includes a chapter providing an overview of different theories of prison violence including the assertion that violence is imported by criminal populations or alternatively the theory that violence is a response to the institutional situation and its failures. This importation versus deprivation debate will be familiar to many, but this is supplemented by a range of other general criminological theories applied to the issue at hand. The book also offers a chapter surveying the effects of prison violence on individuals, prisoners' families, the prison community and wider society. A further chapter discusses the problems of understanding prison violence due to the reluctance to report incidents. The most interesting chapter for most practitioners will be that focusing on 'What is being done?', which briefly summarises a wide range of approaches to reducing prison violence including: classification, gang interventions, weapons reduction, CCTV, activities, restorative justice and, staff training.

This book will be of limited interest to most academics as it summarises current work rather than offering innovative new research or theoretical perspective. However, for practitioners, this could be a very helpful resource; it is a concise and accessible summary of the issues surrounding prison violence and an introduction to how to reduce this. For those working in the field this could be a useful source of reflection, review, and further reading.

Dr Jamie Bennett *is Governor of HMP Grendon and Springhill.*

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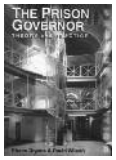

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