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Contents

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Editorial Comment

Over the years, Prison Service Journal has often shone a light on the needs and experiences of particular groups within the prison system. This is in part intended to promote the sensitizing of practice to meet the sometimes overlooked challenges faced by particular people in prison. This edition of PSJ focusses on three particular groups: people convicted of sexual offences; transgender people in prison, and; people who have neurodevelopmental disorders.

Three articles give attention to people convicted of sexual offences. In the first, Alice Ievins of the Prisons Research Centre at University of Cambridge, draws upon a comparative study of the prison systems in Norway and England and Wales. A formal, institutional separation that takes place in England and Wales where people convicted of sexual offenders are held separately in vulnerable prisoner units or specialist prisons. In contrast, such separation is not practiced in Norway. Although some social stigma and distancing takes place in Norwegian prisons, the culture and context are very different. Ievins argues that this reflects profoundly different penal and philosophical attitudes towards shame and integration. Dr Lynn Saunders, long-serving and distinguished governor of HMP Whatton, a prison specialising in working with people convicted of sexual offences, contributes an article based upon her research on the experiences of people being released from prison. The article is a fascinating example of insider research, but is also a challenging dissection of the difficulties of life after prison. Dr. Saunders concludes that 'the solutions to reduce sexual reoffending and successfully resettle people convicted of sexual offences in the community rests, unpopular and unpalatable as this may seem, not solely with the individual convicted of a sexual offence but with the institutions of the state, practitioners in the criminal justice system, employers, and the wider community'. An example of effective, reintegrative resettlement work is that of Circles of Support and Accountability. Circles are run by a number of charitable organisations who train and support those taking part. Each circle works with a person convicted of a sexual offences (the 'core member') and has around 4-6 people, who spend time with the core member and offer a supportive social network that also requires the core member to take responsibility for his/her ongoing risk management. It is an approach that has reported success in reducing reoffending. Dr. Geraldine Akerman and Caitlin Brown's article considers the challenges of people who were released into the community and re-offended. The authors consider the process and whether Circles of Support may have provided a more effective mechanism to help those individuals and protect the public. Together, these three articles draw important questions not only about the techniques, policies and practices of working with men convicted of sexual offences, but they also raise challenging questions about shame, stigma and emotion in public policy and public attitudes. The articles pose fundamental questions about criminal justice philosophy and values.

Dr. Matt Maycock contributes an article considering the experience of transgender people in Scottish prisons. Specifically, Maycock considers the response of those people to the opening of a separate unit for transgender people in HMP Downview in England and whether they would want such a unit available to them. The public debate about gender identity and transgender issues has become, at times, polarised, ideological and even febrile. Maycock's work is particularly valuable as it focusses on the experience of people directly affected and shows the diversity of perspectives. His empirical approach is measured but does not shy away from the complexity of the issues and the fluid, evolving social and policy context. The other specific group addressed in this edition is people with neurodevelopmental disorders. Professor Amanda Kirby and colleagues in a detailed study, expose that many such disorders are either missed or misdiagnosed. The real prevalence and significant of this issue, the authors argue, raises questions about criminal justice responses and indeed wider social support for people with neurodevelopmental disorders.

This edition of PSJ also includes Dr Alicia King and Dr Caroline Oliver's article on vicarious trauma experienced by prison officers. Those who work in the prison system are asked to undertake a complex and demanding role often with people who have complex needs. As the authors reveal, many people who work in prisons can be deeply affected by this. An effective service pays close attention to the needs of those who deliver that service as well as those that receive it.

Prison Service Journal is committed to offering research that asks challenging, sometimes uncomfortable questions about penal practice. It does so in an attempt to promote discussion, debate and improvement. It is offered in the knowledge that there are many people who welcome such an approach and are engaged in a struggle to make a positive difference.

Power, shame and social relations in prisons for men convicted of sex offences

Dr Alice Ievins, *is based at Prisons Research Centre, Institute of Criminology, University of Cambridge*

Since 2016, the Comparative Penology (COMPEN) project, led by Ben Crewe, has been conducting a large-scale comparison of penal policymaking and the prisoner experience in England and Wales and Norway.[1] At its core, the project is an attempt to determine whether the Nordic Exceptionalism thesis — the idea that Nordic penal systems have a liberal-humanitarian culture and have resisted the punitive turn to which all other Western countries have succumbed — stands up to detailed empirical analysis.[2] The COMPEN project is particularly interested in the experience of two groups who are often overlooked in the literature on imprisonment: women, and men convicted of sex offences. It is the second of these groups which is the focus of this article.

The COMPEN project is ambitious in its scale, and the comparative focus has brought a number of theoretical, methodological and linguistic challenges. One of these became clear in 2017, as my colleagues Kristian Mjåland and Julie Laursen and I tried to develop an interview schedule for our forthcoming sub-study of the experiences of prisoners convicted of sex offences. One of our main interests in this project was what different penal systems morally communicate to those they hold.[3] If you go to prison for a sex offence in England and Wales, what is the state saying to you about what you've done? What does being in prison, and what happens to you when you're there, do to your sense of who you are? How is this different in Norway, a country often described as liberal and inclusionary? In earlier projects, I had researched the experience of shame in English prisons for men convicted of sex offences, and so I suggested questions like 'How does being described as a "sex offender" make you feel about who you are?' This is a question I feel comfortable asking in England and Wales, where prisoners convicted of sex offences often talk with vigour about the impact of the label on their life. Julie and Kristian insisted that this question wouldn't work in Norway. The Norwegian word for 'sex offender', 'seksualforbryder', is rarely used by prison practitioners or by prisoners, and so they worried that the question might not mean very much, but also that it might be quite offensive.

This linguistic difference posed a methodological challenge — how can you ask about shame and stigma if mentioning the source of shame deepens it? — but it was also a significant finding, and one that led to further questions. If the 'sex offender' label has less currency in Norway, does that mean that being convicted of a sex offence has a smaller effect on your identity there? Is it a sign that people with sex offence convictions experience less shame, or is it a sign of a different type of shame, one linked less to the label and the associated stigmatised identity? Why is it that different penal systems generate these different forms of shame? And what can they do to help people convicted of sex offences be seen, and see themselves, as ex-offenders or, better, as citizens?

This paper, which is based on the findings of research conducted in five prisons, answers some of these questions. In England and Wales, we conducted ethnographies at two large Category C prisons which only held men convicted of sex offences, and at one Vulnerable Prisoners' Unit (VPU) in a Category B local prison.[4] In total, we conducted 102 interviews, and spent around a year engaging in participant

1. For more details on the project, see www.compen.crim.cam.ac.uk.
2. For a discussion of the Nordic Exceptionalism thesis, see Pratt, J. (2008) 'Scandinavian exceptionalism in an era of penal excess: Part I: The nature and roots of Scandinavian exceptionalism'. *British Journal of Criminology,* 48(2), pp. 119-137; Pratt, J. (2008) 'Scandinavian exceptionalism in an era of penal excess: Part II: Does Scandinavian exceptionalism have a future?'. *British Journal of Criminology,* 48(3), pp. 275-292.
3. See Duff, R.A. (2001) *Punishment, Communication, and Community*. Oxford: Oxford University Press.
4. The fieldwork for one of the Category C ethnographies was conducted for my PhD, entitled 'Adaptation, moral community and power in a prison for men convicted of sex offences'. The other ethnographies described here were all conducted as part of a the Comparative Penology project at Cambridge University, led by Ben Crewe, and with Kristian Mjåland, Julie Laursen and Anna Schliehe. I am grateful to them for carrying out some of the fieldwork on which this paper is based, and for their ongoing thoughts and comments. Thanks also to Rose Ricciardelli and Edward Smyth, and also to the former interviewees who offered their comments on an earlier version of this paper.

observation. In Norway, we conducted research in one treatment wing for men convicted of sex offences, and one open prison that held a lot of men convicted of sex offences. We also interviewed men convicted of sex offences who were held on 'mainstream' wings in Norwegian prisons, because, as this paper will go on to discuss, people convicted of sex offences in Norway are rarely held in separate institutions. We conducted 30 Norwegian interviews, and spent about six months doing participant observation.

Safety, separation and 'the sex offender'

Perhaps the most obvious difference between the two jurisdictions was how they tried to ensure the safety of these men. Cross-jurisdictionally, when prisoners convicted of sex offences are held on wings with 'mainstream' prisoners, they can experience extreme forms of violence.[5] In England and Wales, prison officials aim to keep these prisoners safe through a logic of separation. From their first entrance into prison, they are normally allocated to units on the basis of their offence. Most are held on VPUs and, ideally, the regime is organised in such a way that they never meet 'mainstream' prisoners. Those who receive a long enough sentence are then transferred to a prison that only holds prisoners with similar convictions.

When prisoners convicted of sex offences were more completely separated from 'mainstream' prisoners and held in discrete establishments, they described feeling safer.

In keeping prisoners apart, prison authorities divide them into two categories: 'sex offenders', often conflated with Vulnerable Prisoners (VPs), and 'mainstream prisoners'.[6] When prisoners convicted of sex offences are held on separate wings in the same prison, separating them ensures safety at the most basic level but it also communicates to prisoners that they are different. This communication can be quite direct, as this man made clear when he recounted his time on a VPU in a local prison:

> *'You hear them saying things on the radio like "Oh we can't move the VPs because the Normals are moving". It's like, I'm normal, do you know what I mean?' (John, Category C prison)*[7]

Separating VPs from 'mainstream' prisoners might keep them safe, but it also institutionalises the idea that these are two categories of people and enables a ritualised form of bullying. In the local prison, for instance, I took fieldnotes when accompanying prisoners from the VPU as they walked through the prison:

> *'We go through door and walk towards the garden. Someone says loudly from a mains wing window — loud enough for us to hear but not yelled, no banging, doesn't sound angry, it sounds more habitual — 'Walk by wrong-uns'.' (Fieldnotes, Category B prison)*

When prisoners convicted of sex offences were more completely separated from 'mainstream' prisoners and held in discrete establishments, they described feeling safer. Robin, held in a Category C prison, said that he felt secure as he knew 'no one is really dangerous and everyone is a sex offender, so I haven't got to look over my shoulder'.

However, this safety came with a cost, and it was common for prisoners in establishments which only held men convicted of sex offences to say that staff looked down on them because of their convictions. Officers and managers insisted that this was not the case and maintained that they did not judge people based on what they were in prison for. However, they often talked about how different these prisoners, and the prisons which held them, were from their mainstream equivalents, in ways that were clearly informed by stereotypical images of the 'sex offender' as a weak but sinister groomer. Prisons holding men convicted of sex offences were described as quieter because the prisoners themselves were more compliant and less physically challenging, but staff often said that

5. See Crewe, B. (2009) *The Prisoner Society: Power, Adaptation and Social Life in an English Prison.* Oxford: Clarendon Press; Ugelvik, T. (2014) *Power and Resistance in Prison: Doing Time, Doing Freedom.* Translated by S.G. Evans. Houndmills: Palgrave Macmillan.
6. VPs are held separately from 'mainstream' prisoners under Rule 45. While many have been convicted of a sex offence, people can be held under Rule 45 for a variety of reasons, including debt and 'grassing'. However, prison staff and prisoners often use the two terms as though they mean the same thing.
7. All names are pseudonyms, and any potentially identifying information has been changed.

these men were harder to work with psychologically. They described them as 'clingy', 'needy', 'manipulative' and 'devious', and complained that 'they get in your head' and create a form of 'psychological pressure' (prison officers, Category C prison). Staff regularly insisted that prisoners were likely to 'groom' them, and even the most innocuous conversations could be distorted by assumptions about the character and motivation of 'the sex offender':

> *'It starts with "Have a nice weekend", then it's "Have a nice Christmas", and then it's "Have a nice new year", and then it's "Happy Valentine's Day!" and you're like, "You what?" They're always seeking some gratification.' (Prison officer, Category C prison)*

Prisoners were highly conscious of the category in which they had been placed. Carlton said that while he was physically safer in a prison for men convicted of sex offences than he had been in a mixed prison, 'from an ego perspective', being held there was demoralising: 'I feel like I'm regarded as less of a person in this environment than I was in that environment' (Category C prison). One man put it starkly: 'in here you're not a prisoner or a person, you're a sex offender' (Jake, Category C prison). In all of the English prisons we visited, 'it's because we're sex offenders' was a catch-all explanation for everything that was unpleasant about their experiences, including things that were definitely not caused by their stigmatised identities — the food being poor quality, for example. This consciousness of a debased status was very painful to prisoners, who often assumed that they were being 'judged' even when staff treated them respectfully:

> *'It's like [officers think] "No, you're just the scum of the earth." And that makes you feel like, well, I'm not human then. […] I can honestly say that's what they think really, even though they don't show it, or [they] treat you with respect because they have to. Or sometimes they don't, but most of the time they do. It doesn't mean they're not thinking about what we really are: dirty scum of the earth. "You committed a serious offence that doesn't make you a human."' (Jake, Category C prison)*

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The key phrase here is 'what we really are': this man internalised how he believed he was seen.

Integration, isolation and anxiety

The Norwegian prison system, on the other hand, accommodates men convicted of sex offences according to a very different logic. Mostly, they are held on normal wings which also hold 'mainstream' prisoners. This principle of inclusion is possible in Norwegian prisons because they are much smaller, generally more ordered, and with much smaller staff-to-prisoner ratios (the standard ratio is one to eight). Staff are concerned about the dangers faced by prisoners convicted of sex offences, but they try to manage it in a way which addresses the fact that these men are being threatened as the problem to be solved, and not their very presence. When 'mainstream' prisoners try to find out what other prisoners in their unit have been convicted of, it is those who are asking questions who are moved elsewhere, and not the person with the sex offence conviction. This strategy has clearly impacted the way prisoners with these convictions are seen within the Norwegian prison system. There is no official approach that 'sex offenders' are a different type of prisoner, and staff do not describe them as though they behave differently.[8]

However, the absence of a rigid but secure categorical divide between 'sex offenders' and 'mainstream' prisoners does not mean that there is no distinction between the two groups in Norway. Rather, it means that the distinction that exists is more fluid, generated by prisoners rather than by the institution. Thomas Ugelvik has written about this phenomenon, arguing that sex offenders mark a moral 'boundary' in the Norwegian prison, beyond which 'exists the unethical and the unthinkable, but also the unmanly'.[9]

8. The Norwegian approach to keeping men convicted of sex offences safe doesn't always work and there are real risks associated with it. In 2017, a man convicted of a high-profile sex offence was killed by another prisoner in Ringerike prison. This was the Norwegian prison system's first murder in many decades, and as a result of it, the Norwegian prison service is seriously considering whether they should abandon their current strategy and start to accommodate people convicted of sex offences in separate units, as is increasingly the international norm.
9. Ugelvik (2014), p.218.

As in England and Wales, 'mainstream' Norwegian prisoners expressed quite profound and violent forms of hatred towards sex offenders, and it was they who policed this boundary and decided who was and wasn't acceptable. Prisoners who were known to be convicted of sex offences, particularly those who had offended against children, were often isolated:

> *'I don't speak to the paedophiles.*
>
> *Interviewer: No. No, and you know who they are?*
>
> *Yes. You get to know these things. And you notice it too. They're a little... frozen out.' (Egil, open prison)*

Offences were not always widely known, and prisoners tried to fill this information vacuum by asking what people were in for and demanding to see paperwork. Even for prisoners who were not identified, this experience could be quite frightening:

> *'One time, someone came up to me and said "Are you in for a sex crime?" And I thought "Oh God" but I said "No, why do you say that?" And he said "Oh, somebody told me." "That's completely wrong", I said, and he didn't ask again. I was terrified that day, I was afraid for the situation. My cover story was enough but I didn't like the situation.' (Anderson, treatment wing)*

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It is worth noting that many of the men who ended up on the specialist wing alongside other prisoners convicted of sex offences described being relieved to be held there. Bernt, for example, said that he experienced 'a totally different level of safety' on his specialist unit (treatment wing). While the Norwegian principle of policed inclusion therefore had clear impacts on the way the Norwegian prison system as a whole thought about this group of prisoners, it nevertheless struggled to keep the lid on a more bottom-up prisoner-led form of moral evaluation which generated significant anxiety.

Risk, change and transformation

Prisons in both countries, of course, are not solely required to hold these men safely, but also to change or discipline them. The different ways in which they do this rest on a particular idea of who these prisoners are, and in some cases affect how prisoners see themselves. In England and Wales, the prison system operates on a 'risk management' basis. It uses formalised systems of risk assessment to identify people's risk levels and then demands that they change in quite specific ways, for instance through treatment programmes. At the same time, the system does not always provide prisoners with the opportunities to change, nor does it notice when they have done so. Furthermore, whether prisoners change or not, they will remain on the Sex Offenders' Register for years, perhaps indefinitely, meaning that they will remain permanently labelled irrespective of what they do. The Norwegian system, on the other hand, has resisted the introduction of formalised actuarial risk assessments and instead makes decisions about progression, treatment provision and licence conditions on the basis of individualised decisions. The system also makes fewer specific demands about how prisoners should demonstrate change, and at best instead creates space in which prisoners can 'work on' themselves. For some, though, this lack of structure can be frustrating. Many men in Norwegian prisons complain about their lack of access to interventions, and maintain that rather than giving them space, this lack of access means that their sentences feel empty. However, the lack of legal restrictions which face them on release means that they at least have hope for an un-stigmatised future once they leave the prison.

In England and Wales, prisoners identified psychologists, programmes workers, probation officers and, to some extent, Offender Supervisors as the people with power over their sentence. None of these people were located on the wings, and prisoners therefore described feeling alienated and that significant decisions (those which concerned transfer, progression, early release and access to children) were made on the basis of formalised risk assessments conducted by professionals whom prisoners believed did not know them well. Many prisoners felt estranged from risk discourse, and found it hard to align risk language with how they saw themselves. Manny, for

instance, described the pain of being misrecognised and seen as a bundle of risk factors:

> *'To me it seems like I'm just a caseload number. […] You're still putting me in a negative light and you're lying about me and it hurts me, you understand, it hurts me, it hurts me a lot. People lie and they can just write whatever they want to write about you on paper, "risk to the public", "risk to females", "risk in relationships". I've never been arrested for domestic violence once, there's never been any allegations of me in any domestic violence! "Risk to children". Risk to children where? Never! Risk to children that they may see something that they shouldn't have seen. You just guessed that, where's anybody ever been arrested for that?' (Category C prison)*

Other prisoners complained that the prison system's reliance on formalised risk assessment meant that they were treated like 'a statistic' on 'a graph' (Lesley, local prison), rather than as a moral agent.

The 'power holders' in the English and Welsh system, the programme and case managers, had a specific and often 'psychologised' idea of what change is supposed to look like. Their idea of change had its own specific discourse: it was about changing your thoughts and managing your risk. Some prisoners absorbed this and described journeys of change which seemed genuine but were also clearly influenced by institutional and cognitive-behavioural discourses. One prisoner, for example, answered a question about how he'd changed over his sentence by talking at length about his greater awareness of his 'schemas'. Prisoners who had been through treatment programmes would quite casually say in interviews, or while chatting on the wing, that they would always be a risk, they just needed to learn how to manage it. I even met one prisoner who always wore a wristband he had been given in another prison which said 'Managing my risk'. These people were not cynically living up to what they thought was wanted from them. Rather, their self-perception seemed to have been infiltrated by system-sanctioned risk and psychological discourses.

More often, though, prisoners either shallowly performed or deliberately rejected what the prison wanted from them. They criticised the prison for promoting a 'cookie cutter' form of rehabilitation in which prisoners had very little ability to shape their journey or describe their needs. Arjun, for instance, offered the common criticism that the prison seemed to want people to mess around at the beginning of the sentence and then behave themselves: 'That's part of playing the game, because it seems [they're] then being able to say "Well, we've definitely rehabilitated him"'. He felt that there was limited room for him to develop in a way which felt authentic: 'It doesn't matter what you do, things are done to you and you just have to deal with that process' (Category C prison). Prisoners who went on courses felt obliged to talk about their crimes and their moral journeys — central aspects of their personhood — using very precise language which made it harder for them to talk about it in a way which felt authentic. Lesley, who had been convicted of having sex with a 14-year-old when he was 19, reported whenever he referred to it as a 'relationship' during treatment, he was told at length why it was grooming and not a relationship: 'I couldn't be honest because if I was honest, they would say I was wrong' (local prison).

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Prisoners rarely saw officers as being directly engaged in this change process. Their priorities were on the wing, prisoners thought, and officers agreed, describing their role as to keep peace, to get prisoners what they needed, and to lock and unlock doors, and perhaps to help them with emotional problems. While officers recognised that some aspects of prisoners' behaviour might be inappropriate, or related to 'risk' or 'treatment', they did not necessarily know how to intervene with these behaviours and instead would simply record them on the computer. One life-sentenced prisoner, for instance, reported that he was in his post-intervention review after completing the Extended SOTP (Sex Offender Treatment Programme) and he was told that a Security Incident Report had been put in about him four months earlier because he had said that he found someone in the prison environment attractive. Another young man said that he found out that a female officer had put in a similar report for making a 'flirtatious comment' when he said he liked her new haircut. These men described this strategy of policing as confusing and inconsistent. These men, and others like them, were never told precisely what was wrong about their comments, and this generated significant anxiety and confusion among

prisoners about precisely what (in)appropriate behaviour looked like. Many prisoners, particularly in the Category C prisons, reported feeling uncomfortable and anxious around female staff members, needing to be careful about their behaviour in case it was misconstrued:

> *'I purposefully make sure with all female staff that there is not a chance that my hands could brush them in some way, shape or form, or… So I will back up against a wall. You just don't want — given the nature of the place, you just don't want any comment made back, and it's just better to be safe than sorry.' (Arjun, Category C prison)*

This prison primarily used security processes as a way of monitoring prisoners' behaviour, and paradoxically this strategy of policing made this man feel at risk — of being seen in an unjust light. This had some unfortunate consequences: a large number of the prisoners we've interviewed in England and Wales have said that their sentences have made them less trustful of and more uncomfortable around women, saying that it is easy for them to make false accusations.

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The Norwegian prisons, on the other hand, managed prisoners differently. Powerholders did not use formalised risk assessments, and instead made more individualised and discretionary decisions about release, progression or access to children. This carried significant dangers, and prisoners from ethnic minority backgrounds or who otherwise didn't 'fit in' with Norwegian society complained regularly about favouritism and injustice. Nevertheless, release was rarely contingent on the completion of interventions which prisoners had been unable to access, or which prisoners did not describe as useful, and the absence of risk discourse was clear on the wings. Prisoners never described themselves using the sort of language which was common in English and Welsh prisons, and some were so unfamiliar with risk discourse that they asked for clarification when we asked, in interviews and surveys, whether the prison system cared more their risk factors than who they really were.

Norway's more individualised vision of change was also clear in the sorts of treatment programmes and interventions which were available. Whereas in England and Wales, accredited treatment programmes were the main formally recognised forum for personal development, formal treatment programmes played a much smaller role in the sentences of prisoners in Norway. On the whole, prisoners convicted of sex offences benefitted from the generalised rehabilitative ethos which infuses Norwegian prisons, an ethos which is more about providing people with opportunities to education, work and training than it is about changing their thoughts. Prisoners who engaged in interventions reported having influence over their timing, rather than being forced to undertake them at a time determined by their sentence plans or the outputs of formalised risk assessments — or, worse, simply when they were available. One interviewee, a man on forvaring — an indeterminate sentence for people who have committed serious offences and are deemed likely to reoffend — described the process by which he changed in his previous prison. He started by telling a friend whom he trusted, a fellow prisoner, about his offences. This friend then helped him to write a letter to the programme staff member, who came to them immediately and let him tell his story in his own words: 'Talk until you're done and I'll understand you', she said. She immediately arranged for him to do a programme, saying 'Now I can help you move forward, before you lose any more time' (Ulrik, open prison). Significantly, this process had been prompted by the prisoner's own decision to speak to the programme worker, and it took place at a time he felt comfortable with.

At its best, then, change was not something which was done to prisoners to turn them into a particular type of person. Instead, prisoners were conceptualised as moral agents who worked with prison officials in order to foster their own development. Prison officers were much more engaged in this process than they were in England and Wales. They were actively and regularly engaged in prisoners' lives, were confident in their use of power, and considered their jobs to directly contribute to rehabilitation. They were able to intervene in any inappropriate behaviour quickly, naturally, and informally. One prisoner on the treatment wing, for instance, recounted an incident where he slapped the bottom of a female officer while playing volleyball with her on Constitution Day. Immediately everyone went silent: 'I realised what I did, it was a huge mistake. But

thank God she was just laughing it away and told me not to do it again and I said I won't!' (Anderson). In England and Wales, where disciplinary power was concentrated in the hands of a small number of specialised staff who operated at a distance, such an incident would likely have been written on this prisoners' record and it could have had significant effects on him later on. In Norway, where disciplinary power was more dispersed but also more consistent, the incident was dealt with then and there, by an officer who knew this prisoner, and knew that he recognised he had done wrong. As a result, and unlike in England and Wales, it was rare for prisoners in Norway to say that they felt uncomfortable around female staff.

It was not an unambiguous good that sentences in Norway were less structured, however. Many prisoners, particularly those who served short sentences or were in open prisons, complained about the lack of formal interventions related to their offending. Some worried about their sexual thoughts and feelings, and others described experiencing unresolved feelings of shame which they would benefit from discussing with a professional. Niclas, for example, did not want to be released until he had undergone treatment:

> *I certainly need someone to talk to. Yes. I need to have that when I get out, so I don't… yes, there is a lot that still needs to be put in place. That is why I said that if I could be released tomorrow, I wouldn't want to. No. There are still a lot of thoughts. Shame. (High security prison)*

This is an issue which has received political attention in Norway, and the prison service received extra funding in 2019 to cover the costs of implementing treatment programmes in more prisons. Nevertheless, at the time of the fieldwork, some prisoners like Jakobe said that sentences in open prisons don't 'mean much' (open prison), as very little effort is put into what he called 'recurrence prevention' work. While prisoners certainly described advantages to the more individualised treatment which they received in Norway, then, people did find it difficult if they fell through the gaps.

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Relationships and regulation

In England and Wales, the 'sex offender' master status carried such weight that prisoners identified its discrediting attributes in their peers. Prisoners quite frequently reported, in interviews and in chats on the wing, that their peers were sinister, dangerous, or groomers, and they often implied that their offending identities were responsible for their behaviour:

> *'It goes along with essentially the type of people they are, and whether they've actually put in work to change their characters, because it goes along with their offences.' (Arjun, Category C prison)*

Prisoners observed, monitored and gossiped about each other, looking out for signs of inappropriate behaviour, and they avoided people who they thought were entrenched 'sex offenders'. Others talked about altering their own behaviour in order to avoid being talked about, for instance by avoiding talking to female officers, transgender prisoners, or even female researchers, in order to prevent adverse inferences being drawn. Much of the regulation in English and Weldsh prisons was lateral, then; prisoners reproduced both the ways in which the prison had constructed them, and the ways in which it sought to monitor them, in their relationships with each other.

Susie Scott has described this as 'performative regulation', which she argues occurs when 'people submit themselves to the authority of an institution, internalize its values and enact them through mutual surveillance in an inmate culture. Power operates horizontally as well as vertically, as members monitor each other's conduct, sanction deviance and evaluate their own progress in relative terms'.[10] William, for instance, said that he used explicitly cognitive-behavioural language when he heard people talking inappropriately: 'I do turn round and say, 'You need to go on the course, and pronto. […] You need to sort your life out. You need to sort your thoughts out, your patterns" (Category C prison). Another said he would find it hard in treatment groups not to attempt to assess the authenticity of other people's change:

10. Scott, S. (2010) 'Revisiting the total institution: Performative regulation in the reinventive institution'. *Sociology,* 44(2), pp. 213-231 (p.221).

'Having heard what they've done, I don't think I could sit in the same room and not try and judge their body language or how they are reacting to certain things that are being said to see whether or not they are taking it on board in the right way.' (Louis, Category C prison)

This dynamic was not found in Norway, where social relationships among prisoners were simply not structured by discourses of risk and danger. As described earlier, prisoners convicted of sex offences were certainly judged, often excluded and sometimes endangered by 'mainstream' prisoners, but prisoners did not use officially-sanctioned language when they did this.

Conclusion: Reintegrative and disintegrative shaming

To conclude, I would like to argue that the penal systems in both countries operated very differently, and that this had a significant effect on the sort of shame the prisons communicated. Using terms taken from the work of John Braithwaite, I argue that the imprisonment of men convicted of sex offences in England and Wales mostly operated on a 'stigmatising' logic, whereas in Norway it sought to operate on a 'reintegrative' logic; however, it did not always achieve this.[11]

Braithwaite describes 'disintegrative' or 'stigmatising' shaming as morally communicative practices which involve moral humiliation and suggest that people's worst actions constitute who they are and who they can be. This makes it harder to shed disparaging labels — to move from sex offender to ex-offender to citizen — and generates resentment and social withdrawal.[12] So in England and Wales, prisoners convicted of sex offences are constructed as 'sex offenders', sinister and risky objects who can only change if they comply with the officially-sanctioned narrative. They are also subject to tight restrictions on release and will be included in the Sex Offenders' Register. It is very common for people we interview in England and Wales to say they want to move abroad when they finish their licence, indicating that they feel that their citizenship status has permanently changed.

'Reintegrative shaming', on the other hand, shames the act but not the offender — this is linked to the Norwegian reluctance to use the term 'sex offender'. This enables offenders to accept mistakes in reparative ways, from which they can move on — so people convicted of sex offences in Norway are subject to fewer legal restrictions on release, for example, and they only need to declare convictions which are directly relevant to their employment. However, it also requires the sentence to be experienced as a meaningful ritual, and prisoners in Norway who received no formal interventions or opportunities to talk about their shame, offending or hopes for the future often found their sentences too meaningless to be truly reintegrative.

Almost every prisoner we have interviewed for this project, even those who maintain innocence for their offence, has described wanting to use the sentence as a time of change, personal development and growth. Part of what needs to be done is to help people who want to change — to help sex offenders become ex-offenders — and part of what needs to be done is to welcome them back when they have done so — to grant them their citizenship back. I want to conclude by suggesting that maybe there are dangers in trying too hard to change people. Rowan Williams has argued that people in prison are often isolated from their support structures and placed in an institution which explicitly exhorts them to repent and change.[13] In this context, Williams argues that a chaplain should act as a 'remembrancer', working 'with someone to bring to light a vital sense of what in fact has made them the person they are'.[14] What we should be looking for is not 'dramatic conversion, or even the articulation of repentance in the first place', says Williams, 'but something more like the reconstruction of a person's story, without which the language of conversion and repentance is going to be another image or fiction taking them further away from real needs and real resources'.[15] The language used is religious but the message has wider application. What is needed is not necessarily to change someone from a 'sex offender' to an ex-offender but to help them see that they were never a 'sex offender' in the first place, that the phrase was never an accurate descriptor of who they were. In Williams' words, what is needed is to build on 'different sorts of memory: so that the story that emerges is not one of linear, inevitable progress that towards one disastrous or violent moment. It is a process comparable to the role of creative arts in a prison; a way of asking "Who am I when I'm not a 'criminal?"'.'[16] The challenge for prisons is to ask that question, and to create a setting which makes it easier for people to answer it.

11. Braithwaite, J. (1989) *Crime, Shame and Reintegration*. Cambridge: Cambridge University Press. See also McAlinden, A.M. (2007) *The Shaming of Sexual Offenders: Risk, Retribution and Reintegration.* Oxford: Hart.
12. Scheff, T.J. (2006) *Goffman Unbound! A New Paradigm for Social Science.* Boulder, CO: Paradigm Press.
13. Williams, R. (2003) 'Ministry in prison: Theological reflections'. *Justice Reflections,* 2, pp. 1-15.
14. Williams (2003), p. 3.
15. Williams (2003), p. 6.
16. Williams (2003), p. 5.

The transition from prison to the community of people convicted of sexual offences: Policy and practice recommendations.

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Introduction

The number of people in prison in England and Wales with a current or previous conviction for a sexual offence has risen significantly in recent years, in part because of a growth in the number of convictions for historical offences over this period, but also as a result of growing recognition and understanding of the harm that sexual offending causes. Changes in legislation[2] and developments in professional practice have taken place as a response to these legitimate concerns. However, it is vital that research explores the best methods of both reducing reoffending and supporting people either to become, or return to being, positive citizens who are accepted by their communities.

This article is a summary of the recommendations for policy and practice following a research study as part of a PhD in socio-legal studies at the University of Nottingham. The thesis explores and advances the established literature on desistance, risk assessment, and risk management, critically analyses the expectations and experiences of people convicted of sexual offences in the transition from prison to the community, and examines data from those responsible for their supervision.

The research provides an insight from the perspectives of the people involved in this challenging period, and there were findings in six key areas: the impact of imprisonment on a person but also the benefits of the prison as a community; the importance and role of family support in reducing isolation; the positive impact of employment or purposeful activity on well-being; the stigma and challenges of life in the community; the importance of not simply the provision of accommodation, but the opportunity to establish a home; and the importance of hope and planning for the future. The work has resulted in several recommendations for improvements in policy and practice with a view to both to reducing reoffending and improving the well-being of the individuals concerned.

Background

As the governor of the institution where this research was focused (HMP Whatton), I had spoken to many prisoners prior to their release. Many expressed their anxieties and uncertainties about the transition from prison to the community. Some said that they were not in contact with family, as they had either committed offences within their family or had been disowned by them as a result of their offences. Some had been in prison for such a long period that their families had died. Often, people were worried about the feelings of isolation and loneliness that they might encounter and how they would cope with having no friends outside of the prison environment. Many were unsure how the notification requirements of the 2003 Sexual Offences Act and the restrictions regarding whom they could associate with upon release would impact upon them. Some people had uncertainties about where they would live, as their licence conditions prevented them from returning to their home area and their Offender Manager had been unable to find any alternative accommodation for them.

These conversations, along with the considerable media and political interest in this group of people, prompted me to consider research into this important area. I wanted to find out to what extent people were prepared for their return to the community, with, it seemed, these significant challenges for their successful reintegration. Knowledge of the actual experiences of this group of people from their perspective is scarce.

1. I am grateful for the willingness of participants to give their time and for their frankness at a very difficult time in their lives. HMPPS generously funded this doctoral work, and the School of Law at the University of Nottingham provided an academic base for this study.

2. *Criminal Justice Act 1991; Sexual Offenders Act 1997; Crime and Disorder Act 1998; Sexual Offences (Amendment) Act 2000; Criminal Justice and Court Services Act 2000; Sexual Offences Act 2003; Criminal Justice Act 2003; Anti-Social Behaviour, Crime and Policing Act 2014.* Available at: https://www.legislation.gov.uk/

The research addresses this significant gap in knowledge and gives a voice to a group of people who are arguably the most stigmatised and feared in our society.

Throughout this work, the subjects of study are referred to as 'people convicted of sexual offences' rather than 'sex offenders'. Although this phrase may seem cumbersome, it is important to be positive and forward looking. The research is centred on the whole person and their potential for change, not simply on defining people by their previous behaviour or by what we do not want them to be.[3]

There has been a significant amount of research on the impact of a period of imprisonment on an individual[4] and also a substantial focus on factors influencing desistance from crime. More recently, there have been more limited studies exploring factors specifically influencing desistance from sexual offending.[5] There is a significant body of knowledge on risk prediction and risk management in sexual offending.[6] However, there has been little research exploring the experiences of people leaving prison and returning to the community with a sexual conviction and how their experiences could influence the knowledge base, policy, and practice in the areas of desistance, risk prediction, and risk management.

More recently, there have been more limited studies exploring factors specifically influencing desistance from sexual offending.

For this study, a series of interviews were conducted with eight self-selecting male prisoners to examine their expectations and plans prior to release. The same individuals were then re-interviewed approximately three months after their return to the community to consider how their actual experiences differed from those they had imagined. They were asked to contact the researcher by letter or by telephone at the prison to confirm that they still wished to participate and that they were available at the time and date offered. This offered the participants another opportunity to opt out, if they chose to do so. All the participants who were interviewed in the prison agreed to, and arranged, follow-up meetings for the second interview. The management and supervision of these individuals was also explored through interviews with their respective Offender Managers.

A total of 24 interviews were conducted, made up of 16 interviews with prisoners pre- and post-release and eight interviews with Offender Managers. This was a qualitative study, using semi-structured interviews.[7] Thematic analysis was chosen as the preferred analysis approach, in part because it can 'be used to address most types of qualitative research, ranging from questions about individual lived experience through to those about social construction and meaning'.[8] The following primary research questions were considered. 1) What are the expectations of people leaving prison with a conviction for a sexual offence? 2) How do these compare with the reality of life in the community? 3) How can this group of people be best assisted not to reoffend? 4) What is the impact of licence conditions and statutory restrictions on their resettlement plans and goals? 5) What support is provided to people leaving prison? 6) Do ex-prisoners think that their transition could have been done differently and more usefully?

For both the ex-prisoners and the Offender Managers, the focus of these questions was to explore the actual lived experience of the transition from prison to the community of people convicted of sexual offences and how the law and established practice affects their well-being and therefore their successful resettlement.

3. Willis, G. M. (2015) 'Desistance from sexual offending: Current knowledge and future direction for research and practice'. Research symposium, March 2015. Belfast: Queens University Belfast.
4. Goffman, E. (1961) *Essays on the Social Situation of Mental Patients and Other Inmates.* New York: Anchor Books; Jewkes, Y. (2013) Captive Audience. London: Willan; Bosworth, M. (2012) 'Subjectivity and identity in detention: Punishment and society in a global age', *Theoretical Criminology,* 16(2), pp.123-140.
5. Farmer, M., McAlinden, A.-M., and Maruna, S. (2015) 'Understanding desistance from sexual offending: A thematic review of research findings', *Probation Journal,* 62(4), pp.320-335.
6. Hanson, R. K. and Bussière, M. T. (1998) 'Predicting relapse: A meta-analysis of sexual offender recidivism studies', *Journal of Consulting and Clinical Psychology*, 66(2), pp.348-362; Laws, D. R. and Osborn, C. A. (1983) 'How to Build and Operate a Behavioural Laboratory to Evaluate and Treat Sexual Deviance' in Greer, J. G. and Stuart, I. R. (eds.), *The Sexual Aggressor: Current Perspectives On Treatment.* New York: Van Nostrand Reinhold, pp.293-335; Beech, A. R., Fisher, D. D., and Thornton, D. (2003) 'Risk assessment of sex offenders', *Professional Psychology: Research and Practice,* 34(4), pp.339-352.
7. Barriball, K. L. and While, A. (1994) 'Collecting data using a semi-structured interview: A discussion paper', *Journal of Advanced Nursing,* 19(2), pp.328-335.
8. Braun, V., Clarke, V., and Terry, G. (2014) 'Thematic Analysis' in Rohleder, P. and Lyons, A. C. (eds.), *Qualitative Research in Clinical and Health Psychology.* Basingstoke: Palgrave MacMillan, pp.95-113.

Implications for policy and practice

The key findings of the research considered the implications for both policymakers and practitioners in terms of deciding how best to effectively manage and support a person with sexual convictions leaving prison. Whilst it is important to take into account the need to manage an individual's risk to the public, it is also crucial to provide them with appropriate support and opportunities to live a meaningful life, which will in turn aid both desistance and the risk-management process.

Perspectives on prison life

Inadequate planning and preparation of the person who was due to be released, and the implications of this for a successful transition to the community, were consistent features of the experiences of the research participants. Participants spoke of plans being last minute and often felt that they had little time to plan or consider how they would prepare for and manage this transition. Questions were also raised about the implications of their licence restrictions and the impact of the notification requirements. The opportunity to examine this in more detail is something that both policymakers and practitioners should consider. An earlier introduction to these issues in release planning would be welcome, as a number of participants in this study highlighted.

Prisons releasing people convicted of sexual offences could provide more comprehensive and interactive preparation-for-release programmes, allowing people to consider the key issues in the period prior to their release. These could take place up to six months in advance of the release date and could explore the implications of the notification requirements and when and how to disclose the sexual convictions to prospective partners, friends, and employers. This could potentially reduce the likelihood of non-compliance or even recall. The circumstances of disclosure and the opportunity to practise how this might take place could also assist in developing the confidence of the person prior to their release. This would be particularly useful in supporting the work undertaken in prisons by programmes teams, but it would also be of practical benefit where prisoners are released from prison without having participated in offending behaviour programmes.

There are often operational and organisational reasons for comparatively short notice being given to a person about their allocation to an Approved Premises for release. The availability of places in Approved Premises is limited and reserved for people with sexual and/or violent convictions who are considered to be a high risk of serious harm to the public.[9] The growth in the number of people in prison serving sentences for sexual convictions[10] has placed more pressure on the provision of Approved Premises, and the expansion of appropriate supported housing should be a priority for the Ministry of Justice. As evidenced by the experiences of the participants, people with disabilities and social care needs are particularly disadvantaged by this shortfall, and these issues need to be addressed if the transition from prison to the community is to be successfully managed.

The availability of places in Approved Premises is limited and reserved for people with sexual and/or violent convictions who are considered to be a high risk of serious harm to the public.

A major restructuring of the Probation Service (Transforming Rehabilitation)[11] had taken place at the time of the research interviews, and the shortage of qualified and experienced staff was evident. The Offender Managers interviewed expressed concern about their workloads and the high numbers of people with sexual convictions they were managing who were considered to be a high risk of reoffending. This had an impact on their ability to plan and prepare for the release of people in a timely fashion. The role of the Offender Manager in successful rehabilitation is considered important in desistance literature. The recruitment and retention of additional Offender Managers, therefore, should be a priority for HMPPS to ensure that adequate release planning takes place.

There are a number of other practical improvements that could be made in policy and practice to aid an individual's transition from prison to the community. Although it may potentially be unpalatable for the general public, the development of IT skills and/or access to the internet for people leaving

9. Reeves, C. (2013) '"The others": Sex offenders' social identities in probation Approved Premises', *The Howard Journal of Criminal Justice,* 52(4), pp.383-398.
10. Ministry of Justice (2018) Population Bulletin: *Monthly December 2018*. Available at: https://www.gov.uk/government/statistics/prison-population-figures-2018 (Accessed: 04 July 2020).
11. Ministry of Justice (2013) *Transforming Rehabilitation: A Summary of Evidence on Reducing Reoffending,* London: MoJ.

prison with a sexual conviction is vital, and this is a significant problem to be overcome. This is mainly because a number of critical services, such as applications for Universal Credit and appointments at GP surgeries, are almost exclusively online. The development of prisoners' IT skills prior to leaving prison, and extension of the Universal Credit pilot enabling people to apply for benefits prior to their discharge from prison, would help to ensure that people are better able to deal with the challenges of access to benefits and are not left waiting for money for extended periods after leaving prison.

Licence restrictions preventing access to the internet or ownership of a smartphone with the ability to take or download photographs and video or to stream to or from the internet are also potentially problematic. These restrictions may include a person only being permitted to access the internet in a public place, but the reduction in the number of libraries has affected the number of places where even this is possible. In any case, for security reasons, internet access to bank and credit card accounts is not recommended in public places. Whilst in prison, advice and support on how to negotiate these challenges needs to be provided, together with a realistic appraisal of the consequences of non-compliance.

Licence restrictions preventing access to the internet or ownership of a smartphone with the ability to take or download photographs and video or to stream to or from the internet are also potentially problematic.

A person's release from prison may also present the first time (or the first time in a considerable period) that they have needed to carry out practical housekeeping skills for themselves; often, they will have been cared for by either parents or partners. Particularly for a person who has served a long prison sentence, the development of knowledge and the opportunity to practise laundry, cookery, and menu-planning skills on a limited income would be a useful service and something that could be provided in prisons prior to a person's release. This clearly has some resource implications, as although prisons provide catering and laundry facilities on an industrial scale, small-scale facilities that are comparable to those in domestic households would enable people who are due to be released to practise their skills and to prepare for their reintegration. As the majority of people with sexual convictions who are considered to be a high risk of serious harm will be moving to Approved Premises from prison, this is perhaps something that could be continued there to improve confidence and independence.

The opportunity to shop in the community and to develop menu-planning skills on a limited budget is also important if people are to be able to practise budgeting, particularly if an individual is likely to be receiving benefits upon release. This, however, has political implications, as prisons will need to be allowed to release risk-assessed prisoners on temporary licence. Release on temporary licence (ROTL) from prison is permitted under certain circumstances.[12] However, at the time of the research, this facility is not permitted from closed prisons holding people with sexual convictions (this provision was curtailed following the high-profile case of a person with a serious offence of violence who reoffended whilst on licence in 2014). This change was made despite the evidence that the vast majority of releases from prison on temporary licence are completed successfully and without incident.[13] It would seem appropriate in these circumstances to prioritise ROTL for people with sexual convictions so that they can be supported in their release planning by both prison staff and community-based Offender Managers.

Again, for long-term prisoners, the impact of a release into the community after serving a long prison sentence is even more pronounced, and therefore the opportunity for this transition to be staged or initially safely supervised by prison staff in these cases is critical. This staged approach would enable people to self-monitor and to manage their own risks in a safe, controlled way. For example, exposure to adults and children outside the controlled, secure environment of a prison will offer people a more detailed insight into how they should manage and plan their safe return to the community.

This gradual, staged process, together with the opportunity to develop practical survival skills, would help mitigate the detrimental impact of

12. *The Prison Rules* 1999, Rule 9. Available at: https://www.legislation.gov.uk/uksi/1999/728/article/9 (Accessed 04 July 2020).
13. Her Majesty's Inspectorate of Prisons (2014) *Release on Temporary Licence (ROTL) Failures: A Review by HM Inspectorate of Prisons.* London: HMIP.

institutionalisation and assist in preparing for eventual independence. The provision of opportunities to demonstrate personal initiative, autonomy, and agency has been shown to assist in the desistance process.

Opportunities to reinforce the thinking skills learnt in prison are also important if an individual is to successfully reintegrate and to re-establish their life without reoffending or recall to prison. The knowledge base of the Offender Managers in the community about the offending behaviour programmes in operation in prisons varied in this research. Increasing the knowledge base and skills of Offender Managers is critical so that they are better able to reinforce and remind people of the messages and the skills learnt in the prison-based programmes. This would ensure that the messages given to the person in transition are consistent and best practice about the effectiveness of programmes is enhanced.

As a significant proportion of people with sexual convictions, particularly those serving very long or indeterminate sentences, are not released directly into the community from closed establishments, there are strong arguments that better and sustainable links between open prisons and treatment centres for people with sexual convictions should be developed. This could include: the development of joint training programmes; advice on behaviour and risk management from clinical staff who have worked with people in treatment sites prior to their transfer; virtual tours of open prisons to be shown in treatment sites so that people can familiarise themselves prior to transfer; and developing consistent policies in both treatment sites and open prisons so that people are familiar with the rules and restrictions prior to their move. This will enable the services provided in open prisons to reflect the re-enforcement of the learning from offending behaviour programmes.

Opportunities to reinforce the thinking skills learnt in prison are also important if an individual is to successfully reintegrate and to re-establish their life without reoffending or recall to prison.

Family relationships

The maintenance of family relationships (where possible) is an important factor in the successful transition of a person with a sexual conviction back into the community, but the well-being of family members who are dealing with the impact on their lives of the conviction on both family dynamics and the local community also need to be considered. As discussed in extant research,[14] family members experience both stigma and grief as a consequence of their relationship with a person with convictions for a sexual offence. This is supported by the findings of this research. For example, some family members of participants found that it was difficult to continue their relationships following the family member's conviction and imprisonment. Both policymakers and individual prisons need to consider how to manage and support family members through the process. Whilst it may not be possible for family links to be maintained in some circumstances (because of domestic violence or child protection issues, for example), both policy and practice should aim to support this in all other cases. Prisons should ensure that, where possible, family members are welcomed and kept informed and involved in the decision-making processes about their loved one, but also encouraged to ask questions and be given answers about the rationale for decision making, including decisions on licence and child contact restrictions.

If family members are able to visit prisons, then the opportunity should be taken to involve them in the life of the prison, for example in family days or in case-management meetings, so that they are reassured about the well-being of their loved one and are able to develop an understanding of the reasons for the offence being committed. They then can develop an insight into the risk factors associated with reoffending and can therefore be encouraged to provide guidance and insight when necessary so that they can support the desistance process.

As demonstrated by the experiences of some of the participants, support for family members should continue when someone is released back into the community. This may be in the form of support groups or simply offering advice on both the practical and emotional impacts of dealing with the implications of licence restrictions and notification requirements.

14. Codd, H. (2007) 'Prisoners' families and resettlement: A critical analysis', *The Howard Journal of Criminal Justice,* 46(3), pp.255-263; Souza, K. A., Lösel, F., Markson, L., and Lanskey, C. (2013) 'Pre release expectations and post release experiences of prisoners and their (ex)partners', *Legal and Criminological Psychology,* 20(2), pp.306-323; Naser, R. L. and Visher, C. A. (2006) 'Family members' experiences with incarceration and reentry', *Western Criminology Review,* 7(2), pp.20-31.

Where no family support is available, the provision of alternative support structures is important to try and replicate the advantages of family support and attempt to reduce social isolation. Mentoring programmes or Circles of Support and Accountability[15] projects can be a useful addition to the support network of a person with a sexual conviction re-establishing themselves into the community. Church and community groups can also help to fill this gap by providing alternative sources of social capital. However, the person leaving prison needs to be given realistic and practical guidance on the safeguarding policies of those institutions and how to ensure that the understandable public protection restrictions can be safely managed.

Whilst the responsibility for being part of the community outside of prison rests with the individual, there are also wider implications of this ambition for policy and practice. Community groups themselves should be encouraged to see people convicted of sexual offences as individuals and not a homogeneous group. Risk assessments and risk management should be proportionate to the risk the person actually poses rather than a range of blanket and indiscriminate restrictions. Offender Managers must also encourage appropriate involvement in community groups, and policymakers should encourage informed and individualised risk management rather than a blanket policy of risk avoidance so that the benefits of the community supporting desistance can be realised.

Employment and purposeful activities

The value of work and the impact of unemployment on a person's well-being is well documented.[16] The personal experiences of the people interviewed as part of this research revealed challenges in finding suitable employment or voluntary activities. In particular, these included Offender Manager concerns about risk of contact with the public, employer reticence to employ people with sexual convictions, and community groups concerned about reputational risks or safeguarding issues. Given that work is also an important feature of the desistance process, it is crucial that this particular issue is tackled. Whilst it is important that individuals are offered assistance with gaining employment, such as support with CV writing or interview skills, it is also important to educate, engage with, and support employers to employ people with sexual convictions. Again, this means providing employers with a more informed, balanced perspective on the risks posed by people by looking at them as individuals rather than a homogeneous group. Employers should be encouraged to develop their trust in individuals in an informed and supported way.

In times of high levels of unemployment across the wider population, it is perhaps easier to understand employer reluctance to employ people with sexual convictions.

A Ministry of Justice initiative in 2018 focused on promoting a number of employers, such as Pret a Manger, Halfords, and Balfour Beatty, who had prioritised the employment of ex-offenders with the aim of encouraging more employers to consider the option of the employment of this group of people. However, there has been little focus on the employment of people with sexual convictions.[17]

In times of high levels of unemployment across the wider population, it is perhaps easier to understand employer reluctance to employ people with sexual convictions. However, when there are apparent skill shortages across a range of sectors, it is perhaps more surprising that employers are unwilling to take on people with sexual convictions, particularly when the reoffending rates of this group are so low.[18] There is perhaps a role for the voluntary sector to take the lead, and for central and local government to offer advice, support, or incentives to take on and to safely manage this group of people. In addition, the education of voluntary sector and community-based organisations to safely open up their services to people convicted of sexual offences upon release from prison should be a priority. If necessary, organisations should be encouraged to develop appropriate risk planning and

15. Kitson-Boyce, R., Blagden, N., Winder, B., and Dillon, G. (2018) '"This time it's different" Preparing for release through a prison-model of CoSA: A phenomenological and repertory grid analysis', *Sexual Abuse: A Journal of Research and Treatment,* 31(8), pp.886-907.
16. Waddell, G. and Burton, A. K. (2006) *Is work good for your health and well-being?* London: The Stationery Office.
17. Ministry of Justice (2018) *Employing prisoners and ex-offenders*. Available at: https://www.gov.uk/government/publications/unlock-opportunity-employer-information-pack-and-case-studies/employing-prisoners-and-ex-offenders (Accessed 04 July 2020).
18. Hanson and Bussière's (1998) meta-analysis reported that the average recidivism rate among people convicted of sexual offences is 13.4% (see n.6).

advised on how to manage different restrictions and requirements. These voluntary activities offer the opportunity to support the desire of individuals to atone for their wrongdoing and to 'give something back'.

Stigma and challenges

The impacts of the stigma of a sexual conviction on both an individual and their family have been analysed by a number of authors,[19] and the provision of generic licence conditions[20] for this group arguably adds to the challenges facing a person in the transition from prison to the community, if not the stigma. The legal and administrative framework for the management and control of people with sexual convictions is significant.[21] The rigid and inflexible application of generic licence conditions is not effective in reducing the risk of reoffending or in assisting an individual's successful resettlement and arguably does little to reduce reoffending. Although generic licence conditions are organisationally easier to administer, they do not have particular utility when dealing with the risks posed by individual people. A more individualised approach to both risk and risk management is likely to be more effective in achieving the desired outcome of controlling and monitoring an individual during their licence period. Licence conditions are more likely to achieve their objectives if they link in to risks identified by the prison-based offending behaviour programmes and an individual's self-identified risk.

These voluntary activities offer the opportunity to support the desire of individuals to atone for their wrongdoing and to 'give something back'.

The label 'sex offender' is almost certainly the cause of a significant amount of stigma.[22] Criminal justice organisations and others need to move away from this negative shorthand, and labelling someone forever does not encourage them to see themselves as something other than that label. A proactive policy change with direction from the centre, supported and reinforced in official documents, policies, and legislation, would encourage this. If a person's desire is to be something different in the future from what they were in the past, they should be encouraged and supported to do so, and not to forever be defined by (probably) the worst thing that they have ever done.

Accommodation and home

The importance of the provision of accommodation in the desistance process is well established.[23] However, the importance of a person having the opportunity to establish a home, a personal space, surrounded by their personal items, and having agency and control over this space, is not something that has previously been considered by the desistance literature. Whilst the majority of people with a sexual conviction with a high risk of sexual reoffending are provided with a short-term placement in Approved Premises of at least twelve weeks after they have left prison, lower-risk people are not necessarily automatically provided with any accommodation. Although they must still inform the police of their whereabouts as part of the notification requirements, they often do not have the necessary financial backing to fund their own accommodation and they also often have significant difficulty in obtaining accommodation in the private rental sector because of their sexual conviction, as evidenced by the participants in this research.

Single men are generally not considered a priority group for social housing; if no family support is available, they will therefore potentially be homeless. Night shelters, bed and breakfast accommodation, or rough sleeping are often the only options available to them. Therefore, supported housing should be made available for isolated people with sexual convictions; this would reduce the risk posed to the public and also improve the well-being of the individual concerned.

Even after the initial period in Approved Premises, the accommodation arrangements for people with sexual convictions are often transitory and insecure. This insecurity potentially has an impact on a person's risk of reoffending. The importance of the creation of a home, rather than simply the provision of accommodation, is crucial to their well-being and therefore their successful resettlement.

19. Susman, J. (1994) 'Disability, stigma and deviance', *Social Science & Medicine,* 38(1), pp.15-22; Tewksbury, R. (2012) 'Stigmatization of sex offenders', *Deviant Behavior,* 33(8), pp.606-623.
20. National Offender Management Service (2015) *Licence Conditions, Licences and Licence and Supervision Notices. Prison Service Instruction 12/2015, Annex A*. Available at: https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-12-2015-licences-conditions-licence-supervision-notices.pdf (Accessed 04 July 2020).
21. Ministry of Justice (2012) MAPPA Guidance 2012 (version 4). London: MoJ.
22. Willis (2015), see n.3.
23. Allender, P., Brown, G., Bailey, N., Colombo, T., Poole, H., and Saldana, A. (2005) *Prisoner Resettlement and Housing Provision: A Good Practice Ideas Guide.* Coventry: Centre for Social Justice, Coventry University.

Clearly, this has implications for both government policy and also the provision of an adequate supply of suitable social housing. The link between safe housing and the re-establishment of an individual as part of a wider community is also a critical point. Although Approved Premises are a useful starting point for people when they leave prison, they are not a solution to the problem of the provision of safe, decent, secure housing, and more investment in suitable housing stock is required to ensure that this provision is sufficient. In addition, appropriate individualised risk assessments need to be factored into the process, rather than a generic, one-size-fits-all approach to the management of this group of people. This will require a change in policy and better communication between agencies in the management process.

Hope and future planning

Encouraging hope and planning for the future overlaps with a number of the other identified themes. How policymakers and practitioners working with people with sexual convictions can help both the well-being of the individual and also the desistance process is a critical issue for future planning; everyone has 'the right to hope'.[24] As a result, conditions legal, administrative, and practical need to be put in place to ensure that people with convictions for sexual offences have some degree of agency to manage their own risks and, therefore, their own future. Clearly, insight into what these risks are is critical, but so is the need to support people to manage these risks. In one example from this research, a participant's licence restrictions prevented him from going near a secondary school. However, as he said, he could simply go to a shopping centre if he wanted to look at teenagers; it was a matter for him to manage his risks. Another participant also knew what he needed to do not to be in the same situation that led to his offence and how to self-manage. Professionals cannot always be available to monitor, supervise, or oversee an individual. It is vital that an environment in the community is created whereby an individual sees and feels the benefits of not reoffending and has sufficient self-worth to manage their own behaviour and risks.

The wider use of anti-libidinal medication[25] to reduce sexual preoccupation is clearly an option for individuals to provide support to reduce the likelihood of sexual reoffending. Research participants who were taking such medication expressed the importance of their optimism and hope for the future as they recognised that the medication not only had the potential to improve their well-being but also to reduce the likelihood of reoffending, thus satisfying the wider public protection aims of the criminal justice agencies. However, for such medication to be truly effective, an individual must have the choice to participate rather than being compelled to do so, therefore giving them realistic agency over their future plans.

Proactive ways of encouraging hope and optimism in prison and onwards into the community can also be promoted by peer-support projects and education in prison, including the Open University and vocational or business-skills programmes. In addition, prison community activities can improve the self-esteem and self-worth of individuals.

It is important to improve and foster a sense of agency and choice in the individual, creating and nurturing a feeling of hope and encouraging positive planning for the future so that they do not want to or feel the need to reoffend — in essence, to create a situation where the individual feels that they have a positive sense of self-worth and deserve more for themselves and others, rather than to create more victims and to spend more time in prison. Capitalising on this optimism should be key in the development of future policy and practice.

Conclusion

The experiences of the participants in the study indicate that the solutions to reduce sexual reoffending and successfully resettle people convicted of sexual offences in the community rests, unpopular and unpalatable as this may seem, not solely with the individual convicted of a sexual offence but with the institutions of the state, practitioners in the criminal justice system, employers, and the wider community. Changes to legal practice and public perceptions are critical if the risks people pose to others are to be safely and appropriately managed and people convicted of sexual offences are to be allowed to return to being active and productive citizens. The perception of these individuals as a homogeneous group of highly dangerous, manipulative, and predatory people needs to be challenged, and these labels should be confined to the very small number of people to whom they apply.

The practical suggestions resulting from the research can undoubtedly help in this ambition; however, fundamentally, fostering a wider understanding that people convicted of sexual offences are 'people like us', often with the same needs desires and personal issues, is a greater challenge.

24. European Court of Human Rights (2013) *Case of Vinter and Others v. The United Kingdom.* Available at: http://hudoc.echr.coe.int/eng?i=001-122664 (Accessed 04 July 2020).
25. Winder, B., Lievesley, R., Elliott, H. J., Norman, C., and Kaul, A. (2014) 'Understanding the Journeys of High-risk Male Sex Offenders Voluntarily Receiving Medication to Reduce their Sexual Preoccupation and/or Hypersexuality' in Wilcox, D. T., Garrett, T., and Harkins, L. (eds.) *Sex Offender Treatment: A Case Study Approach to Issues and Interventions.* Chichester: John Wiley & Sons, Ltd., pp.342-370.

'No one told me about Circles': Perspectives of Circles of Support and Accountability and Perceived Support to Prevent Sexual Reoffending

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Introduction

The proportion of reoffences committed, dependent on the type of index offence, has remained broadly stable over time. The lowest rate of reoffending in the adult cohort was observed amongst those with a sexual index offence, with a rate of 13.6 per cent[1]. At present, so-called 'through the gate services' (TTGS) focus on practically supporting all individuals who have committed an offence in preparation for release. TTGS are responsible for providing individuals who have committed sexual offences accommodation in a range of locations depending on their level of risk and need. The National Probation Service manage those with sexual convictions when they are in custody, and on release, and help individuals prepare for release and utilise relevant organisations to help with accommodation, employment, training and education, finance, benefits, and health and social care. TTGS are provided automatically to those in prisons which are set up to help resettlement, for instance by helping with CV's, vocational courses, etc., although not all individuals who have committed sexual offences will reside and subsequently be released from such establishments. In addition to these statutory services, charities such as the Safer Living Foundation[2] and the Lucy Faithfull Foundation[3] provide support to individuals who have committed sexual offences upon release, although resources limit the number of individual's such charities are able to support.

There can also be restrictions as to the placement of those with sexual convictions. For instance, offence history can result in individual's being barred from some hostels, hotels or bed and breakfast establishments, and, when funded by the National Probation Service, need to be personally authorised by the Chief Probation Officer and/or the Director General for Probation. Indeed, research regarding those being released having committed a sexual offence[4;5;6;7] have reported difficulties in finding accommodation and employment. This can be a result of legal restrictions placed on them with regard to where they can live and or work. Furthermore, it can be due to public perceptions (or fear of them) due to their offence history. Some research has shown individuals subject to such

1. Ministry of Justice (2019). Proven reoffending statistics quarterly bulletin, July 2017 to September 2017. Retrieved from https://www.gov.uk/government/statistics/proven-reoffending-statistics-july-to-september-2017 31.8.19.
2. The SLF It is a joint venture between HMP Whatton and Nottingham Trent University, and is supported by the likes of the National Probation Service (East Midlands) and Nottinghamshire Police. As a Charitable Incorporated Organisation that adopts a multi-agency approach with a strong research component, the SLF is focused on reducing sexual offending and re-offending through rehabilitative and preventative initiatives.
3. The mission of the LFF is to prevent the sexual abuse of children and young people by working with protective adults, those affected by abuse and those perpetrating it, including young people with harmful sexual behaviour. They educate families, professionals and the public to help children and young people to stay safe. Through Stop it Now they provide a confidential helpline.
4. Tewksbury, R. (2012). Stigmatization of sex offenders. *Deviant Behavior,* 33, (8), 606-623. http://dx.doi.org/10.1080/01639625.2011.636690.
5. Tewksbury, R., & Connor, D. P. (2012). Incarcerated sex offenders' perceptions of family relationships: Previous experiences and future expectations. *Western Criminology Review, 13,* 25-35. https://doi.org/10.1177/0032885512467318.
6. Tewksbury, R., & Copes, H. (2013). Incarcerated sex offenders' expectations for re-entry. The Prison Journal, 93, (2) 102-122. http://dx.doi.org/10.1177/0032885512467318.

residency restrictions show increased levels of stress[7] and report a persistent sense of vulnerability[8]. Further, some of those released feel they will never be free from the label of a 'sex offender', the status of that label being seen above other identifiers the person may have, for example fatherhood[9]. Researchers[4] reported that some individuals who committed a sexual offence described fearing being viewed by others as 'the lowest of the low' and the 'worst of the worst' which reportedly resulted in them withdrawing from social opportunities, thus increasing their social isolation. Many individuals convicted of sexual offences also report problems maintaining social and familial relationships due to their status as a 'sex offender'[5;6]. Indeed, research has emphasised the importance of reducing social isolation, with a particular focus on enhancing familial relationships[10], to reduce an individual's risk of reoffending. Thus, it appears some existing strategies currently implemented may inadvertently contribute to an increase in offence-related risk factors for some individuals.

For some individuals who have committed a sexual offence, it is apparent the risk of reoffending is higher and additional support is needed to adequately manage their risk of reoffending. Expanding on this further, some individuals released having been charged with a sexual offence can find it difficult to gain support to manage their emotions in relation to sexual interests[11]. The Integrated Theory of Desistance from Sexual Offending (ITDSO[12]) relates to how those convicted of sexual offences can successfully re-integrate in the community. As both deviant sexual interests and poor emotional coping are known risk factors for sexual recidivism[13], the perceived support by individuals who have committed a sexual offence upon release in relation to this is arguably essential to reduce the risk of reoffending. This issue is discussed further[14], through exploration with individuals preparing for release. They found that individual's pertaining the belief that they were going to be supported by 'normal' people, helped provide them with a sense of belonging they had not experienced previously. Further, individuals in the process of desistence from sexual reoffending have noted the importance of social support and new employment opportunities[15], as well as reporting a sense of hope and optimism for their future[16]. Consistent with the principles of ITDSO, individuals appearing to be in the process of sexual desistance have reported structural and social processes, as well as internal personal shifts, as relevant to positive change and desistance from sexual offending. Whilst the sexual desistance research is growing, understanding how public protection services can mirror the latest findings remains challenging.

Circles of Support and Accountability (CoSA) is an organisation which attempts to provide support through recruiting, training and supervising volunteer members of the public to provide tailored support and monitoring of those who have been convicted of sexual offences when they are being released from custody. Support is offered as a means of reducing feelings of isolation and emotional loneliness, factors known to relate to sexual reoffending[17]. Its' efficacy is reported elsewhere[18;19;20;21;22] but, in general, it is seen as a

7. Tewksbury, R., & Mustaine, E. E. (2009). Stress and collateral consequences for registered sex offenders. *Journal of Public Management & Social Policy,* 15, (3), 215-239.
8. Tewksbury, R. & Lees, M. (2007). Perceptions of Punishment: How Registered Sex Offenders View Registries. *Crimes & Delinquency, 53,* (3), 380-407.
9. Mingus, W., & Burchfield, K.B. (2017). From prison to integration: Applying modified labelling theory to sex offenders. *Criminal Justice Studies,* 25, (1), 97-109.
10. Farmer, L. (2017). *The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime*. UK: Ministry of Justice.
11. Akerman, G. (2017 online first). Providing treatment in a prison-based therapeutic community for those who have committed sexual offences. *International Journal of Offender Therapy and Comparative Criminology.*
12. Göbbels, S., Ward, T., & Willis, G. M. (2012). An integrative theory of desistance from sex offending. *Aggression and Violent Behavior, 17,* (5), 453-462.
13. Mann, R.E., Hanson, K.R., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22,* (2), 191-217.
14. Kitson-Boyce, R., Blagden, N., Winder, B., & Dillon, G. (2019). "This time it's difference" preparing for release through a prison-model of CoSA: A Phenomenological and Repertory Grid Analysis. *Sexual Abuse: A Journal of Research and Treatment, 31,* (8), 886-907.
15. McAlinden, A.M., Farmer, M. & Maura, S. (2017). Desistance from Sexual Offending: Do the Mainstream Theories Apply? *Criminology and Criminal Justice, 17,* (3), 266-283.
16. Farmer, M. (2015). Understanding desistance from sexual offending: A thematic review of research findings. *Probation Journal,* 62, (4), 320-335.
17. Hanson, R. K., & Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 118 prediction studies. *Psychological Assessment. 21*(1), 1-21.
18. Kitson-Boyce, R. (2018). Do CoSA work? A review of the literature. In Elliott, H., Hocken, K., Lievesley, R., Blagden, N., Winder, B., & Banyard, P. (Eds.) *Sexual Crime and Circles of Support and Accountability. UK*: Palgrave.
19. McCartan, K. (2016). *Circles of support and accountability: Cabinet office - Social Action Fund evaluation.* Project Report. University of the West of England, Bristol, UK.
20. Wilson, C., Bates, A., & Völlm, B. (2010). Circles of support and accountability: An innovative approach to manage high-risk sex offenders in the community. *Open Criminology Journal, 3,* (1), 48-57.
21. Wilson, R. J., Picheca, J. E., & Prinzo, M. (2005). Circles of support and accountability: An evaluation of the *pilot project in south-central Ontario. Ottawa, Canada:* Correctional Service of Canada.
22. Wilson, R. J., Picheca, J. E., & Prinzo, M. (2007b). Evaluating the effectiveness of Professionally Facilitated volunteerism in the Community Based management of high Risk sexual offenders: Part Two-A Comparison of the recidivism rates. *The Howard Journal of Criminal Justice, 46,* (4), 327-337.

supportive network for those being released from custody having committed a sexual offence. The person who has been released from is referred to as the 'Core Member'. The 'Circle' around them generally 4-6 people, spend time with the core member and aims to provide a supportive social network that also requires the Core Member to take responsibility (be 'accountable') for his/her ongoing risk management. The Circle can also provide support and practical guidance in such things as developing their social skills, finding suitable accommodation or helping the Core Member to find appropriate hobbies and interests. Volunteers are fully informed of the Core Member's past pattern of offending, and whilst helping them to settle into the community the Volunteers also to assist them to recognise patterns of thought and behaviour that could lead to their re-offending. Within it, the Core Member can grow in self-esteem and develop healthy adult relationships, maximising his or her chances of successfully re-integrating into the community in a safe and fulfilling way. The Core Member is involved from the beginning, is included in all decision making and, like all other members of the Circle, signs a contract committing him or herself to the Circle and its aims. Each Circle is unique, because it is individually designed around the needs of the Core Member.

Core Member can grow in self-esteem and develop healthy adult relationships, maximising his or her chances of successfully re-integrating into the community in a safe and fulfilling way.

This paper considers the viewpoint of three men who were released having committed sexual offences, their perceived support in the community, their awareness of CoSA at the time of their release and now, and their views on community support which would be beneficial upon release. As the current paper focuses on men who did sexually reoffend, their perceptions of support may provide essential insight into identifying and supporting high risk individuals to protect against sexual reoffending. The present study was part of a larger piece of work, which focused on increasing awareness of CoSA and exploring if any additional training was needed for volunteers with CoSA to work with this client group. All participants had been through a process of leaving prison and sexually offending again and expressed deep regret for this. Their subsequent work within the Prison-based Therapeutic Community (TC) had arguably enabled them to be more honest about that they had done and be more accepting of others.

Method

Data Collection and Participants

Within the prison-based TC, comprising of five treatment wings, resident research representatives are voted in by fellow residents. The authors met with the research representations on each wing who subsequently announced the research to the community and invited participants to apply. The residents who fitted the criteria were also identified, that is having been previously released following being charged or convicted of a sexual offence, and reoffending, as that was the topic in discussion. The information about the research was given to them and those who took part provided written consent. While there was an interview schedule to guide the focus group and encourage participants to consider their past experiences, at times it was deviated from in order to focus on the actual experiences of the participants and fully explore their narratives. Three men (referred to as Harry, George and Oliver), volunteered to participate in the research. All had been convicted of a sexual offence, have previously been released and committed a further sexual offence for which they are now serving a prison sentence. The focus group was facilitated by both authors, lasted just over an hour and was audiotaped. The group took place in May 2019. The participants had committed sexual offences against adult women. There was some discussion at the start of the focus group in order to relax the participants. The themes that were the discussed asked what experience the participants had (if any) of working with CoSA, how helpful this had been, what support they had received in the community, and what was missing. What they had learned in therapy and offending behaviour programmes to help understand their motivation to offend, and how they were apply this to their plans for the future. The participants were asked what particular needs they would have in the future, in terms of emotional management. The participants were asked if they had any particular support in relation to their sexual offending.

It is worth noting that both researchers are female. One of whom is known to two of the participants, and not well to the other. The second author was not known to any of the participants. This may well have an impact on the discussion.

It was later transcribed and analysed by the researchers independently using Interpretative Phenomenological Analysis (IPA[23]). IPA is an idiographic approach in which individual responses are analysed in detail before moving on to the next, generating general themes. This method allows for a detailed examination and interpretation of lived experience. It is noted[24] that the number of participants depends on: *1. the depth of analysis of a single case study; 2. the richness of the individual cases; 3. how the researcher wants to compare or contrast single cases; and 4. the pragmatic restrictions one is working under.* As there were few residents who had experience of the research subject it was helpful that those who did were willing to take part. Each researcher immersed herself in the data, making notes and analysing emerging themes, and those with a weaker evidential base were removed. Quotes were used to illustrate the themes to retain the voice of the participants' personal experience. There was then a discussion between researchers to agree on wording of the themes that emerged.

Results and discussion

Results

The superordinate and sub-themes are exemplified with narrative examples. As space is limited not all the themes are reported but the full information is available from the corresponding author.

Feeling fearful

Fearful of self/reoffending — not ready to change

Harry. I questioned myself prior to release but I didn't tell anyone out of fear of being kept in prison. I was questioning why I was still having the thoughts but out of fear of rest of life in prison I didn't talk.

Oliver. Fearful of my anger, I took it out of the house, the arsons. I left prison this wouldn't have mattered. I left very angry and was determined to go on how I was. Now I've made changes and now it becomes more relevant.

George. Had the fantasy but no one to talk to. Fear of putting it out I'd get flak.

Participants had mixed reasons for not talking about their thoughts and fantasies, being kept in prison, sent back to prison or not perceiving they had anyone to talk to, but each was fearful of re-offending. Previous research[25] reports how those being released from custody can soon feel overwhelmed. Oliver acknowledges the level of his anger and how he took it out on others through arson. Grievant and angry hostile rumination are associated with sexual, interpersonal violence, and violent recidivism[13, ,26; 27]. These are arguably evident within this subtheme, suggesting the participants are likely to have presented with these around the time of their re-offense. It also suggests all the men in the current study were aware and fearful of, to varying degrees, some of the underlying difficulties associated with their risk of reoffending. Whilst they may not have been able to directly relate this to risk of sexual reoffending, for example Oliver notes his anger but was unable to link this to factors associated with his sexual reoffending, their descriptions imply a level of self-doubt and fearfulness regarding their own safe functioning in the community. It appears this fearfulness of themselves, and risk of reoffending, inhibited their ability to disclose risk-related matters, such as fantasies, inadvertently functioning to heightened and perpetuate some of the

...such as fantasies, inadvertently functioning to heightened and perpetuate some of the factors associated with their risk of reoffending.

23. Smith, J. A., & Osborne, M. (2003). Interpretative phenomenological analysis. In Smith, J A. *Qualitative Psychology: A Practical Guide to Research Methods,* (pp. 25-50). London: Sage.
24. Pietkiewicz, I., & Smith, J.A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal,* 20, (1), 7-14.
25. Fox, K.J. (2017). Contextualizing the policy and pragmatics of reintegrating sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 29,* (1), 28-50.
26. Norlander, B., & Eckhardt, C. (2005). Anger, hostility, and male perpetrators of intimate partner violence: A meta-analytic review. Clinical Psychology Review, 25, (1), 119–152.
27. Huesmann, L. R. (1998). The role of social information processing and cognitive schemas in the acquisition and maintenance of habitual aggressive behavior. In R. G. Geen & E. Donnerstein (Eds.), *Human aggression: Theories, research, and implications for policy.* New York: Academic Press.

factors associated with their risk of reoffending. All participants were able to describe the presence of fearing themselves and their risk of reoffending, suggesting this was a shared lived experienced for all the men in the current study.

Fearful others will 'find out'

Harry. Had a good support network but as in denial of sexual offending so they didn't know that side of me. I couldn't talk about it as I'd go straight back inside. Got job on drays but when men having chats about normal things, when they looked at me, I had nothing to say. I only had 20 years in prison. The dray people were ordinary people, they may say I won't work with him — another may be interested in wrong reasons.

Oliver. Family didn't know my past, living a lie. I was stuck in two lives. I couldn't say anything as they would not know that was me. I couldn't talk to wife as she didn't know I'd been in prison.

Harry spoke of being 'in denial' which is not generally linked to risk of re-offending [13], but in his case his inability to discuss his fantasies led to them building up. His fear of being recalled to custody overrode his wish to talk about his feelings. Likewise, Oliver's description suggests he also felt a degree of fearfulness regarding disclosure to others, even his wife with whom he states did not know he had been incarcerated. Previous research[28] suggested maintaining a social distance between themselves and others enabled individuals to manage the way they are viewed, and the impression that is subsequently formed. Thus, for those who have committed sexual offences, maintaining social distance from others can prevent them having to disclose their past, where they have been and what they have done. However, maintaining social distance to such a degree may be problematic if the individual is unable to form psychologically meaningful and safe relationships. Indeed, a key principle of the prison-based TC is to provide residents with an emotionally corrective experience whereby individuals are exposed to an environment and individuals with whom they can begin to reorganise problematic interpersonal strategies to ones which are pro-social and safe. Whilst non-disclosure to others is not necessarily related to an individual's ability to form such relationships, in the case of the participants in the present study, their fearfulness of others knowing their offending history appears to have heighted feelings of mistrust, exacerbated the suppression of related thoughts or feelings and prevented them from being able to develop pro-social relationships. In the case of Oliver, it seems he was able to form some relationships and was married, although the secrecy he held means the degree of emotional closeness was most probably superficial. As seen below, George described feeling fearful of all intimate relationships, particularly with adult females with whom his offending was against.

George. I'm fearful of relationships outside — it's easier inside. The thought of relationship or intimacy with a female makes me so fearful. I'm fearful of forming a relationship or having intimacy — I'm fearful that something would be said.

Ultimately, for all the participants in the current study, their varying degrees of fearing others likely maintained the underlying risk factors associated with sexual reoffending. This suggests providing an environment where individuals are able to talk about troubling thoughts without fear of being recalled to prison is of upmost importance to dismantle fearfulness which, the case of the current participants, appears to directly relate to their risk of reoffending.

Fearful to disclose

Hidden past

Oliver. I had made a new life, but I had a hidden past. If I went to mental health they would have gone to police. I have been reassured because of where I am and who I am. The things that changed my life, I had never had a family, but I got the family environment it changed my life, but it was too late. I was always on Crimewatch. Family didn't know my past, living a lie. I was stuck in two lives. I couldn't say anything as they would not know that was me. I went from a person happy living on the streets to having a house and family. It was major change but a big lie. People always say I keep nose clean for 20 years, but I didn't. I was committing arson — getting warnings at written and verbal warnings work for aggression. Self-harming was outrageous. My family didn't question me. I couldn't talk to wife as she didn't know I'd been in prison.

28. Goffman, E. (1959). *The presentation of the self in everyday life.* Woodstock: Overlook Books.

Fear of losing what you have built up

Oliver. With my family not willing to give it up for anything. For not having it for 35 years, I didn't drink or take drugs — ended up in arson, severe self-harm, ways of getting anger out, wouldn't show it to children. Fearful of my anger, I took it out of the house, the arsons. Anything that made me angry, I'd be paranoid. I'd get angry so quickly. You remember how I was when I first came, I was so angry. I feel calm and relaxed now. I hate this place [Prison] but I keep much calmer and more relaxed. It's important to feel like a member, part of something. When you spend your life alienated it's nice to be part of something

Oliver's account arguably reflects an externalised and dysfunctional coping strategy, an identified risk factor for sexual reoffending [13]. The Integrated Theory of Desistance from Sexual Offending (ITDSO[12]) suggests that the individual wants to change, and also possess the cognitive and emotional capacities to take advantage of opportunities, 'decisive momentum' which acts as 'a necessary, but not sufficient condition for behaviour or identity change'[12]. Oliver seems to have reached that point but can reflect that it was not always the case, particularly around the time of his initial release. Researchers,[29] reported how each individuals' negative evaluation of their past offending could act as a motivation not to re-offend and promote an openness and readiness to change.

Techniques to avoid disclosure

Harry. I couldn't talk about it as I'd go straight back inside. Back then I don't think they would have done anything differently. I was questioning why I was still having the thoughts but out of fear of rest of life in prison I didn't talk. Now I am in for life as I did offend.

Oliver. I did [have support] due to mental health but they told me if I said something relating to potentially committing a crime, they would have to report it. I didn't want to say. I was so aggressive in the support group, just to get out of it.

George. My head was spinning pressure of what I'd been through, local papers etc. Gave me sleeping meds — I didn't take it — used drugs and alcohol, I didn't have anything I had to deal with it my own way and sadly I went on to offend.

As having a support network to whom it is possible to discuss problems aids desistance, not having so could well increase likelihood of re-offending. Others,[30] suggest that having a high level of motivation to change leads to more successful outcomes if working towards self-improvement goals. The participants reported that they felt under pressure and did not have such goals or outlets, arguably increasing their risk of reoffending. Harry spoke of having anti-social peers upon his initial release, which is correlated with general and sexual recidivism[31], [13]. It appears the participants' fearfulness, as previously outlined, dampened their motivation to change and ability to begin trusting others and forming more pro-social relationships.

As having a support network to whom it is possible to discuss problems aids desistance, not having so could well increase likelihood of re-offending.

Perceived Support on Release

Lack of knowledge about what's available

George. I had no groups, not aware of anything — for example Samaritans. I wasn't aware of anything. As a sex offender[32] I'm concerned what's available. I need to know what's available, what's available. I would take any support I could. I questioned if it applied to me.

Harry. If I knew there was available support I would have spoken. Wish there had been a

29. LeBel, T. P., Burnett, R., Maruna, S., Bushway, S. (2008). The "chicken and egg" of subjective and social factors in desistance from crime. European Journal of Criminology, 5, (2), 131-159.
30. Paternoster, R & Bushway, S. (2009). Desistance and the "feared self". Toward an identity theory of criminal desistance. *Journal of Criminal Law and Criminology, 99,* 1103-1156.
31. Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct (4th ed.).* Newark, NJ: LexisNexis/Matthew Bender.
32. Whilst George uses that term the authors preference is for person first language.

safe place for talking and support, 1:1 or wherever.

Lack of support in Community. This was a theme they all agreed with.

George. No support on release. I had to deal with things in my own way used own support — drugs and alcohol.

Harry. I didn't have anything I had to deal with it my own way and sadly I went on to offend. People in the community were supportive of our rehabilitation —I was on a bus and being hassled by reporters and they chased the reporters away. The environment was offender-friendly, they knew what the prison was about, that forms trust.

Participants spoke of having troubling sexual fantasies, with no one to whom to disclose this to and a perceived lack of support from the community. They spoke of having dysfunctional coping strategies (using drink, drugs, arson to manage emotions), and had some support (for instance the people in the town where Harry worked) but they generally felt unsupported. Attitudes supportive of sexual offending, including pro-rape and sexual entitlement beliefs, are empirically supported risk factors for sexual offending[33; 13]. Recent programmes developed to help those who have committed sexual offences have goals of developing healthy thinking, healthy sex, positive relationships, managing life's problems, and a sense of purpose, all things that were missing with these participants[34].

Further, it appears all participants in the current study shared the same lived experience of not knowing what support was available on their initial release and perceiving a lack of community support at the time. For Harry, who spoke about people in the community chasing reporters away and 'knowing' about prison, this still was not enough to prevent his sexual reoffending. Arguably, this level of perceived community support was largely superficial with individuals he did not know but with whom he simply lived in the same area with. Whilst this may promote some level of social belonging, the issue of not being able to form meaningful social relationships and a lack of community support where they could safely discuss their fears and problematic thoughts still remained unattainable. This could be through a lack of relevant services, lack of promotion of services to individuals in prison prior to release and/or difficulties identifying and supporting individuals to access available and suitable support. As all the participants highlighted a fearfulness of themselves and disclosing to others, access to such support where a safe and non-judgemental environment was enacted could have alleviated some of this fear. What is apparent, is that all participants perceived little to no community support upon release which, when combined with the other themes from the current study, potentially increased their risk of reoffending, as each participant stated.

Attitudes supportive of sexual offending, including pro-rape and sexual entitlement beliefs, are empirically supported risk factors for sexual offending

Self-responsibility for utilising support

Oliver. On release — and parole officer — they should give you all the information of what is available, right from the start. Then ball is in your court, you read it in privacy, and you have the information and can seek them out. The onus on you to look for what's available. It wouldn't be hard to find — could trawl for info on internet but should be made available. I'm asking for Circles, but why wouldn't that be given to me on release. It would be minimal cost.

Harry. At the end of the day it's my responsibility to be absolutely honest. You said you were having those thoughts. Loads of people come back because they don't talk.

Oliver takes less responsibility for his actions, blaming others for a perceived lack of support, whereas Harry acknowledges it is his responsibility for his actions

33. Helmus, L. Hanson, R. K., Babchishin, K. M., & Mann, R. E. (2013). Attitudes supportive of sexual offending predict recidivism: A meta-analysis. *Trauma, Violence, and Abuse,* 14, (1), 34-53.
34. Walton, J. S., Ramsay, L., Cunningham, C. & Henfrey, S. (2017). New directions: integrating a biopsychosocial approach in the design and delivery of programs for high risk services users in Her Majesty's Prison and Probation Service. *Advancing Corrections: Journal of the International Corrections and Prison Association,* 3, (1), 21-47.

to seek out and utilise relevant support. It is possible Oliver still retains some grievant thinking in relation to community support although, arguably, accurately summarises the perceived experience of some individuals' who have been released following a sexual offence conviction.

Lack of support with accommodation

> *Oliver, I had no support in a parole hostel. No support. Day 1. I was in a hostel it was a shithole. I wanted to go back to my home area, so I offended to get back to that area.*

> *Harry. Got moved to a hostel, where people are too busy to talk to you. The hostel was awful, chaos. To be put in a hostel was worst thing. Just walking out of hostel into town I thought I had a sign on my head that's what led me to fantasy time.*

The lack of help in attaining accommodation was described. Accommodation is seen as an important factor in desistance[35] and has been identified as an independent factor significantly increasing the likelihood of reoffending after release[36]. Again, the participants' descriptions of their shared lived experience upon initial release appears to reflect known risk factors in reoffending.

Accommodation is seen as an important factor in desistance and has been identified as an independent factor significantly increasing the likelihood of reoffending after release.

Understanding of Circles

Participants showed a lack of understanding and knowledge of CoSA, which may not be surprising given that it is reported[20] that even those involved with CoSA had a lack of understanding of its purpose.

Lack of Awareness

> *Oliver. I heard about them on the news. That's the only organisation I heard about. On the news they said there is an organisation for people who have thoughts about children and can talk in privacy.*

> *Harry. I have a Quaker friend who was on a Circle. You could be more open with a Circle rather than Probation Officer or when you are in prison, I could talk about risk and then would decide among themselves if it was cumulative.*

> *Oliver. On release — and parole officer — they should give you all the information of what is available, right from the start. On the news they said there is an organisation for people who have thoughts about children and can talk in privacy. If there was someone to talk to you…. You need a pamphlet with list of resources. Go into a group who will help — I won't go to a police station; they would give you a cell. If I tell OM they will say tell them to take you into prison.*

> *George. There needs to be support networks and groups out there. No one told me out there was Circles.*

It is not surprising that the participants were not aware of CoSA or had misconceptions. Thompson and Thomas[37] reported that some Core Members stated they held little understanding of the purpose and intentions of CoSA before they participated. Whilst all the participants described little to no understanding and/or awareness of CoSA upon their initial release, their descriptions suggest a level of awareness they share now. Their descriptions of how they understand CoSA, as a safe space to discuss thoughts related to and risk of sexual offending, suggests this may meet their previously outlined descriptions of feeling unable to safely talk about troubling thoughts and a lack of community support.

35. Duwe, G. (2018). Can circles of support and accountability (CoSA) significantly reduce sexual recidivism? Results from a randomized controlled trial in Minnesota. *Journal of Experimental Criminology, 14,* (4), 463–484.
36. Brunton-Smith, I. & Hopkins, K. (2013). The factors associated with proven re-offending following release from prison: findings *from Waves 1 to 3 of SPCR.* UK: Ministry of Justice.
37. Thompson, D., & Thomas, T (2017). *The Resettlement of Sex Offenders after Custody, Circles of Support and Accountability*. UK: Taylor and Francis.

Misconceptions of Circles

Oliver. It would be 'bored housewives' group — who panic when I say anything — now I will have support, they won't all run out screaming. I will be able to talk like I do here, not think I'm a mad maniac. So, you can't be in a group of bored housewives or men in midlife crisis, they wouldn't know what to say. One day I had the opportunity of students coming out of college, obviously something was going on in my head — where could that have gone? Where might it have ended up? It could have gone so far then. If I had a group then I could have talked, years later I can't remember my thought processes then, but must have been bad. Could think what was going through my head. When I came to prison it was 30 years later, my thoughts have changed.

Oliver. I don't want to go to group with men with mid-life crisis — I need people who can relate to me. I need people with the same thoughts. You'd have to say it to like-minded people, not just talk to a doctor. He would think I'm at risk. So, you can't be in a group of bored housewives or men in midlife crisis, they wouldn't know what to say. In group I can say it — we can say we have similar thoughts.

The participants demonstrated a misunderstanding of who would volunteer with CoSA and its purpose. This could be due to a lack of publicity for it, or for a lack of will on their part to seek support. It is suggested[20] that Core Members (individuals who have committed a sexual offence and are part of the Circle) who subscribe to negative beliefs about women may be particularly demotivated by female volunteers. It is noted that some participants assumed it would be female volunteers. Further, their misconceptions may arguably reflect their previously outlined fearfulness of disclosing troubling thoughts and/or fantasies and mistrust of others, rather than an accurate understanding of what CoSA could provide. Nonetheless, these misconceptions highlight the underlying need to better educate potential users of the service about its purpose and role in their reintegration back into the community,

The participants demonstrated a misunderstanding of who would volunteer with CoSA and its purpose. This could be due to a lack of publicity for it, or for a lack of will on their part to seek support.

Reoffending was likely

George. The thought of re-offending was not my intention, but it was a risk.

Oliver. I left prison this wouldn't have mattered. I left very very angry and was determined to go on how I was. I fed off the fear on people's faces —I liked to see that on peoples' faces. I got that hatred I felt for myself. That's what I'm doing. I fed off it.

Oliver demonstrates his anger and the inevitability of his re-offending. Some barriers to desistance, for instance the stigmatisation and suspicion of others, can result in a self-fulfilling prophecy so that the individual can internalise this view of themselves and fulfil the prediction by returning to criminal behaviour[38]. Combined with the previous themes highlighting a lack of motivation to change, fearfulness of reoffending as well as a perceived lack of community support, the shared belief that reoffending was likely is unsurprising. The shared experience of all the participants in the current study reflects a belief that other people could not be trusted, others did not want to help them and a lack of hope that life could be better, arguably maintaining the poor motivation to change.

Self-Risk Assessment

Discussing sexual fantasies dissipates them

Harry. It goes around in my head. I used fantasy. I use fantasy to control it. I got out

38. 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.

not knowing it would come out again. I just did on psychodrama — what I did on fantasy was what happened to me. I didn't know that. If they don't share, they go on to do it. Loads of people come back because they don't talk. As soon as you say it there's less chance of it happening.

Oliver. When fantasies are talked about it takes the pleasure out of them. It starts to dissolve.

Insightful of escalating risk. There's a different if I start to fixate or thoughts are running away. For me the warning signs would be me isolating — playing lip service — getting rid of people, good riddance. Didn't think of it as a risk, I saw it as a strength. Now see the need for intimacy. Need love that doesn't have conditions — can laugh, cry etc.

Further research,[17] found sexual deviancy, sexual pre-occupation, poor self-control, grievance thinking, and lack of meaningful intimate relationships with adults to be the most important factors related to risk: all of these were identified by the participants. Further, as they were not disclosing their current sexual thoughts and so their risk could not be accurately assessed. Nonetheless, all the participants were able to reflect on their shared experience of discussing sexual fantasies as a way of dissipating the power these have over their functioning. Given their previous descriptions of feeling fearful and/or unable to discuss thoughts related to sexual offending and/or fantasies, it is likely they were unable to do this upon their initial release.

Oliver. When I met wife, I didn't think she would be a wife, but she got pregnant and for the first time ever I could show my children care and be vulnerable. I was able to cuddle baby and show my love for first time. I'm not a big horrible person. I can cuddle my children — I still cuddle them in their 20's my parents never did that for me.

George. Grew up in houseful of women, mum, grandma and sister, etc. I cheated and had lots of sexual partners. It was inevitable I would do it [re-offend]. Lots to look at from different angles.

George's comments highlight a range of issues going on at the same time. His complex views of women, his concerns about re-offending, but not having anyone to talk to about them, and not having acknowledged his past or resolved the feelings about it.

Relationships with others and impact of shame

Harry. I slowly got to know people; it was a small village. That time was sociable. When I was doing it, I thought 'what would those in X say' they were positive role models. When I first came people didn't like me. I haven't felt better than I have for the past 6/7 months. Others now smile at me.

George. I spent all my time with friends. I felt safest with friends, let guard down. My shame and guilt shut me down for a long time. Now I do smile, and others want to interact with me. Now I do get on with others.

Oliver. Now I see others smiling — is it because I've been more relaxed — I don't know how it's worked. I want to interact with others. I had never had a family, but I got the family environment it changed my life.

Most desistance research[39] highlights the importance of family support in desistance. Further, having shame and guilt can also impact on self-identity and thus on relationships. Researchers[40] describe how those who have committed a sexual offence maintain self-preservation through management of shame and guilt and protecting their loved ones. This dilemma seems apparent in the fear of disclosure and the impact that may have on self and family. Social isolation and loneliness are a widely accepted risk factor for sexual recidivism[13; 41], so it is likely that reduced isolation, would aid desistance[42]. Indeed, the participant's shared experience of feeling shameful likely reflects their previously outlined fearfulness and/or inability to talk about their troubling thoughts and fantasies related to sexually inappropriate and/or offending behaviour and inability to form pro-social intimate relationships.

39. Laub, J.H., & Sampson, R.J. (2001). Understanding desistance from crime. *Crime and Justice,* 28, 1-69.
40. Ware, J. & Mann, R.E. (2012). How should "acceptance of responsibility" be addressed in sexual offending treatment programmes? *Aggression and Violent Behaviour,* 17, (4), 279-188.
41. Malinen, S., Willis, G. M., & Johnston, L. (2014). Might Informative media reporting of sexual offending influence community members' attitudes towards sex offenders?. *Psychology, Crime and Law,* 20(6), 535-552.
42. Höing, M., Bogaerts, S., Vogelvang, B. (2013). Circles of Support and Accountability: How and Why They Work for Sex Offenders. *Journal of Forensic Psychology Practice, 13*, (4), 267-295.

Creating a safe environment to talk

Feeling able to talk

> *Harry. Wish there had been a safe place for talking and support, 1 — 1 or wherever. As soon as you say it there's less chance of it happening. All I ask if someone listens. I used to, all I ask is for someone to listen, not be judgemental. My fantasy was horrific, but I told people; I told fantasy of kidnap rape, inflict harm and kill the person. I accept the consequences of that. Early on in offence the fear my victim showed stopped me. I knew I was coming back to prison. The choice to reoffend was there. As if I didn't have that fear. I wish I had someone to talk to. I just did on psychodrama — what I did on fantasy was what happened to me. I didn't know that.*

Harry reports his need for someone to whom he can talk about his troubling sexual fantasies at the time of his initial release. Currently, the availability of such services is in its infancy, with interventions such as the Aurora programme under the auspices of the Safer Living Foundation in Nottingham making strides in providing this service. The Aurora programme enables group members to discuss and learn to manage such fantasies. In addition, the StopSO and Lucy Faithfull telephone helplines offer such support. Arguably, such services may address the gaps in support identified by the participants in the current study.

> *Oliver. Even asking the group could make you seem at risk. I just needed people to help. Who would you tell? You couldn't go to police. Probably — they would have a fit. Why can't I talk to those who help? I could meet with circles have a cup of coffee and talk. I would always be paranoid, thoughts rattled round my head. Now I talk about it. I say why I'm pissed off. Once it's out it's okay — before it would have led to violence — now it doesn't.*

> *George. We are in group together we can bounce off each other. In group we spoke of sexual acts — fantasies and role play. If like-minded people in that niche to say it in a safe place. It would be helpful to have a group or support to talk to.*

The ITDSO involves a positive view of self and draws on the desistance theories, for instance the role of cognitive transformation on route to a pro-social identity[43]. Furthermore, others[44] highlight the need to develop pro-social self-narratives. From the participant descriptions, it appears group settings with individuals who experience similar thoughts or reflection may be helpful in providing an environment in which this is possible, thus addressing some of the needs previously outlined. All participants in the current study highlighted feeling able to talk as an essential factor in promoting positive change, an aspect which they all highlighted was missing upon their initial release.

Reintegration

> *George. Fear of going to community with a brand of sex offender.*

> *Harry. I'm 100 per cent institutionalised — been in structured environment since age of 9 years been in prison since I was 21, I visualise living on my own freestyle problematic — somewhere with structure — not barbed wire but structure. It's hard to admit, those who have done a short time don't feel institutionalised. I do. Slower integration into the area you will live in.*

These accounts from George and Harry echo some of the underlying principles of CoSA in relation to easing the transition into community settings. CoSA aims to encourage individual accountability of offending alongside accepting individuals for their entirety: mirroring strategies identified to reduce future sexual deviance[45]. As identified within Relationships with Others, shame and guilt about one's identify can increase the risk of offending. This, combined with perceived stigmatised by others in the community, may further increase the likelihood of sexual deviance[47;46].

Summary

The three participants in the current study shared their lived experience of initial release following conviction for a sexual offence, prior to their subsequent sexual reoffending. Analysis of the data revealed pertinent

43. Maruna S (2001) *Making good: How ex-convicts reform and rebuild their lives,* American Psychological Association Books
44. Ward, T., & Laws, D. R. (2010). Desistance from sex offending: Motivating change, enriching practice. *International Journal of Forensic Mental Health, 9,* (1), 11-23. doi:10.1080/14999011003791598
45. Braithwaite, J. (1989). *Crime, shame and reintegration.* Cambridge, UK: Cambridge University Press.
46. Braithwaite, J. & Mugford, S. (1994). Conditions of successful reintegration ceremonies. *British Journal of Criminology, 34, (2),* 139-171.

themes, including fearfulness and perceived lack of community support. Further, analysis revealed themes of self risk-assessment both at the time of their initial release and today, alongside reflections of what has supported their therapeutic journey to-date. The three participants thought that they had gained insight on their risk and future needs through discussion in therapy and reported they found participating in the research helpful to focus their thoughts on the future. As taking a strengths-based approach is integral to the work in a prison-based TC the need to develop a prosocial identity is vital. The subsequent work in the TC had enabled them to be more honest about that they had done and the thoughts and fantasies they had following their earlier release. Such progress demonstrates psychotherapeutic work,[47;48] and can be considered an important aspect of psychological change[49].

The participants also discussed their risk after prison and were asked about their understanding of CoSA. It is suggested[12] that it is important to have mentors in the community and CoSA can provide such. They, like the SLF projects, can provide social modelling to the individual, as well as provide encouragement to maintain desistance. CoSA may arguably be able to address many themes identified from the current study, including a lack of support with accommodation, feeling there was no safe space to talk about troubling thoughts related to risk of reoffending and feeling unable to talk to anyone. The volunteers for CoSA can also encourage them to build social networks, outside of the CoSA, from which to move forward, promoting positive change and encouraging the development of more pro-social relationships. Their work is found to reduce risk of re-arrest for a new sexual offence by 88 per cent and a decrease in general recidivism, ranging from 49 to 57 per cent[37]. It is also reported that individuals who have engaged with CoSA have also reported gains in emotional wellbeing, prosocial attitudes and behaviours as well as improvements in their social network[50]. However, the three participants had not engaged with CoSA following their previous release. The prison-model developed by the Safer Living Foundation, in a treatment prison in the UK for those who have sexually offended[51], and so it may well be useful for all men in that position. All participants spoke of the importance of feeling comfortable and safe to talk, about their sexual thoughts and fantasies, a notion arguably addressed both within the TC and within CoSA. The findings add to literature exploring service-user's views of factors contributing to sexual reoffending through their shared lived experience, as well as aiding community services understanding of perceived needs.

Limitations

The feedback provided helps inform CoSA in their practice to assist with individual's reintegration into the community. However, the three participants may have a very different experience from those being released now, and so may not be applicable to others in that position. This may be further exacerbated as all three participants are currently residents at a therapeutic community prison. Individuals who have committed sexual offences and who are not currently engaging with therapy or within a therapeutic environment may describe very different experiences and/or needs. Furthermore, as the data was gathered within a group setting this arguably may have influenced the confidence of participants to share experiences which were not addressed. Although this is consistent with the TC approach, future research may wish to explore individual-based interviews. It was not possible to repeat the study with more respondents due to the lack of individuals in the position under investigation. A replication of this study would help increase the knowledge base and depth of data. A further mixed-method methodology would also be helpful to enrich the data. For example, a blend of qualitative and quantitative research can be used, thus drawing from the strengths, and minimising the weaknesses of both. Methods such as repertory grids[52] and personal construct theory,[53] can be used to enrich the participants' meaning making[54].

47. Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change.* UK: Guilford Press.
48. Linehan, M. (1993). *Cognitive-Behavioural Treatment of Borderline Personality Disorder.* Guilford Press.
49. Higginson, S., & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy: Theory, Research and Practice,* 81, (3), 309-328.
50. Bates, A., Williams, D., Wilson, C., & Wilson, R. J. (2014). Circles south east: The first 10 years 2002–2012. *International Journal of Offender Therapy and Comparative Criminology, 58,* (5), 861–885.
51. Saunders, L., Kitson-Boyce, R.J., & Elliott, H. (2014). Safer Living Foundation: circles of support and accountability. In: The Second Annual HMP Whatton Conference, HMP Whatton, Whatton, Nottinghamshire, June 2014.
52. Winter, D. A. (2003). Repertory grid technique as a psychotherapy research measure. *Psychotherapy Research*, 13, (1), 25-42.
53. Kelly, G. A. (1991) *The psychology of personal constructs. Volume 1: A theory of personality. New York*: W. W. Norton and Company.
54. Blagden, N., Winder, B., Thorne, K., & Gregson, M. (2014). "Making Sense of Denial in Sexual Offenders: A Qualitative Phenomenological and Repertory Grid Analysis." *Journal of Interpersonal Violence 29,* (9),1698–731.

‘I want the male and the female wings. I don’t want a special trans wing for people.’ Transgender people in custody in Scotland’s views about transgender specific facilities within prisons

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Introduction

For a relatively small proportion of the wider prison population, transgender people in custody have been the focus of significant recent policy and media debate in Scotland and Internationally. This debate has taken a particular form following the opening of a wing of HMP Downview specifically to house transgender people in custody in England in March 2019. This unit is just one of the options for housing transgender people in English prisons — it is also possible that they are located in men’s or women’s prisons, based on individual risk assessment. Despite this focus, there have been no studies that have considered the views of transgender people in custody regarding HMP Downview and what this specific wing represents for the management of transgender people in custody. This constitutes a significant gap in what we know about transgender people’s views on how they want to be managed in custody, with reflections on HMP Downview facilitating insights into the views of a diverse, heterogeneous group of people in custody.

More widely, this article argues that debates on any aspect of Criminal Justice policy or practice are enriched by considering the analysed accounts of people in custody. These unique insights and experiences have to be at the core of future policy direction in relation to the management of transgender people in custody and the establishment of any future prison facilities specifically for transgender people in custody.

An overview of research on transgender people’s experiences of custody

It is evident that the evidence base relating to the experiences of transgender people within custody is relatively limited, and peer-reviewed research that does exist tends to be largely located in the US. Critically, there have been no published studies on the experiences of transgender people in custody in Scotland until now and the evidence base relating to the UK more widely is relatively limited. Research that has been published on transgender people in custody is dominated by issues surrounding health, policy analysis and the housing of people in custody based on gender, and the lack of understanding on transgender issues by prison staff. A recent literature review of research on transgender people in England and Wales, as Gorden et al indicate that:

> *‘…existing research (discussed in this literature review) indicating that transgender people in prison are significantly more likely to experience more problems than other prison populations.’*[1]

More specifically, this review highlights three areas of concern within the published research relating to transgender people in custody in England and Wales:

> *‘…this helped to identify three key areas that represent specific issues for transgender people in prison: placement in the prison establishment; victimisation and treatment; and healthcare provisions.’* [2]

1. Gorden C, Hughes C and Astbury-Ward EM (2017) A Literature Review of Transgender People in Prison: An ‘invisible’population in England and Wales. *Prison Service Journal.(233):* 11
2. Ibid, p. 13

Specifically, in relation to health issues and transgender people in custody, a number of studies have critiqued health policies[3], as well as UK approaches to preventing suicide in transgender (as well as lesbian, gay and bisexual) people in custody.[4] A study analysing interview data on 315 transgender inmates in California prisons for men indicated that transgender inmates fare far worse on standard demographic and health measures than their non transgender counterparts in the US population, the California population, the US prison population and the California prison population.[5] A qualitative analysis by Brown[6] reviews over 100 letters voicing concerns during imprisonment received from transgender people in 24 US States. Results of these letters prove transgender healthcare issues top the list, with 55 per cent of respondents claiming it features as their main concern. Additionally, research has suggested that transgender people in custody are more likely to be the victims of transphobic attacks and sexual assault than the wider prison population, stating there would be a "clear risk of harm' where a transgender person in custody 'was not located in a prison appropriate to their acquired gender'.[7] It is also evident in the cases of Joanne Latham, Jenny Swift and Jade Eatough, three transwomen who all committed suicide whilst placed in male prisons in England and Wales.[8] There has also been controversy about offences committed in prison by transgender prisoners, for example the case of Karen White.[9]

Prison staff training on transgender issues is a theme to emerge in a number of studies. For example, Forder's[10] research focuses on the trans-female population in English prisons. Comments appear regarding a lack of confidence in prison staff, namely, in using the appropriate pronoun. Forder also identifies the need for the education of prison staff to meet the needs of the transgender population. He states a genuine interest from UK officers to develop their understanding of issues relating to transgender people, not only in their professional capacity but in the wider context as he states 'some prison staff have transgender children or relatives of their own'[11]. This lack of understanding is also identified by Kendig and Cubitt et al.[12] in a consensus reached by 27 selected experts from a number of stakeholders at an international symposium.

...research has suggested that transgender people in custody are more likely to be the victims of transphobic attacks and sexual assault than the wider prison population.

Transphobia has received relatively little focus,[13] with little consideration of the forms that this might take within prison contexts. A small number of studies have considered the challenges of the management of transgender people in custody as well as policies relating to transgender people in custody[14]. Simopoulos and Khin[15] suggest that the management of transgender people in custody relate to issues such as clothing, searching, names and issues all analysed in this paper.

3. Brown GR and McDuffie E (2009) Health Care Policies Addressing Transgender Inmates in Prison Systems in the United States. *Journal of Correctional Health Care* 15(4): 280-291.
4. Read M and McCrae N (2016) Preventing Suicide in Lesbian, Gay, Bisexual, and Transgender Prisoners: A Critique of U.K. Policy. *Journal of Forensic Nursing 12*(1): 13-18.
5. Sexton L, Jenness V and Sumner JM (2010) Where the Margins Meet: A Demographic Assessment of Transgender Inmates in Men's Prisons. *Justice Quarterly 27*(6): 835-866.
6. Brown GR (2014) Qualitative Analysis of Transgender Inmates' Correspondence:Implications for Departments of Correction. *Journal of Correctional Health Care* 20(4): 334-342.
7. Beard J (2018) Transgender prisoners. Reportno. Report Numberl, Date. Place Publishedl: Institution. 3
8. Apter C (2018) *When will the prison service act upon the vulnerability of transgender people?* Available at: https://www.mentalhealthtoday.co.uk/innovations/when-will-the-prison-service-act-upon-the-vulnerability-of-transgender-people
9. https://www.theguardian.com/uk-news/2018/oct/11/transgender-prisoner-who-sexually-assaulted-inmates-jailed-for-life Accessed 15th August 2020
10. Forder P (2017) Conversations with transgender prisoners and the staff that care for them' Released Inside. G4S Report
11. Ibid, 17
12. Kendig NE, Cubitt A, Moss A, et al. (2019) Developing Correctional Policy, Practice, and Clinical Care Considerations for Incarcerated Transgender Patients Through Collaborative Stakeholder Engagement. *Journal of Correctional Health Care.* 1078345819857113.
13. Erni JN (2013) LEGITIMATING TRANSPHOBIA. *Cultural Studies 27*(1): 136-159
14. Jamel J (2017) Transgender offenders within the prison estate: A comparative analysis of penal policy. *Sexualities Research.* Routledge, pp.167-181. Lamble S (2012) Rethinking gendered prison policies: impacts on transgender prisoners. *ECAN Bulletin.*(16): 7-12. Knight C and Wilson K (2016) Transgendered People in the Criminal Justice System. *Lesbian, Gay, Bisexual and Trans People (LGBT) and the Criminal Justice System.* London: Palgrave Macmillan UK, pp.147-178. Routh D, Abess G, Makin D, et al. (2017) Transgender Inmates in Prisons:A Review of Applicable Statutes and Policies. *International Journal of Offender Therapy and Comparative Criminology* 61(6): 645-666.
15. Simopoulos EF and Khin Khin E (2014) Fundamental Principles Inherent in the Comprehensive Care of Transgender Inmates. *Journal of the American Academy of Psychiatry and the Law Online* 42(1): 26-36.

TA small number of studies theoretically consider what transgender people in custody mean for theories of gender as they resonate within largely binary prison systems internationally.[16] Cumulatively, considering the published studies on transgender people in custody indicate that there are a number of gaps in the literature that go further than the lack of research on this area in Scotland. In particular, gaps emerge that relate to qualitative research concerning transgender people in custody, which foreground the lived experiences of custody and reflect the management of transgender people in custody, something that this article seeks to address.

The transgender people in custody policy context in Scotland

In 2019 the Scottish Government opened a consultation relating to a Recognition Reform (Scotland) Bill, which if it came into law would reform the process by which transgender people gain legal recognition of their lived gender through a gender recognition certificate. In essence the Bill would make transitioning easier, which has caused much debate and polarised opinion in Scotland.[17] Much of the debate about the Bill relates to single sex services and spaces, such as prisons.[18] In relation to Scottish prison policy specifically, in 2014 the SPS introduced a policy relating to transgender people in custody and gender identity more widely; 'Gender Identity and Gender Reassignment Policy for those in our Custody'. The policy seeks to:

> *…ensure that individuals who identify as transgender people or who intend to undergo, are undergoing or have undergone gender reassignment receive respect and fairness at all times from the Scottish Prison Service.*[19]

...individuals who identify as transgender people or who intend to undergo, are undergoing or have undergone gender reassignment receive respect and fairness at all times from the Scottish Prison Service.

Critically, unlike similar policies (for example in England and Wales), the policies and guidance around suitable housing for transgender people in custody in Scotland do not require a Gender Recognition Certificate (GRC).[20] Since the introduction of the Gender Recognition Act 2004 the Scottish Prison Service has contended the requirement of a GRC:

> *'Applying for a Gender Recognition Certificate is optional and is not required in order to have protection from gender reassignment discrimination'*[21]

In response to a Freedom of Information (FOI) request regarding a male to female transgender person, The Scottish Prison Service responded,

> *'As a convicted transgender woman, she would be treated the same as all women in the female estate' (SPS, 2016).*

Meaning not only could the prisoner be placed in a women's prison, but would have access to the same facilities and services as other women, if the individualised risk assessment indicated that this was safe to do. This response is in accordance with Section 149 of the Equality Act 2010, The Prisons and Young Offenders Institutions (Scotland) Rules 2011 (1:6) which state, 'the Governor must seek to eliminate within the prison discrimination against people in custody on the grounds of gender reassignment'. The SPS policy has

16. Jenness V (2010) From Policy to Prisoners to People: A "Soft Mixed Methods" Approach to Studying Transgender Prisoners. *Journal of Contemporary Ethnography* 39(5): 517-553. Jenness V and Fenstermaker S (2014) Agnes Goes to Prison:Gender Authenticity, Transgender Inmates in Prisons for Men, and Pursuit of "The Real Deal". *Gender & Society 28*(1): 5-31. Pemberton S (2013) Enforcing Gender: The Constitution of Sex and Gender in Prison Regimes. *Signs: Journal of Women in Culture and Society 39*(1): 151-175. Sumner J and Sexton L (2016) Same Difference: The "Dilemma of Difference" and the Incarceration of Transgender Prisoners. *Law & Social Inquiry 41*(3): 616-642.
17. https://www.theguardian.com/uk-news/2019/jun/20/scotland-to-run-new-consultations-before-updating-gender-law https://www.engender.org.uk/content/publications/Engender-response-to-the-Scottish-Government-consultation-on-the-Gender-Recognition-Reform-Scotland-Bill.pdf https://murrayblackburnmackenzie.org/gender-recognition-act-reform/
18. Women and Girls Scotland (2019). Female Only Provision: A Women and Girls in Scotland Report. Scotland, Women and Girls Scotland.
19. SPS (2014) Gender Identity and Gender Reassignment Policy for those in our Custody. Edinburgh: SPS. 5
20. In the UK, a Gender Recognition Certificate (GRC) is legal proof of gender in accordance with the Gender Recognition Act 2004.
21. SPS (2014) see n.19

been subject to some critique, although this critique is not founded on empirical engagement with transgender people or women in custody (or more widely male people in custody or prison staff), something that this study foregrounds. It is within this policy and research context that this project is situated, a context within which, until now, no one has asked transgender people, men, women and staff living and working in custody[22] about their views on these issues. More specifically this article asks the question, where do transgender people in custody want to be housed in custody?

Methods

At the time of ethical approval for this project there were 17 people in custody were identified as transgender in the Scottish prison estate (representing 0.2 per cent of the entire prison population). All 17 transgender people were given the project information sheet and 15 participants consented to take part in the study, however, two participants refused to take part on the morning that the interview was scheduled. Semi-structured interviews taking a life history approach[23] examining pre-prison lives, exploring in detail aspects of life in prison as a transgender person, as well as post-prison 'visions' were conducted with all 13 participants. All interviews were recorded and transcribed by an external agency. Transcripts were subsequently checked and anonymised, followed by an inductive thematic analysis[24] in Nvivo 12.

The sample

This project outlines the accounts of 13 participants, equating to a 76 per cent sample of the entire Scottish transgender person in custody population at the time of data collection. Of the 13, eleven participants were transitioning from male to female and two from female to male. All participants were at various stage of their transition, while one participant had completed part of the surgical part of her transition. Five participants had begun transitioning prior to coming into custody, while eight had started the process within custody. The findings below illustrate the complexity of these transitions and identities in custody, a social context which has profound implications for performances of gender within it.[25]

Ethics

While there is little visibility of the specific experiences of transgender people in custody in Scotland, many of the participants in this study had taken part in previous studies (on a range of topics). As one research participant mentioned:

> ...until now, no one has asked transgender people, men, women and staff living and working in custody about their views on these issues.

'Because obviously, I've done stuff like this before [take part in research in prison], and never hear anything. So it's good to be able to have somebody say, look, we're going to give you this back so you can see' (Participant 2).

Consequently, each of the 13 participants were sent a draft of this paper and given a month to respond or ask questions (12 of whom were still in custody some months later, one participant was contacted at a home address given during the initial interview). Contact details of the researcher was provided and a commitment to meet and discuss any concerns in relation to any aspect of the paper was given to all participants. Of the 1 who took up the option to discuss the paper further, this resulted in amendments and improvements to the paper. Specifically, in relation to prison research, Brosens[26] suggests five levels of participation: informing, consulting, involving, collaborating and

22. While the views of men, women and staff living and working custody are not the focus of this paper, the views on gender, non-binary and transgender issues specifically within prison of a range of men, women and staff in custody are being analysed in a number of studies associated to the one reported on here.
23. Crewe B (2013) Writing and reading a prison: making use of prisoner life stories: Ben Crewe considers the value of prisoner life stories as part of an ethnographic approach. *Criminal Justice Matters 91*(1): 20-20.
24. Fereday J and Muir-Cochrane E (2006) Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods* 5(1): 80-92.
25. Malloch MS (1999) Drug use, prison, and the social construction of femininity. *Women's Studies International Forum* 22(3): 349-358. Maycock M and Hunt K (2018) *New Perspectives on Prison Masculinities*. London: Palgrave.Moran D, Pallot J and Piacentini L (2009) Lipstick, Lace, and Longing: Constructions of Femininity inside a Russian Prison. *Environment and Planning D: Society and Space* 27(4): 700-720.Sabo DF, Kupers TA and London WJ (2001) *Prison masculinities /edited by Don Sabo, Terry A. Kupers, and Willie London*. Philadelphia, PA: Temple University Press.
26. Brosens D (2018) Prisoners' participation and involvement in prison life: examining the possibilities and boundaries. *European Journal of Criminology.* DOI: 10.1177/1477370818773616. 1-20.

empowering. It is hoped that this study has involved transgender people in custody in a meaningful and sensitive way.

Findings — Reflections on HMP Downview

HMP Downview (a female closed category prison in England) opened a wing specifically to house transgender people in custody in March 2019. At the time of submission, there have been no studies published in relation to the specific wing for transgender people and no accounts published from those living or working there. Additionally, nothing about the transgender wing is mentioned in any inspection or other reports relating to HMP Downview.

The establishment of the specific wing for transgender people at HMP Downview was discussed with each of the 13 participants in this study, in order to frame a part of the interviews around the management of transgender people in custody. The transgender wing at HMP Downview, proved to split opinion amongst the participants, although the majority of participants viewed this negatively largely as a consequence of separating transgender people from the mainstream prisoner populations. The discussion about where transgender people feel they should be housed in prison as well as the possibility of specific transgender wings in prison goes to the core of transgender identities in custody. For some participants transgender identities were a specific, positive position, while other participants viewed transgender identities negatively, as they discussed wanting to be treated and seen as male or female (issues discussed in theoretical terms in Maycock forthcoming). Findings are clustered around positive and negative reflections on HMP Downview in order to provide wider insights into transgender identities and the management of transgender people in custody.

...majority of participants viewed this negatively largely as a consequence of separating transgender people from the mainstream prisoner populations.

Positive views about HMP Downview

It is important to recognise that a number of participants viewed HMP Downview and the possibility of transgender specific wings in custody as potentially positive and something they would welcome in Scotland. In particular it was felt that as this would provide more support and a shared experience of transitioning in custody:

> *Trans males and trans females? See that would be perfect for me. See if it was somebody like that…but see in here obviously sometimes like… It's understanding, I mean they're going through the same as me. (Participant four)*

While this is a minority position within the interviews, this is an insightful quote as this points to the isolation and marginalisation that many of the participants in this study experienced as a consequence of being a transgender person in custody. Another participant viewed a specific wing for transgender people as desirable to support people transitioning before they could enter male or female wings fully transitioned:

> *...if it was a matter of until I had the operation being put in a wing, I'd rather have a little middle ground what would be filled with other transgender prisoners. That's a, sort of, middle point until I can carry on into the female wing. (participant nine)*

Such specific wings could then be places of support while people were at various stages of their transition journey. A number of participants suggested more radical approaches, with non-binary wings being suggested by one participant, within the context of a discussion of the constraints of the binary prison system in Scotland:

> *I think there should be a separate wing within a prison, for people who want to identify as non-binary, but they can still have access to the mainstream. I think because they want to be accepted in the general mainstream population. (Participant two)*

Although as the quote indicates, it was still deemed important that anyone who might want to be in any separate wing have access to mainstream wings if they wanted, although the extent to which people in custody might be able to choose where they were located in such a flexible way was unclear. The quote above suggests a kind of utopian vision, where people in custody are able to determine where they are located within the prison estate, and doesn't in anyway reference the individual risk assessments undertaken by the SPS (and other jurisdictions) that ultimately

determines the location of transgender and non-binary people in custody. Other elements of the wider research project within which this project is situated, points to a complex situation within which the acceptance and rejection of transgender people in custody by other people who live and work in prison is influenced by a wide range of factors. Finally, one participant suggested changes in future prison design, with the possibility of an intersex wing that would house a diversity of people:

> *Wherever you establish HMP Glasgow, establish having female wings and male wings, and think ahead in terms of the intersex wing now, because if you start planning Barlinnie or HMP Glasgow,[27] if it's starting to get built, you've lost the chance. (Participant eleven)*

Although planning for HMP Glasgow is at an early stage, it seems unlikely that this new prison will include an intersex wing when it opens. Once more these views are positive and optimistic, resonating with other research that has explored aspects of hope within prison settings,[28] although this from a particular gendered perspective. The views in this section by a minority of the participants outlines a number of positive views on specific housing for transgender people in custody, with a number of potential solutions to the question of how best to house transgender people in custody suggested. The sentiments in the section below analyse more critical or negative responses to the prospect of a specific wings for transgender people in custody.

Negative Views about HMP Downview

The majority of the participants in this study reflected quite negatively upon the transgender wing at HMP Downview often stating that they wouldn't want to be located in such a wing. Often these negative reflecting related to see this as a type of unwelcome segregation:

> *I think it's like segregation. It's like saying that they are different when we're all trying to say we're all the same. I think a separate wing would be highly inappropriate because it is segregation again which we outlawed years ago. (Participant seven)*

This illuminates the importance of location within the prison system as having the potential to both validate and undermine the lived gender of transgender people in custody. This is something that participants in this study reflected on further, even for those participants who were located in wings of their lived gender. This took the form of participants reflecting on being located in single cells (something quite rare within the Scottish prison estate), being search more infrequently than other people of their gender (due to staff finding this uncomfortable) and sometimes being managed differently to people of the same gender through being in protection and segregation units quite frequently:

> *I was in a protection hall, I got kept in protection for my own safety, because of it [being transgender]. In my opinion, it was a way to go, right, get rid of you. I'm a pain because they're having to do things out of the ordinary, if you know what I mean. (Participant one)*

When asked to further elaborate in relation to these negative responses, it was possible to get further insights into the extent to which there exists a transgender 'community' or shared identity in custody. There was a recurring sense that transgender people might not necessarily get on if they were located in a wing with other transgender people, as they might only have their transgender status in common:

> *I don't like that idea [of a transgender wing] because...the problem is like. For example, say you've got one autistic person. The last thing you want to do is put them...loads of autistic people in the same room because they're not going to get along. Just because they're autistic doesn't mean they like each other and it's in the same sense as putting. There were two transgender people when I was down in [prison in England] and one of them, [name of prisoner], none of us could stand, because she was one of those ones where she shoved it in your face. (Participant 13)*

This quote subverts the assumption that transgender people in custody are a homogenous group, who might naturally all get along in custody. An alternative reading of the above quote might undermine assumptions about the specialisation of provision and training in prison settings, that such approaches are doomed to fail.[29] A number of participants discussed social transitioning as a transgender person in custody, something that has been considered in community contexts,[30] but not in great deal within prison settings. Within this context, a number of participants suggested that learning to be socially male or female in custody would be particularly

27. HMP Glasgow will be one of the largest prisons in Europe and is due to open in 2025.
28. Liebling, A., et al. (2019). "Are Hope and Possibility Achievable in Prison?" The Howard Journal of Crime and Justice 58(1): 104-126.
29. Wilson, D. and Brookes, M. (forthcoming), "A failed success: the Barlinnie Special Unit", *International Journal of Prisoner Health*,.
30. Sherer I (2016) Social Transition: Supporting Our Youngest Transgender Children. Pediatrics 137(3): e20154358.

challenging in a wing specifically for transgender people. A number of participants questioned how they would learn to behave in ways considered normal for people in their lived gender, if they were only able to interact with other transgender people:

> *Yeah, that's not healthy [the transgender wing at HMP Downview]. That's not going to help someone socially transition at all. If anything, it's going to hinder it. From the sort of social transitioning and sort of finding out who I am, it's been very difficult. (Participant three)*

This section has illustrated a diversity of views on the management of transgender people in custody and highlights the significance of institutional decisions that have the potential to both affirm as well as subvert the lived gender of transgender people in custody. The varied responses to the prospect of transgender specific housing within prison settings outlined in this and the previous section, highlight the diversity of the views of transgender people interviewed as part of this study, in a wider context within which this specific group of custody have often been seen as a homogenous group.

Conclusion

The accounts of the 13 transgender people in custody in this paper highlight a number of issues that have not been considered within the Scottish (or wider British) context, until now. The insights outlined in this paper give a voice to a much discussed, but consistently marginalised, group of people in custody. It is important to note that this study is part of a wider project analysing performances of gender within the SPS estate. Foregrounding the narratives of transgender people in custody illuminates aspects of prison life that are critical in shaping evolutions to the 2014 SPS Gender Identity Policy. This project is influencing the future direction of this policy in Scotland, through analysing the views of transgender people, men, women and staff who all have a stake in the successful management of this group of people in custody.

More widely this paper provides unique insights into performances of gender within the contemporary Scottish prison system, that resonates with wider debates in Scotland around sex and gender,[31] and the extent to which these debates potentially threaten women only spaces.[32] Comments in this paper raise questions about the extent to which transgender identities are specific and distinct and therefore require specialist provision within prison settings (such as HMP Downview). Alternatively, are gender identities chosen which will result in shared accommodation (the current situation in Scotland), and if they are chosen at what stage does a transgender person in custody move to the accommodation of their lived gender (after individual risk assessments have been completed). Other research in the wider project suggests that transgender people in custody have a diversity of views of these issues, with some stating that they felt that some transgender people posed a risk and should never live in halls of their lived gender, others saying by default transgender people should live in halls of their lived gender, and a third group that suggested people should move depending on where they are with their transition. One participant in particular was able to move from the male to the female estate, but chose not to as she felt that she needed more time on hormone treatment to be accepted and feel comfortable in the female estate. The diversity of views in this paper suggests that the polarised debates about transgender rights does not always accurately reflect the lived experiences and perspectives of transgender people themselves.

Something that emerges as a particularly unique finding in this study is the desire of transgender people in custody to be treated in the same manner of people of the same gender as them. This resulted in a number of participants wanting to be searched more, to share a cell and shower at the same time as other people in custody, something that is in contrast to what would be seen as undesirable to their fellow people in custody. This search for standardised treatment in relation to gender within custody is something that both the transgender men and women in this study strived for.

This study has a number of limitations. The experiences of the male transgender people in custody interviewed in this study are in many ways contrasting to the female transgender people in custody, in particular in relation to their management within the SPS estate. Additionally, this paper privileges the views of transgender people in custody, and does not report on other parts of the study that consider the views of women, men and staff about these issues. This is certainly an area for future analysis as the transgender prison population changes with an increasing proportion of transgender men coming into custody.

The contrasting of views concerning HMP Downview and the potential for transgender specific prison wings expressed in this paper illustrates the significant diversity amongst the transgender people in custody interviewed as part of this study, a group who are often portrayed in homogenous and narrow ways. It is inconceivable that the lived experience of other vulnerable groups of people in custody (such as women, young people and some men) would be missing from debates around their imprisonment, which is what this paper (and its associated studies) seeks to begin to address. It is hoped that further research foregrounds these often neglected narratives, in order to shape improvements in the policy and management of transgender people in custody.

31. https://www.scotsman.com/news/opinion/columnists/opinion-we-need-more-clarity-gender-rights-debate-scottish-government-1398508
32. https://www.versobooks.com/blogs/4090-i-m-not-transphobic-but-a-feminist-case-against-the-feminist-case-against-trans-inclusivity

A qualitative study exploring vicarious trauma in prison officers

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Background

Prison officers are at risk of being directly exposed to several potentially traumatic events including violence, suicide and self-harm. Officers are also at risk of being exposed to secondary (or vicarious) trauma when they hear about the victimisation of prisoners and colleagues. Vicarious trauma is a phenomenon that occurs when working empathically with victims of trauma and involves the gradual alteration of an individual's belief system. Research shows that mental health and forensic professionals experience vicarious trauma; however, research on prison officers is sparse. This research aimed to explore prison officers' experiences of vicarious trauma.

Prison officers (n=8) were interviewed about their experiences. Data were analysed using Interpretative Phenomenological Analysis (IPA) and Template Analysis (TA).

Five themes were identified; *experiences of direct and indirect trauma, ways of coping, normalisation of trauma, empathic connections with prisoners and a broken system.*

Results suggest that officers may be exposed to developing trauma symptomology. Their experiences may most closely link to the concept of Corrections Fatigue. Implications for organisational and clinical practice are discussed.

Introduction

Working within a prison environment is challenging, perhaps more so now than ever, with problems of overcrowding and under-staffing. The prison population can be dangerous, violent and intimidating. Prisoners often have high levels of emotional disturbance as a result of adverse life experiences, traumas and victimisation. Prison officers have the role of ensuring the security, safety and wellbeing of both prisoners and staff. Recent statistics indicate a steady rise in violence within prisons, including both inmate-to-inmate assaults and inmate-to-staff assaults[1].

Prison officers are also exposed to high rates of suicide and self-harm. 46 per cent of female and 21 per cent of male prisoners have attempted suicide, compared with only 6 per cent of the general population[2].

Exposure to trauma is higher in the prison population than in the general population[3]. Inmates have often been victims of crime and trauma themselves, both prior to being imprisoned and during their sentences[4, 5]. Indeed, experiencing trauma has been found to be a risk factor for offending[6, 7]. Post-traumatic stress disorder (PTSD), a trauma related disorder[8] is also higher in the prison population than the general

population[9, 10,] as well as other mental health disorders that can develop following trauma, including

1. Ministry of Justice (2018). *Safety in Custody Statistics, England and Wales: Deaths in prison custody to June 2018 and assaults and self-harm to March 2018.* Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf
2. Ministry of Justice (2013). *Safety in Custody Update December 2013.* Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/305614/safety-in-custody-to-dec-2013.pdf
3. Tye, C.S., & Mullen, P.E. (2006). Mental disorders in female prisoners. *Australian and New Zealand Journal of Psychiatry,* 40, (3), 266-271.6
4. Ardino, V. (2012). Offending behaviour: the role of trauma and PTSD. European Journal of Psychotraumatology, 3, (1), 18969.
5. Fazel, S.F., Hayes, A.J., Bartellas, K., Clerici, M., & Trestman, R. (2016). The mental health of prisoners: a review of prevalence, adverse outcomes and interventions. *Lancet Psychiatry, 3,* (9), 871-881.
6. Carlson, B.E., & Shafer, M.S. (2010). *The Prison Journal, 90,* (4), 475-493.
7. Honorato, B., Caltabiano, N., & Clough, A.R. (2016). From trauma to incarceration: exploring the trajectory in a qualitative study in male prison inmates from north Queensland, Australia. *Health and Justice,* 4, (3), 10.
8. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author
9. Baranyi, G., Cassidy, M., Fazel, S., Priebe, S., & Mundt, A.P. (2018). Prevalence of posttraumatic stress disorder in prisoners. *Epidemiological Reviews, 40,* (1), 1-12.
10. King, A., Jones, C., & Oliver, C. (2019). The prevalence of PTSD in young people who have offended. *A dissertation submitted in partial fulfilment for the Doctorate of Clinical Psychology, The University of Birmingham.*

psychotic illnesses and major depression[10, 11]. Therefore, those charged with the task of managing prisoners on a day-to-day basis are likely to be exposed to multiple traumas through their close contact with them.

Vicarious trauma. Working with victims of trauma can have a significant impact on professionals. One way professionals may be impacted is through vicarious trauma[12]. VT relates to a gradual and long-term change to an individual's belief system after working empathically with victims of trauma[12]. VT develops when individuals work empathically with victims of trauma and experience long-term exposure to stories of victimisation, changing the individual's belief, thought and memory systems[13]. This can have a negative impact on a person's interaction with the world and other people.

Research has shown that VT is experienced by a range of professionals including therapists working with people who have committed sexual offences, counsellors, social workers, oncology nurses, psychologists and forensic mental health nurses[14, 15, 16, 17, 18, 19]

However, research on VT in prison officers is sparse; two studies have explored VT in prison officers and findings suggest that officers may be at risk of developing VT [20, 21]. The first study[20] examined risk and protective factors for VT and secondary traumatic stress disorder (STSD) in prison officers in the USA. The study found that participants experienced several symptoms of VT and that perceived job stress was a significant risk factor for VT symptoms. A qualitative study[21] explored experiences of prison officers in a therapeutic community within a prison. Themes linked to VT were identified including negative changes to health and perceptions of risk.

The aim of the present study, therefore, was to add to the above limited existing literature on how prison officers in England and Wales experience VT. Although this paper focuses on the negative impact of working in prisons, research on the positive impact of prison work has been explored elsewhere in the literature and is acknowledged[22].

Methodology

A qualitative research design was chosen (where the optimum number of participants is between 4 and 10) to collect rich, meaningful, data from participants. Participants were prison officers (n=8) who had passed their probationary period and were currently working in any mainstream prison in England and Wales. Officers were excluded if they were currently working in a therapeutic role, for example within a therapeutic community, or if they had previously worked in any other role with victims of trauma, for example veteran or police officer, because the aim of the research was to explore the experiences of prison staff in general, non-specialist prisons. Ethical approval was granted by the Research Ethics Committee at the University of Birmingham and the National Offender Management Service (NOMS) National Research Committee for England and Wales. Participants were recruited through the Prison Officers' Association (POA) via the member email distribution list on a first-come-first-served basis. Three prison officers expressed an interest but unfortunately did not meet the inclusion criteria and were therefore ineligible to take part. Two participants consented but did not take part. Six further prison officers were eligible but contacted the researcher after the maximum number of participants had consented to the study and were therefore unable to take part. A final sample of eight participants took part in the research, five male and three female.

Data were collected in two ways; telephone interviews or via a written version of the interview schedule. Interview questions were devised in

11. Sirdifield, C., Gojkovic, D., Brooker, C., & Ferriter, M. (2009). A systematic review on the epidemiology of mental health disorders in prison populations: a summary of findings. *The Journal of Forensic Psychiatry & Psychology, 20* (1), 78-101.
12. McCann, L., & Pearlman, L.A. (1990). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress,* 3, (1), 131-149.
13. Baird, K., & Kracen, A.C. (2006). Vicarious traumatisation and secondary traumatic stress: a research synthesis. *Counselling Psychology Quarterly, 19,* (2), 181-188.
14. Bell, H., Kulkarni, S., & Dalton, L. (2003). Organisational prevention of vicarious trauma. *Families in Society, 84,* (4), 463-470.
15. Depass, C.M. (2005). Vicarious trauma in correctional mental health staff. *A dissertation submitted in partial satisfaction for the degree Doctor of Clinical Psychology, Carlos Albizu University.*
16. Ilieffe, G., & Steed, L.G. (2000). Exploring the counsellors experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15,* 4, 393-412.
17. Malkina-Pykh, I.G. (2017). Associations of burnout, secondary traumatic stress and individual differences amongst correctional Psychologists. *Journal of Forensic Science Research, 1,* (1), 18-34.
18. Munger, T., Savage, T., & Panosky, D.M. (2015). When caring for perpetrators becomes a sentence: recognising vicarious trauma. *Journal of Correctional Health Care, 21,* (4), 365-374.
19. Trippany, R.L., White Kress, V.E., & Wilcoxon, S.A. (2011). Preventing vicarious trauma: what counsellors should know when working with trauma survivors. *Journal of Counselling & Development, 82,* (1), 31-37.
20. Thomas, B. (2012). Predictors of vicarious trauma and secondary traumatic stress among correctional officers. *A dissertation submitted in partial fulfilment of the degree Doctor of Psychology at the Philadelphia College of Osteopathic Medicine.*
21. McManus, J. (2010). The experiences of officers in a therapeutic community prison: an interpretative phenomenological analysis. In: Grendon and the emergence of therapeutic communities. *Developments in Research and Practice,* pp 217-231.
22. Saylor, W.G., & Wright, K.N. (2008). Status, longevity, and perceptions of the work environment among federal prison employees. *Journal of Offender Rehabilitation, 17,* (3), 133-160.

accordance with principles of Interpretative Phenomenological Analysis (IPA) to allow exploration and meaning-making[23]. The questions within the interview schedule are below:

Broad question	Prompts/sub questions
1. How long have you been serving as a prison officer?	
2. What category of prison have you:	a) previously worked in? b) work in currently?
3. What got you into working as a prison officer?	
4. What is it like to work as a prison officer?	a) What does the role involve? b) What are your roles and responsibilities? c) What is a general day like?
5. What do you enjoy about your work as a prison officer?	
6. What are the more difficult parts to the role?	a) Can you tell me about any aspects of the role that have caused you distress? b) What is it like to work closely with colleagues who have had difficult experiences on the job? c) What is it like to work closely with offenders who have been victims of crime themselves?
7. How do you deal with these more difficult aspects of the role?	a) At work b) At home c) Self-care, interests, activities d) Support, therapy, colleagues, external organisations
8. How has working as a prison officer impacted/changed you?	a) Professionally b) Personally

Telephone interviews were conducted in a private office at the University of Birmingham and lasted between one and one and a half hours. Interviews were audio recorded using an encrypted Dictaphone and transcribed following a two-week reflection period in which participants could request that some, or all, of their interview be excluded from the research. Participants were debriefed at the end of each interview. Participants responding in written format were sent the interview questions via post or secure email.

Data from telephone interviews were analysed using IPA[23]. IPA was chosen as an appropriate analysis tool as there is limited research on VT in prisoner officers, so a full exploration of participants' experiences would be beneficial. IPA allows for full exploration, as it is concerned with how individuals make sense of their own personal experiences rather than with objective statements about experiences. IPA can therefore be used as a tool to explore a topic area of which much is unknown due to there being little existing literature. IPA uses systematic coding to look for subthemes and overarching themes within the data to make sense of and understand the data set. Written data were analysed using Template Analysis (TA); a form of thematic analysis which is suitable for analysing textual data[24]. A template was created using the themes from the interview data which was then applied to the written data set.

Findings

The written data mapped onto the themes from the interview data. No new themes were found. The

23. Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method & Research. UK:* SAGE Publications Ltd.
24. Brooks, J., & King, N. (2014). *Doing Template Analysis: evaluating an end-of-life care service.* Research Methods Cases, UK: SAGE Publications Ltd.

findings below therefore relate to both the telephone interview and written data sets. For each theme, a brief description and supporting quotes are provided.

Theme 1 — experiences of direct and indirect trauma

This theme described a range of traumatic events witnessed directly or vicariously by participants, including self-harm, suicide, violence and indirect traumas:

> *Seeing prisoners slashed or boiling water and sugar thrown over them. Walking into a cell and seeing the aftermath of someone having had their face half beaten off. Finding a dead prisoner slumped over with his head in the toilet (Luke).*

> *You don't, what they're telling you about this abuse of drugs and this abuse they've been through and the trauma they've been through and people telling you they've been shot — stuff like that you don't actually let go in, so you're not like, you know, but it does (pause) it does go in on some level (Hayley).*

Now I am older I can manage stress differently and maybe do a quick fifteen minute chat before going home with a colleague discussing it

Theme 2 — ways of coping

All participants described ways of coping with the difficult experiences they faced as prison officers. Ways of coping were grouped into four categories;

a) Avoidance:

> *I've got to the stage where I don't want to talk about what's happened if I have a confrontation with someone or you know, there's an argument and try and break up a fight or an argument or even deal with the aftermath of somebody being assaulted, you try to, you shut it off, you leave work, you hand your keys in, you go out the front of the prison, and that's it. You try and put it in the back of your mind because you don't want to talk about it (Graham).*

b) Adaptive coping strategies:

> *I have a very good, strong, friendship group of prison officers and we would leave for coffee and lunch, and you know if you're talking it, it just, I don't know, I don't know if it's just me but I really feel like it's my way of putting things straight in my head, by talking it out, erm, it also puts it straight, makes you see things a bit differently (Hayley).*

> *Now I am older I can manage stress differently and maybe do a quick fifteen minute chat before going home with a colleague discussing it (Lucy).*

c) De-sensitisation:

> *Erm, as I say sometimes, you're so de-sensitised that it's just another person telling you that they've been raped, it's just another you've heard it and heard it (Hayley).*

d) Activation of threat system:

> *You're always thinking it could be you. Always on your guard and feeling under attack. It brings up other things that have happened to me. You need to be strong enough. You think, it could be you just around the corner. I often go into work thinking 'oh, what's going to happen (Peter).*

Theme 3 — normalisation of trauma

A theme of how traumatic experiences become normalised over time was present in four of the participants' dialogues. This included a repetitive cycle of traumatic events:

> *Yeah, I suppose when you look back, I suppose there is. See, every day there's an incident, every day. Whether you're directly involved or indirectly involved. If there's something on a wing, an alarm bell is called, then staff attend (Graham).*

One participant consciously acknowledged the long-term emotional and cognitive impact the cycle of trauma has had on him:

> *I suppose the only, it would enhance the cynical side of you or the miserable side to you*

because you just go, it's another person, another officer, another friend whose just been treated like this. Or, bloody hell, they really can stoop to a new level (Jack).

Here, Jack refers to indirect experiences of trauma and victimisation, and how repetition increases a sense of cynicism and misery about the world. A sense of misery and despair about the world was also conveyed by Hayley after she experienced a prisoner experience flashbacks of past abuse, described previously:

I would be quite, I'd be quite strange like, I could read something in the paper and like cry about it. I hate the thought of putting somebody else through pain and torture. Like, causing someone else pain, and I just think, I just think like (long pause) what is, do you know, how do you help somebody like that? Where do you begin? (Hayley).

Normalisation of trauma was further highlighted through the description of a cultural expectation to cope with trauma exposure effectively:

So, you've got no healthcare, so it means you have to deal with any suicide attempts or any serious self-harm issues, you've got to deal with them on a daily basis. You don't think about it anymore. It's just part of the job (Graham).

Participants also described how not coping as expected would be viewed as a weakness by others:

'It's just [sighs], it's harder to explain when you don't want to talk about it. Well, you try not to talk about it because you don't want anyone else to think you can't cope' (Graham).

One participant elaborates on the impact of the cultural expectation to cope with trauma exposure and how it contributes to his distress:

So, I think sometimes, I don't think it's the violence or the fact that you've seen somebody hanging that upsets you, it's how you're expected to get on with it, deal with it by the management. So, it makes you angry. Because you think, well actually, I just need to go and sit down for half an hour because I've just found someone purple, blue, red-faced because he's been choking for the last half an hour and now he's dead. I just want to go and get that out of my head or go for a walk. And they're like, oh, no you can't go anywhere, get back on the landings, it's only another one, shut up, get on with it (Jack).

Jack attributes his emotional distress to the expectation to cope placed on him, more so than the traumatic event itself. Jack's exert also links to how the cycle of trauma has de-sensitised the whole system, not just frontline officers.

Theme 4 — empathic connections with prisoners

A theme about the ability to have empathic connections with prisoners was evident across all participants. Participants spoke of how gender influenced their ability to feel empathy towards prisoners, with female participants finding it easier to empathise with female prisoners. They appeared to hold the viewpoint that female prisoners have offended as a result of earlier traumas:

Participants spoke of how gender influenced their ability to feel empathy towards prisoners, with female participants finding it easier to empathise with female prisoners.

I think for me, the hardest times for me were the X years at HMP X because that was female, and I had more of an affinity with the women because of their circumstances that some of them were in there. They'd been put on the game or they were raped, or you know buggered, whatever, those are the hardest, they were the hardest to deal with, I think… You've got people (women) in there for manslaughter and murder because they stuck a knife in their husband because of 25 years of being abused, so you know, that's different (Katie).

Knowledge of prisoners' offences also appeared to impact empathy:

I don't really care about what's happened to them. I heard horrific stories of prisoners on the vulnerable prisoners' unit. I read letters to family and victims. I'd be on the wing listening to them, it's horrendous, talking about what they want to do to people (Peter).

Participants identified that sexual offences made it harder to empathise with prisoners:

Researcher: Do you think the job has made you think more about the victims of crime?

Graham: Yeah, definitely. Definitely. Because I would (pause), when I was at HMP X I ended up working on the sex offender's wing. And that's got to be the worst place you could ever be. Because they talk about what they've done as if they're talking about a football match you've both gone and watched. Their mentality about what, what they think and what they've done. They don't see it as if they've done anything wrong. Because to them it's ok.

All participants acknowledged times when they have emotionally connected with prisoners and their experiences:

Sometimes, when I'm listening to people talking, I'm thinking, oh god you've got nothing to worry about, you know, some of the things I've had to deal with and the prisoners have had to go through in their lives, and the abuse they've gone through, and you think, you've got nothing to worry about (Peter).

The quote from Peter above demonstrates an empathic understanding of how prisoners have been victims of abuse and how this is likely to have adversely affected them. It appears that participants do, at times, allow themselves to think about prisoners as victims rather than only as perpetrators.

Participants also acknowledged that at other times they purposefully kept prisoners at an emotional distance to protect themselves from distress:

I just think (pause) I have to try and forget about them. I don't know, it's just like, it's de-sensitised you, you kind of just have to. I don't know like (pause) you actually can't take it in sometimes. I think you protect yourself, before you let it, you don't let it affect you because you put that mental block up before, like so I'm not even taking it in' — Hayley.

Theme 5: A broken system

A theme of how both the prison system as a whole and individual prison establishments are broken was described by participants. This included descriptions of splits within the staff team which negatively affected wellbeing and experiences in the workplace. This split was evident between new and old staff and how this negatively affected trust and perceptions of safety:

Because some staff will say, oh I can't work with that person or I can't work on that wing, can you put me somewhere else? And I think, we're all prison officers, but it's just (pause), well, the mentality of some staff now, they don't think of everyone, they just think of themselves. Just themselves all the time. So, you know whether you'll be able to trust that person or whether that person is going to do that job they should do or whether they're going to watch your back. And if there's an incident, will they go towards the incident (Graham).

An empathic understanding of how prisoners have been victims of abuse and how this is likely to have adversely affected them. It appears that participants do, at times, allow themselves to think about prisoners as victims rather than only as perpetrators.

The broken system was also depicted by anger towards those in power within the prison service. Some of this anger directly linked to a lack of resources, for example:

No, I've had enough of it, I've had enough of it. You know, it's changed over the years and none of it for the better…Management. Management have doubled in size and officers have been slashed by over a third (Katie).

Participants expressed objections to several organisational factors including lack of money, lack of staff and changes to the culture of the prison service.

Anger was also directed towards the organisation for taking away power from prison officers:

That's another thing they've done, taken lots of things away now, they've taken us to European court where we now can't take any sort of industrial action. So that's another

thing they've taken away from prison staff (Graham).

Anger also seemed to link to a perceived lack of care for participants and prisoners:

…even sometimes prisoners will talk to you and they'll say, oh that CM or that governor has said that, and it makes you think; they're treating the prisoners with the same arrogance, cockiness, nastiness as us, so then it, you just end up, whether hate is the right word, but you just end up disliking them even more. And I suppose, most of my anger, disappointment, upset and frustrations are aimed at the management, at how they treat us (Jack).

Discussion

Themes highlighted several important theoretical implications. Firstly, participants have been exposed to both direct and indirect traumas and reported managing such traumas through a range of coping strategies. Secondly, participants' accounts potentially linked to trauma symptomology including PTSD, secondary traumatic stress disorder (STSD) and VT. PTSD/STSD symptomology was evident in theme 2 (ways of coping) in relation to avoidance, withdrawal, nightmares and hypervigilance. Additionally, changes to schemas as seen in VT were also evident throughout theme 2 when participants described becoming cynical and mistrusting of others (schema of trust), and a continuous anticipation of danger (schema of safety). These schema alterations link to those posited to occur in the literature on VT[12] and suggest that

participants may be experiencing some aspects of VT. Although these schema disruptions are clear from the data, the mechanism through which they occurred is less clear. Exposure to direct trauma, for example repeated assaults, exposure to indirect trauma for example hearing about sexual prisoners being the victim of childhood abuse, or a combination of exposure to both direct and indirect trauma may be the cause. In addition, schema disruptions may be as a result of exposure to the prison environment itself; a concept outlined in the model of Corrections Fatigue (CF)[25].

CF is described as the unique cumulative effect of prison work over time resulting in negative changes in three domains; declined physical health/functioning, negative personality changes, and dysfunctional workplace ideology/behaviour as a result of organisational factors, operational issues and experiences of direct and indirect trauma[24].The theme *'experiences of direct and indirect trauma'* maps directly onto the concept of CF in terms of direct and indirect trauma exposure. The subthemes of 'avoidance' and *'activation of threat system'* match the symptoms of CF in the areas of declined physical health and negative personality changes. The theme of *'normalisation of trauma';* and it's subtheme of the 'expectation to cope' also correlate with the idea of a 'culture of toughness' in CF which contributes to dysfunctional workplace ideology. '*Connection versus distance'* highlighted the struggle between acknowledging and denying that prisoners have also been victimised and may link to the dual role prison officers hold of 'helper and disciplinarian', outlined in CF. Finally, the theme *'a broken system'* also correlates with the organisational and operational issues outlined in the CF model and how these negatively impact workplace ideology and behaviour, including overtime, high workload, deficient training on healthy workplace culture, demanding social interactions and low decision authority. Themes throughout the data appear to closely correlate with much of CF model. The limited existing literature on VT in prison officers outlined in

Exposure to direct trauma, for example repeated assaults, exposure to indirect trauma for example hearing about sexual prisoners being the victim of childhood abuse, or a combination of exposure to both direct and indirect trauma may be the cause.

12. McCann, L., & Pearlman, L.A. (1990). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* (1), 131-149.
24. Brooks, J., & King, N. (2014). Doing Template Analysis: evaluating an end-of-life care service. *Research Methods Cases, UK: SAGE Publications Ltd.*
25. Denhof, M.D., & Spinaris, C.G. (2014). A Theoretical Process Model of Corrections Fatigue. Retrieved from: http://desertwaters.com/wp-content/uploads/2013/08/Corrections-Fatigue-Model-Attachment-Document.pdf

the introduction may also reflect symptomology more in line with CF than VT alone. The findings around negative job perceptions, healthy changes and perceptions of risk[20 21] map onto factors outlined within the CF model of declined physical health, workplace ideology and behaviour, and negative personality changes. CF may therefore offer a more inclusive model of the impact of working within the prison environment, which adds to the impact of VT alone.

Implications

The present findings indicate that prison officers are potentially at risk of developing symptomology of PTSD, STSD, VT and CF. Findings also highlighted a prison culture of keeping emotions and distress hidden, which exacerbates distress and may lead to the development of mental health problems. The prison service would benefit from a whole system and long-term approach to challenging this culture, which would promote the discussion of the emotions, distress, trauma and mental health of prison officers. This might involve: providing staff training on risk factors and early warning signs of trauma symptomology and mental health problems; training on and promotion of self-care and healthy lifestyles; more staff wellbeing events; promoting the sharing of positive experiences of counselling and therapy; and increased access to support services and forums where officers can offload difficult experiences in a safe space.

Findings also highlighted how prison officers are exposed to severe traumas and may receive little immediate and long-term support to cope with the impact of these. Prison establishments in England and Wales would benefit from developing additional support strategies to help officers deal with the aftermath of trauma. This might include mandatory and regular psychology-led individual and/or group supervision for all frontline staff, psychology-led reflective practice sessions for all frontline staff, and managerial follow-up when officers have been referred to Occupational Health to ensure the right treatment has been offered and received. HMPPS has published a policy on post-incident care[26] which stipulates mandatory debriefs after incidents including 'providing practical and emotional support and information'; however, participants' narratives suggest this is not always followed. Auditing the use of this policy would help identify establishments which need support in policy adherence.

Operational factors implicated in the development of CF also need to be addressed. These include, but are not limited to, cuts to frontline staff; increasing prisoner numbers; changes to pensions and pay; and staff shortages through absence and sickness.

Limitations

This study has several limitations including the low sample size, which makes it difficult to generalise findings to the wider prison officer population. However, as there is limited research on VT in prison officers, this research adopted a qualitative approach and did not aim to provide a nomothetic account of VT in prison officers. In qualitative research the analysis and interpretation are heavily influenced by the researcher and therefore different themes may have been identified by other researchers. Attempts to minimise this were made by triangulating the data analysis with the second researcher and using two distinct data collection methods. In addition, there may be bias within the sample itself. Participants are likely to be prison officers who have pre-existing ideas about their own trauma experiences and the prison service, and therefore the sample may be unrepresentative of the overall prison officer population in England and Wales.

Conclusions

In conclusion, this research suggests that some prison officers do experience direct and indirect trauma symptomology, however it is not clear through which mechanisms these develop. Further research is needed on trauma in prison officers in the UK, particularly quantitative research which can be generalised to the wider prison officer population. The prison system would benefit from a cultural shift in its attitude towards distress, trauma, and help-seeking, in order to increase the support available for officers working in such a complex and demanding environment.

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Young men in prison with Neurodevelopmental Disorders:

Missed, misdiagnosed and misinterpreted

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Introduction

It has long been recognised that young people are at increased risk of committing crime relative to adults[1]. Supporting these young people in prison is also complicated, as they are potentially more vulnerable than adults in the Justice sector[2].

A desire to understand this population further has led to growing interest in the presence of Neurodevelopmental Disorders (NDDs) and, in the UK, the related term Learning Difficulties and Disabilites (LDDs). NDDs/LDDs have been seen as a potential marker of vulnerability[3]. NDDs are a group of common conditions that, following DSM-5 criteria[4], include Attention-Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), Developmental Coordination Disorder (DCD, also known as Dyspraxia), Developmental Language Disorder (DLD), Dyscalculia, Dyslexia, Intellectual Disability (ID) and Tic Disorders. There is also growing interest in related adversity, for example head injury (which may result in Traumatic Brain Injury (TBI))[5] and Adverse Childhood Experiences (ACEs), which share many symptoms with NDDs[6].

The literature indicates that young people who offend frequently have NDDs, TBI and/or trauma histories but few enter prison with diagnoses. NDDs and TBI may be commonly missed or misdiagnosed. Even when a young person has a diagnosis it may not accurately portray their *complete* profile of functional difficulties. The nature and pattern of difficulties is important, as this may alter the intervention approach. Alongside lack of awareness among prison staff, NDDs may result in increased vulnerability, risk of victimisation by other prisoners, reduced access to educational and vocational programmes and reduced potential for referral for further assessment. Those, ironically, who have experienced the most adversity may be the ones who miss out most on support.

A common vulnerability

The diagnosed prevalence of NDDs among children and young people in the UK ranges from between one in 200 to one in 50 for ADHD to between one in 50 and nearly one in 15 for Dyslexia[7]. Much higher prevalence rates are found within populations of vulnerable young people. For example, UK studies report ADHD rates ranging from one in ten among all young people in Liverpool Youth Offending Services[8] to three-quarters of those serving custodial sentences for four or more offences in a regional secure training centre[9].

1. Jeffery T Ulmer and Darrell Steffensmeier, "The Age and Crime Relationship: Social Variation, Social Explanations," in *The Nurture Versus Biosocial Debate in Criminology: On the Origins of Criminal Behavior and Criminality,* ed. Kevin M Beaver, J C Barnes, and Brian B Boutwell (London, UK: SAGE Publications Ltd., 2014), 377–396.
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5. Hughes et al., *Nobody Made the Connection: The Prevalence of Neurodisability in Young People Who Offend.*
6. Talin Babikian et al., "Chronic Aspects of Pediatric Traumatic Brain Injury: Review of the Literature," *Journal of Neurotrauma* 32, no. 23 (2015): 1849–1860; H K Chang et al., "Traumatic Brain Injury in Early Childhood and Risk of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder: A Nationwide Longitudinal Study," Journal of Clinical Psychiatry 79, no. 6 (2018); Ling-Yu Yang et al., "Association of Traumatic Brain Injury in Childhood and Attention-Deficit/Hyperactivity Disorder: A Population-Based Study," *Pediatric Research 80,* no. 3 (2016): 356–362; Bessel A Van Der Kolk, "Developmental Trauma Disorder: A New Rational Diagnosis for Children with Complex Trauma Histories," *Psychiatric Annals* 35, no. 5 (2005): 401–408.
7. Mary Ann Megan Cleaton and Amanda Kirby, "Why Do We Find It so Hard to Calculate the Burden of Neurodevelopmental Disorders?," *Journal of Childhood & Developmental Disorders 4*, no. 3 (2018): 1–20.
8. Cath Lewis and Alex Scott-Samuel, *Health Needs Assessment of Young Offenders in the Youth Justice System on Merseyside (Liverpool,* UK, 2013).
9. J Rayner, Tom P Kelly, and F Graham, "Mental Health, Personality and Cognitive Problems in Persistent Adolescent Offenders Require Long-Term Solutions: A Pilot Study," *Journal of Forensic Psychiatry and Psychology 16,* no. 2 (2005): 248–262.

Not just Neurodevelopmental Disorders

NDDs rarely exist in isolation: they commonly co-occur both with each other and with various physical and mental health conditions[10]. These include conditions such as TBI and ACEs .

TBI is known to be highly prevalent among young offender populations, with rates ranging from one in six to nearly three in four in one review[11]. Many young people in prison will have experienced multiple ACEs[12]. These may include abandonment, abuse and other trauma. This may be a common source of emotional, behavioural and psychological dysregulation, which can be conceptualised as Developmental Trauma Disorder[13].

Needs are often missed and/or misdiagnosed

Prison systems and staff may assume that those who have NDDs will arrive diagnosed, be able to articulate their difficulties and ask for appropriate help. In fact, this is rarely the case. Many young people entering the Justice System may not have any formal diagnoses (or, alternatively, may have diagnoses for some but not *all* of the challenges they experience). Additionally, diagnoses in a prison context may often be based on 'behaviour' or a psychological framework, such Conduct Disorder or Borderline Personality Disorder, rather than considering NDDs and/or history of TBI or ACEs.

There are many reasons why a young person may have been missed or misdiagnosed prior to entering prison. Parental engagement with health and educational services may have been limited, resulting in no access to screening or assessment processes[14]. Additionally, many young offenders have missed much of their education, for example through school exclusion, and some will have moved around the system (being a Looked After Child and/or Young Person (LACYP))[15].

Misdiagnosis is also a considerable issue affecting individuals with NDDs. For example, ADHD[16], ASD[17], DLD[18] and other NDDs are frequently misdiagnosed as 'bad behaviour'. In other cases, NDDs may be misdiagnosed as another condition[19]. Confusion may also occur when history of head injury is not considered, as TBI can result in 'secondary' ADHD as well as symptoms that mimic ASD and ID[20]. Some children may appear to 'recover' from their TBI(s), as the behavioural impact may not become apparent until adolescence[21]. In these cases, symptoms are infrequently correctly attributed to the TBI.

Unidentified support needs may lead to potential misrepresentation

The impact of having one or more NDDs, with or without TBI, may render individuals more vulnerable to offending, being coerced/manipulated into offending and/or impulsively making a confession. For example, it is recognised that individuals with ASD are less risk-aware and less socially protected, even compared with individuals with Down's

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15. Oak Foundation, *Falling through the Gaps: Fragmented and Underfunded Systems Are Failing Care Leavers Who Serve Prison Sentences, in Custody and in the Community* (London, UK, 2019); Jessica Jacobson et al., *Punishing Disadvantage:* A Profile of Children in Custody (London, UK, 2010).
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19. (e.g. Aggarwal and Angus, 2015)
20. Babikian et al., "Chronic Aspects of Pediatric Traumatic Brain Injury: Review of the Literature"; Chang et al., "Traumatic Brain Injury in Early Childhood and Risk of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder: A Nationwide Longitudinal Study"; Brandy Compton et al., "Prevalence of Traumatic Brain Injury in Children with Attention-Deficit/Hyperactivity Disorder: A Cross-Sectional Study," *The Florida Medical Student Research Journal 2,* no. 1 (2017): 1; Heather T Keenan, Gillian C Hall, and Stephen W Marshall, "Early Head Injury and Attention-Deficit/Hyperactivity Disorder: Retrospective Cohort Study," *British Medical Journal* 337 (2008): a1984, http://www.bmj.com/cgi/doi/10.1136/bmj.a1984; Yang et al., "Association of Traumatic Brain Injury in Childhood and Attention-Deficit/Hyperactivity Disorder: A Population-Based Study"; Jeffrey E Max et al., "Predictors of Attention-Deficit/Hyperactivity Disorder Within 6 Months After Pediatric Traumatic Brain Injury," Journal of the American Academy of Child & Adolescent Psychiatry 44, no. 10 (2005): 1032–1040, http://dx.doi.org/10.1097/01.chi.0000173293.05817.b1; Jeffrey E Max et al., "Predictors of Secondary Attention-Deficit / Hyperactivity Disorder in Children and Adolescents 6 to 24 Months After Traumatic Brain Injury," *Journal of the American Academy of Child & Adolescent Psychiatry* 44, no. 10 (2005): 1041–1049, http://dx.doi.org/10.1097/01.chi.0000173292.05817.f8.
21. James Tonks et al., "Is Damage to the Pre-Frontal Cortex Dormant until Adolescence, or Difficult to Detect? Looking for Keys That Unlock Executive Functions in Children in the Wrong Place," *Medical Hypotheses* 108 (2017): 24–30.

Syndrome[22]. Children with ASD are significantly more socially vulnerable than typically developing children[23] and at increased risk of being manipulated or exploited by others to commit crime[24].

Young people with ADHD are more likely to commit reactive and/or opportunistic offences and to be apprehended, and less likely to appreciate the seriousness of their actions[25]. Young people with ADHD may not trust their memory during police interrogation, resulting in responses that appear evasive[26]. They may be more motivated to comply with requests and avoid conflict, resulting in greater rates of false confession[27].

Supporting young people in prison — meeting their needs

Individuals with NDDs and TBI are at increased risk of *cumulative* adversity including: increased risk of mental health difficulties and substance use disorders[28], increased risk of victimisation within prison[29] and also poor educational[30] and employment outcomes[31]. Thus, NDDs and TBI may impact on young people's ability to engage with and succeed at educational and vocational programmes within prison that aim to reduce reoffending[32].

Aims of the study

The main aim of the study was to explore the rate and pattern of self-reported difficulties in four key functional areas (relating to attention and concentration; social and communication; coordination and organisation; and literacy and numeracy) among 188 young men in Her Majesty's Prison (HMP) and Young Offenders' Institute (YOI) Polmont, Scotland, UK. Secondarily, it considered whether there was an association between these functional difficulties, self-reported head injury and previous formal NDD diagnoses.

Materials and Methods

Sampling and procedure

Young men in HMP and YOI Polmont were recruited over a ten-month period (November 2017 to August 2018) using a convenience sampling method as part of routine screening for LDDs undertaken by SPS. All young men were invited to the Learning Centre as part of their induction. All young men who attended the Learning Centre and volunteered to be screened within the study period were recruited.

All participants included in the study provided two levels of informed consent. The process was agreed by SPS and is now routine: firstly, consent was obtained to screen for functional difficulties associated with NDDs; secondly, consent was obtained for anonymised data to be used by Do-IT Solutions Ltd. for research purposes. Written permission for Do-IT Solutions Ltd. to perform secondary analyses and publish anonymised data was also provided by SPS.

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29. Nancy Loucks and Jenny Talbot, *No One Knows: Identifying and Supporting Prisoners with Learning Difficulties and Learning Disabilities: The Views of Prison Staff (Scotland)* (London, UK, 2007).
30. Cleaton and Kirby, "Why Do We Find It so Hard to Calculate the Burden of Neurodevelopmental Disorders?"; Mary R Prasad, Paul R Swank, and Linda Ewing-Cobbs, "Long-Term School Outcomes of Children and Adolescents with Traumatic Brain Injury," *Journal of Head Trauma Rehabilitation* 32, no. 1 (2017): E24–E32; Amir Sariaslan et al., "Long-Term Outcomes Associated with Traumatic Brain Injury in Childhood and Adolescence: A Nationwide Swedish Cohort Study of a Wide Range of Medical and Social Outcomes," *PLoS Medicine* 13, no. 8 (2016): e1002103; Amery Treble-Barna et al., "Long-Term Classroom Functioning and Its Association With Neuropsychological and Academic Performance Following Traumatic Brain Injury During Early Childhood," Neuropsychology 31, no. 5 (2017): 486–498.
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Do-IT Profiler

Do-IT Profiler is a person-centred, computer-based, modular screening and assessment system[33]. It has been used extensively in the Justice sector[34]. It has built-in accessibility features including: voiced question and answer options; alternative function keys to limit the need to use a mouse; a zoom-in function to increase font size; and the ability to change the text and background colour to aid readability. Completion does not require users to type or enter text.

On initial log-in, an introductory video is viewed. The user then completes questionnaires at their own pace, taking breaks as necessary. The average total completion time for the questionnaires is 25-40 minutes. Each response is recorded and automatically collated. Within SPS, a staff member was always present during completion. Staff were trained in the use and content of the Do-IT Profiler and could assist users, for example by pressing keys, if required. Once completed, practical guidance dependent on the user's specific responses is generated for both the user and staff.

The following information was collected using this system.

Personal information

Participants answered demographic questions regarding gender, ethnicity, first language and marital status. They also indicated whether they had previously been given a formal diagnosis of NDDs (options: 'Asperger's Syndrome', 'Autism Spectrum Disorder (ASD)', 'Down's Syndrome', 'Other Learning Disability', 'Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)', 'Dyslexia', 'Dyspraxia/Developmental Coordination Disorder (DCD)', 'Dyscalculia' or 'Other Learning Difficulty') and whether they had a history of head injury. History of head injury was assessed using the following questions: 'Do you currently have, or have you had a significant injury to your head or face?' (options: 'Yes' or 'No') and 'If yes, were you knocked unconscious as a result of this injury?' (options: 'Yes' or 'No').

Questionnaires were designed to reduce participant and organisational burden and be able to be practically administered in a prison setting. This meant more detailed questions about head injury, self-harm and suicidality could not be included. Additionally, questions were only included if there were clear, practical guidelines or supports in place for participants. Thus, questions regarding childhood abuse, historical and current domestic violence victimisation and other ACEs were not included, even though these are important factors relating to youth offending[35]. Ethical concerns regarding the capacity of prison staff to adequately support participants following potential disclosure were an additional reason for non-inclusion.

Screening for functional difficulties

This screening questionnaire has been developed and validated in UK general and prison populations[36]. The questions are partially derived from existing standardised tools, including the Adult Developmental Coordination Disorder Checklist[37] and the Adult Dyslexia Checklist[38].

Participants answered a 60-item questionnaire, divided equally into four key functional areas relating to: attention and concentration; social and communication; coordination and organisation; and literacy and numeracy [39]. Participants rated the 60 items (e.g. 'I am easily distracted by noises or activity around me') on a four-point Likert scale ('Very like me', 'A bit like me', 'Not really like me' and 'Not like me at all'). A total score was derived per section by summing the score for each question in the section, resulting in a maximum score of 60 per section with a higher score representing fewer difficulties.

In order to identify the most vulnerable group, that is those with the greatest number of self-reported difficulties, the sample was sub-divided into three groups per section. Those scoring in the ≤25th percentile within a section were considered to have the most severe functional difficulties, those scoring between the 26th-50th percentile were considered to have some functional difficulties and those scoring >50th percentile were considered to have reported the least functional difficulties (i.e. any difficulties reported were not severe enough to functionally affect individuals' day-to-day lives). All

33. Amanda Kirby and Ian Smythe, "Do-IT>," last modified 2019, accessed March 4, 2019, https://doitprofiler.com/.
34. Amanda Kirby and Lisette Saunders, "A Case Study of an Embedded System in Prison to Support Individuals with Learning Difficulties and Disabilities in the Criminal Justice System," *Journal of Intellectual Disabilities and Offending Behavior* 6, no. 2 (2015): 122–124.
35. Michael T Baglivio et al., "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders," *OJJDP Journal of Juvenile Justice 3,* no. 2 (2014): 12–34; Kimberly Bender, "Why Do Some Maltreated Youth Become Juvenile Offenders?: A Call for Further Investigation and Adaptation of Youth Services," *Children and Youth Services Review* 32, no. 3 (2010): 466–473; Local Government Association, *The Relationship between Family Violence and Youth Offending* (London, UK, 2018).
36. Ibid.
37. Amanda Kirby et al., "The Development and Standardization of the Adult Developmental Co-Ordination Disorders/Dyspraxia Checklist (ADC)," *Research in Developmental Disabilities 31,* no. 1 (2010): 131–139.
38. Ian Smythe and John Everatt, "Checklist for Adults with Dyslexia," in *The Dyslexia Handbook,* ed. Mike Johnson and Lindsay Peer (London, UK: British Dyslexia Association, 2002).
39. J Smith and Amanda Kirby, "Identification and Implication of Specific Learning Difficulties in a Prison Population," *Forensic Update* 84 (2006): 15–19.

percentile cut-offs were derived from the sample, as suitable population norms were not available.

Results

Participants

Of the young men invited to participate, 188 completed both the personal details questionnaire and the questionnaire screening for functional difficulties. The majority of these young men had never been married, were White and spoke English as a first language (Table 1). Of those who did not speak English as a first language, nearly all spoke Scots and/or Scottish Gaelic as a first language and the remaining one in ten spoke an 'other' language.

Table 1: Demographic and educational information.

	No.	per cent
Ethnicity		
White	179	95.2
Mixed	2	1.1
Asian or Asian British	4	2.1
Black or Black British	1	0.5
Other	2	1.1
First language		
English	150	79.8
Scots and/or Scottish Gaelic	35	18.6
Irish and/or Ulster Scots	0	0.0
Welsh	0	0.0
Cornish	0	0.0
Other	3	1.6
Marital status		
Never married	152	80.9
Married	3	1.6
Civil partnership	20	10.6
Divorced	0	0.0
Separated	13	6.9
Widowed	0	0.0
Looked After Child and/or Young Person		
Yes	71	38.0
No	115	61.5
Not sure	1	0.5
Prefer not to say	1	0.5
Excluded from school		
Never	29	15.4
Once	18	9.6
Twice	18	9.6
3 or more times	122	64.9
Prefer not to say	1	0.5
Age left education		
12 years and under	10	5.3
13-14 years	41	21.8
15-16 years	108	57.4
17-18 years	23	12.2
19 years and over	6	3.2
General school attendance		
Excellent school attendance, absent for illness only	25	13.3
Occasionally missed school (absent <25 per cent of the time)	54	28.7
Regularly missed school (absent ~50 per cent of the time)	67	35.6
Hardly attended school (absent >75 per cent of the time)	38	20.2
Never attended school	4	2.1

Educational and care histories

Nearly two-fifths of the young men reported a history of being 'in care' (i.e. LACYP) and many reported a history of educational disadvantage (Table 1). In particular, two-thirds reported having been excluded from school three or more times, more than four-fifths reported having left education at or before age 16 years and less than one-fifth reported that they were only absent from school for reasons of illness.

Four-fifths of those who had ever been LACYP had been excluded from school three or more times, but this was true of only half of those who had never been LACYP. Likewise, a greater proportion of those who had been excluded from school three or more times (Similarly, half of those who had been excluded from school three or more times had ever been LACYP, compared with a sixth of those who had never been excluded from school.

Reported functional difficulties

Just over half of the young men scored at or below the 25th percentile and thus reported having severe functional difficulties in one or more of the following areas: attention and concentration; social and communication; coordination and organisation; and/or literacy and numeracy. A further quarter of them scored in the 26th-50th percentiles, and thus had some functional difficulties in one or more areas, and just under a fifth scored above the 50th percentile, and thus had the least functional difficulties in any area.

All possible combinations of screened functional difficulties were reported (Table 2). Among those who had reported functional difficulties, a fifth reported severe difficulties in one functional area, a fifth reported severe difficulties in two functional areas, 7 per cent reported severe difficulties in three functional areas and 8 per cent reported severe difficulties in all four of the key functional areas tested.

The most common combinations of severe functional difficulties were: co-occurring attention and concentration difficulties, social and communication difficulties, coordination and organisation difficulties and literacy and numeracy difficulties (8 per cent); and coordination and organisation difficulties only (7 per cent).

Table 2: Pattern of self-reported functional difficulties.

	No.	per cent
Least functional difficulties in any areas	34	18.1
Some functional difficulties in one or more areas	51	27.1
Severe functional difficulties in one area		
Attention and concentration difficulties	12	6.4
Social and communication difficulties	6	3.2
Coordination and organisation difficulties	13	6.9
Literacy and numeracy difficulties	12	6.4
Severe functional difficulties in two areas		
Attention and concentration + social and communication difficulties	6	3.2
Attention and concentration + coordination and organisation difficulties	5	2.7
Attention and concentration + literacy and numeracy difficulties	4	2.1
Social and communication + coordination and organisation difficulties	6	3.2
Social and communication + literacy and numeracy difficulties	6	3.2
Coordination and organisation + literacy and numeracy difficulties	4	2.1
Severe functional difficulties in three areas		
Attention and concentration + social and communication + coordination and organisation difficulties	5	2.7
Attention and concentration + social and communication + literacy and numeracy difficulties	2	1.1
Attention and concentration + coordination and organisation + literacy and numeracy difficulties	4	2.1
Social and communication + coordination and organisation + literacy and numeracy difficulties	3	1.6
Severe functional difficulties in four areas		
Attention and concentration + social and communication + coordination and organisation + literacy and numeracy	15	8.0

Previous Neurodevelopmental Disorder diagnoses

The presence of previous NDD diagnoses was investigated among those young men who reported having functional difficulties — full details of this are reported in Table 3.

Among the 54 young men who reported severe attention and concentration difficulties, just over one-quarter had a previous diagnosis of ADHD or ADD. Similarly, of the 50 young men who reported severe literacy and numeracy difficulties, just over one-quarter had a previous diagnosis of Dyslexia. However, only 6 per cent of those who reported severe social and communication difficulties had a previous diagnosis of ASD or Asperger's Syndrome and only 2 per cent of those who reported severe coordination and organisation difficulties had a previous diagnosis of DCD or Dyspraxia. Among those meeting the cut-off for severe social and communication difficulties or coordination and organisation difficulties, having other severe functional difficulties appeared to increase the likelihood of having received a diagnosis whereas the opposite was true for those who met the cut-off for severe attention and concentration difficulties or literacy and numeracy difficulties. Overall, there was evidence of a gap between reported symptoms and previous diagnosis, particularly for ASD and DCD diagnoses.

Table 3: Previous formal NDD diagnoses among those reporting functional difficulties.

Severe functional difficulties detected with screening	No. (per cent)	
	Previous diagnosis*	**No previous diagnosis***
Attention and concentration difficulties (all)	15 (27.8)	39 (72.2)
Attention and concentration difficulties only	5 (41.7)	7 (58.3)
Attention and concentration difficulties + other difficulties	10 (23.8)	32 (76.2)
Social and communication difficulties (all)	3 (6.3)	45 (93.8)
Social and communication difficulties only	0 (0.0)	6 (100.0)
Social and communication difficulties + other difficulties	3 (7.1)	39 (92.9)
Coordination and organisation difficulties (all)	1 (1.8)	54 (98.2)
Coordination and organisation difficulties only	0 (0.0)	13 (100.0)
Coordination and organisation difficulties + other difficulties	1 (2.4)	41 (97.6)
Literacy and numeracy difficulties (all)	14 (28.0)	36 (72.0)
Literacy and numeracy difficulties only	4 (33.3)	8 (66.7)
Literacy and numeracy difficulties + other difficulties	10 (26.3)	28 (73.7)

* Comparisons were made against the following formal diagnoses: attention and concentration difficulties versus an ADHD or ADD diagnosis; social and communication difficulties versus an ASD or Asperger's Syndrome diagnosis; coordination and organisation difficulties versus a DCD or Dyspraxia diagnosis; and literacy and numeracy difficulties versus a Dyslexia diagnosis.

The presence of functional difficulties was investigated among those young men who reported having a previous NDD diagnosis — full details of this are reported in Table 4. Within the whole cohort, a sixth reported having a previous diagnosis of ADHD or ADD, 3 per cent reported having a previous diagnosis of ASD or Asperger's Syndrome, 1 per cent reported having a previous diagnosis of DCD or Dyspraxia and one in ten reported having a previous diagnosis of Dyslexia. However, many of these individuals did not report severe functional difficulties in associated areas. Among those reporting a previous diagnosis of ADHD, nearly half did not report severe attention and concentration difficulties. Likewise, among those reporting a previous diagnosis of ASD, half did not report severe social and communication difficulties. Among those reporting a previous diagnosis of Dyslexia, a third did not report severe literacy and numeracy difficulties. Finally, of the two individuals reporting a previous diagnosis of DCD, one did not report severe coordination and organisation difficulties. The young men who reported having an NDD diagnosis did not report severe functional difficulties, but this may not mean they were misdiagnosed. Many of them scored within the 26th-50th percentile, rather than above the 50th percentile, and thus did report some difficulties in areas relevant to their formal diagnosis. This was particularly true of those who reported having a previous diagnosis of ADHD.

Table 4: Functional difficulties among those reporting a previous formal NDD diagnosis.

Previously diagnosed NDD	No. (per cent)			
	Met screening criteria for…			Least functional difficulties associated with any NDD
	Severe functional difficulties associated with this NDD*	Severe functional difficulties associated with other NDD(s) only*	No severe functional difficulties, some difficulites in one or more areas	
ADHD/ADD	15 (53.6)	9 (32.1)	3 (10.7)	1 (3.6)
ASD/Asperger's	3 (50.0)	2 (33.3)	1 (16.7)	0 (0.0)
DCD/Dyspraxia	1 (50.0)	0 (0.0)	0 (0.0)	1 (50.0)
Dyslexia	14 (66.7)	4 (19.0)	2 (9.8)	1 (4.8)

* Functional difficulties in the following areas were associated with the following formal diagnoses: attention and concentration difficulties with ADHD or ADD; social and communication difficulties with ASD or Asperger's Syndrome; coordination and organisation difficulties with DCD or Dyspraxia; and literacy and numeracy difficulties with Dyslexia.

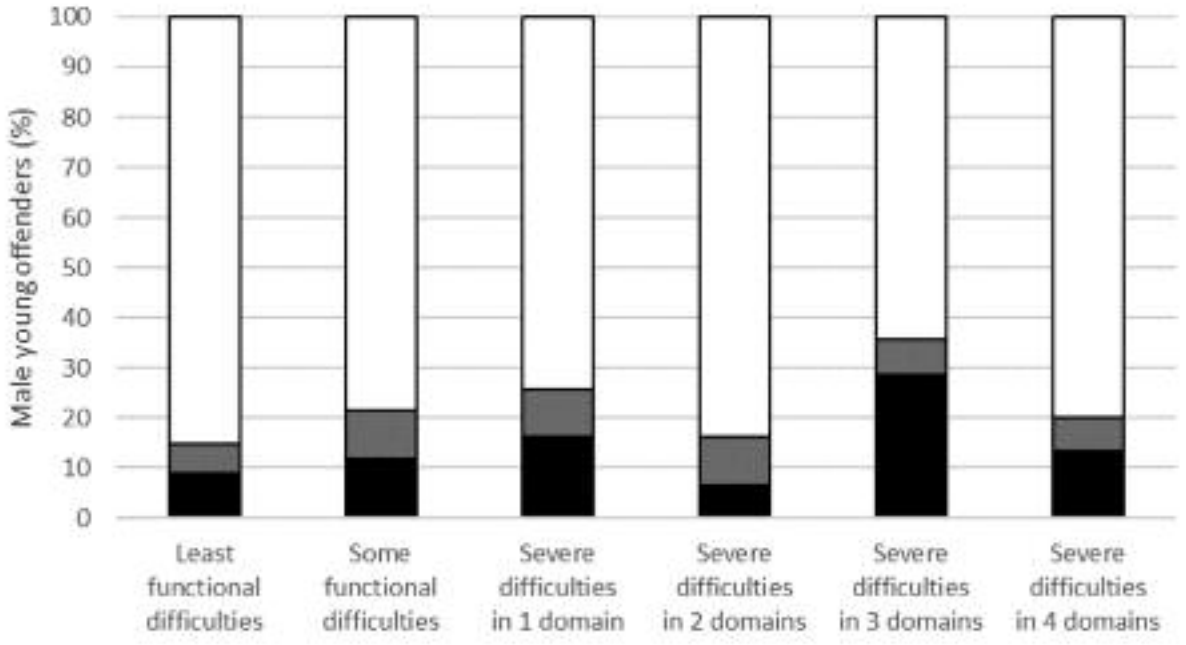
History of head injury

Overall, one-fifth of young men reported experiencing head injury and just under one-sixth reported experiencing one or more head injuries with loss of consciousness (LOC). Head injuries with LOC are more likely to be severe and to be associated with ongoing symptoms such as poor memory or attention. The association between functional difficulties and head injury was investigated — this is shown in Figure 1.

Among the young men with the least functional difficulties in any of the four key areas, nearly one in ten had experienced at least one head injury with LOC. Among those with some functional difficulties in at least one area, one in ten had experienced at least one head injury with LOC. However, among those reporting severe functional difficulties, rates of head injury showed no clear relationship to the number of functional areas affected. There were no significant differences in the rate of head injury with or without LOC between young men reporting the least functional difficulties (n = 34) and young men with severe functional difficulties in one or more areas (n = 103; p = 0.2978, two-tailed Barnard's Exact Test).

However, considerable variability was observed in the rate of head injury with LOC depending on the pattern of functional difficulties reported. For example, among young men with severe functional difficulties in one area, one-quarter of those with 'attention and concentration difficulties only' and one-third of those with 'social and communication difficulties only' reported having experienced at least one head injury with LOC. However, less than one in ten of those with 'coordination and organisation difficulties only' and those with 'literacy and numeracy difficulties only' reported having experienced this.

Figure 1: History of head injury among the sample of young men.



Key: LOC, loss of consciousness. Sample size (l-r): 34, 51, 43, 31, 14, 15.

Correlations between functional difficulties, diagnoses and past history

The associations between functional difficulties, NDD diagnoses and history of being LACYP, of at least one school exclusion and of having at least one head injury were investigated — these are shown in Table 5.

Young people with a history of being LACYP were significantly more likely to have self-reported difficulties with literacy and numeracy whereas those with a history of school exclusion were significantly more likely to have been given a diagnosis of ADHD and Dyslexia. Those with a history of at least one head injury were also significantly more likely to have been given a diagnosis of ADHD or Dyslexia.

Table 5: Correlation between functional difficulties, formal NDD diagnoses and past history.

	Odds ratio (95 per cent CI)		
	Ever LACYP	**Excluded from school at least once**	**History of at least one head injury**
Attention and concentration			
Self-reported severe difficulties	1.77 (0.92, 3.40)	0.87 (0.37, 2.17)	1.68 (0.79, 3.50)
ADHD diagnosis	1.49 (0.65, 3.39)	5.03 (1.00, 122.79)	4.23 (1.78, 10.02)
Social and communication			
Self-reported severe difficulties	1.44 (0.73, 2.82)	0.50 (0.22, 1.18)	1.56 (0.71, 3.32)
ASD diagnosis	1.64 (0.28, 9.80)	0.34 (0.06, 2.85)	1.95 (0.23, 11.04)
Coordination and organisation			
Self-reported severe difficulties	0.98 (0.50, 1.88)	1.34 (0.55, 3.63)	1.05 (0.47, 2.23)
DCD diagnosis	1.25 (0.48, 3.15)	3.55 (0.69, 87.36)	1.20 (0.36, 3.34)
Literacy and numeracy			
Self-reported severe difficulties	3.06 (1.57, 6.07)	0.93 (0.39, 2.42)	0.64 (0.25, 1.45)
Dyslexia diagnosis	1.05 (0.47, 2.23)	3.06 (1.57, 6.07)	3.73 (0.09, 147.65)

Italics: $p < 0.05$ (mid-p exact test).

Limitations of the study

This cross-sectional study employed a convenience sampling method and took place within a single prison. The majority of young men who participated were White, unmarried and spoke English as a first language. No information was available regarding young men who declined to participate, so it is unknown whether they differed from sampled young men. Ninety-six percent of the Scottish prison population is White[40], so the sample was representative of the general prison population in this regard.

The sample was a convenience sample. Only individuals who both attended the Learning Centre and volunteered to take part in the study were sampled. Additionally, individuals who withdrew consent or stopped answering questions part-way through the study were excluded. It may be reasonable to assume that individuals with functional difficulties might be less likely to attend the Learning Centre, less likely to want to participate, more likely to withdraw consent and more likely to fail to complete the questionnaires. This may have affected the representativeness of the sample and, thus, the conclusions. In particular, the reported prevalence of functional difficulties may be lower in the study sample than the actual prevalence of functional difficulties in the overall prison population.

The screening questionnaire relied on self-report of symptoms associated with NDDs in order to assess their functioning in a practical, time-efficient and consistent manner. Self-report has been used as a reliable means of assessment among adults with ADHD, for example, although they, like adults and adolescents with TBI, tend to under-report the severity of their symptoms[41]. Among adults, self-report questionnaires have reasonably high sensitivity at predicting receipt of an ASD diagnosis[42].

Questions were only included in questionnaires if they were necessary, if they could be practically administered in a prison setting and if there were clear, practical guidelines or supports in place for participants. This placed limitations on the detail we could collect regarding head injury, self-harm and suicidality and prevented the inclusion of any questions about domestic violence victimisation and other ACEs.

40. Georgina Sturge, *UK Prison Population Statistics* (London, UK, 2018).
41. J J Sandra Kooij et al., "Reliability, Validity, and Utility of Instruments for Self-Report and Informant Report Concerning Symptoms of ADHD in Adult Patients," *Journal of Attention Disorders* 11, no. 4 (2008): 445–458, http://journals.sagepub.com.proxy-ub.rug.nl/doi/pdf/10.1177/1087054707299367; J M Leathem, L J Murphy, and R A Flett, "Self- and Informant-Ratings on the Patient Competency Rating Scale in Patients with Traumatic Brain Injury," *Journal of Clinical and Experimental Neuropsychology* 20, no. 5 (1998): 694–705; K R Wilson, J Donders, and L Nguyen, "Self and Parent Ratings of Executive Functioning after Adolescent Traumatic Brain Injury," *Rehabilitation Psychology* 56, no. 2 (2011): 100–106.
42. Bram B Sizoo et al., "Predictive Validity of Self-Report Questionnaires in the Assessment of Autism Spectrum Disorders in Adults," *Autism* 19, no. 7 (2015): 842–849.

Exploring these topics would be a valuable subject of future work.

All analyses were based on within-cohort comparisons, as appropriate, socioeconomically-matched general population data was not available. Thus, the young men categorised as having the 'least severe' functional difficulties may still have had comparatively severe difficulties relative to the general population.

Discussion

This study presents the first study looking broadly at self-reported NDD symptoms in young men in a prison setting. It demonstrates that young men in prison are a highly heterogenous population with great variability in presentation and pattern of challenges and functional impairments. Notably, all possible combinations of severe functional difficulties were observed and no more than 8 per cent of the young men reported the same combination of severe functional difficulties. This is important to note as it suggests a need for individualised formulations and support.

Potential missing diagnoses

Although just over half of the cohort reported having severe functional difficulties in one or more areas and a further one-quarter reported some functional difficulties, comparatively few had formal NDD diagnoses. In particular, only 2 per cent of those with severe coordination and organisation difficulties had a DCD diagnosis and only 8 per cent of those with severe social and communication difficulties had an ASD diagnosis. Although some of these cases may represent difficulties as a result of other reasons, for example Cerebral Palsy, DLD, TBI or ACEs, it is possible that many represent missed NDD diagnoses.

This lack of diagnoses may be related to the chaotic lives experienced by many young people in prison, including a history of being LACYP and/or excluded from school which may result in a lack of engagement with services that provide diagnoses[43]. Our preliminary analysis comparing these groups does not entirely support this theory as, for example, those with a history of school exclusion were more likely to have an ADHD or Dyslexia diagnosis than those who were not. It is possible that this may be a function of our sampling strategy, which only sampled young men who attended the prison's Learning Centre. Alternatively, it may be that these young people are obtaining diagnoses, but only doing so comparatively late — for example after having experienced adversity such as repeated school exclusion over several years — when diagnoses maybe of less use to improve outcomes. A third possibility is that these young people are obtaining diagnoses but not getting any support following their diagnoses, resulting in the diagnoses becoming a self-fulfilling prophecy rather than a way to improve outcomes. A recent study of children with diagnosed ADHD who received pharmacotherapy supports this. It found that UK children were most likely of all European children to have 'a great deal of difficulty' getting referred to a specialist and getting a diagnosis, had the longest referral waits and were least likely to have ever received behavioural therapy[44].

...many young people in prison, including a history of being LACYP and/or excluded from school which may result in a lack of engagement with services that provide diagnoses

The marked levels of apparent underdiagnosis in this cohort may also be related to the well-documented 'postcode lottery' that affects provision of diagnostic services in the UK[45]. The diagnosis an individual receives remains, in many cases, determined by the services provided by their local healthcare board[46], the knowledge and biases of their parents and of gatekeepers such as teachers and GPs[47], the particular

43. Jacobson et al., *Punishing Disadvantage: A Profile of Children in Custody; Lewis and Scott-Samuel, Health Needs Assessment of Young Offenders in the Youth Justice System on Merseyside;* Oak Foundation, *Falling through the Gaps: Fragmented and Underfunded Systems Are Failing Care Leavers Who Serve Prison Sentences, in Custody and in the Community.*
44. Moshe Fridman et al., "Access to Diagnosis, Treatment, and Supportive Services among Pharmacotherapy-Treated Children/Adolescents with ADHD in Europe: Data from the Caregiver Perspective on Pediatric ADHD Survey," *Neuropsychiatric Disease and Treatment* 13 (2017): 947–958.
45. Norman Lamb, *The Autism Diagnosis Crisis: Research from Rt Hon Norman Lamb MP and the All Part Parliamentary Group on Autism Uncovers Stark Regional Variation and Long Waits for Autism Diagnosis* (London, UK, 2018).
46. Calum Ross, "NHS Grampian Accused of 'shocking' Discrimination against Adults with ADHD," *The Press and Journal,* last modified 2018, accessed January 28, 2019, https://www.pressandjournal.co.uk/fp/news/aberdeen/1512913/nhs-grampian-accused-of-shocking-discrimination-against-adults-with-adhd/.
47. Mami Miyasaka, Shogo Kajimura, and Michio Nomura, "Biases in Understanding Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder in Japan," *Frontiers in Psychology* 9, no. FEB (2018): 1–13.

specialists that are seen[48] and the ability of the individual and/or their parents to access services[49]. In particular, some less well-known conditions, such as DCD and DLD, often fail to be considered and assessments for these may be particularly difficult to access[50].

It is also possible that the apparent underdiagnosis in this cohort may, in some cases, be the result of diagnostic thresholds. Some individuals, despite having functional difficulties in a number of areas, do not reach the diagnostic threshold for any or all of the particular conditions associated with these difficulties. It is quite common, for example, for individuals with ADHD or DLD to have what is described as 'Autistic tendencies' — that is sub-threshold ASD[51]. However, diagnostic thresholds can result in inequitable provision of support and services. The cumulative pattern of challenges experienced by someone with symptoms of multiple NDDs at a sub-threshold level may be functionally more impairing than the challenges experienced by someone who meets diagnostic criteria for, and has symptoms of, a single condition only. However, without a diagnosis, individuals with sub-threshold NDDs are rarely deemed eligible for educational or medical support. Other contributing factors such as TBI, abuse experiences and family disadvantage are rarely considered when diagnosing. From clinical experience we note that 'Autistic features', for example, are commonly reported in young people with TBI histories, yet 'recovering from TBI' is not recognisable as a primary diagnosis.

Thus, the current medical and categorical approach to assessing and providing support risks only identifying and supporting those with comparatively few difficulties. This leaves those with multiple, complex difficulties, greater impairment and more negative psychosocial factors unidentified and unsupported.

It is quite common, for example, for individuals with ADHD or DLD to have what is described as 'Autistic tendencies' — that is sub-threshold ASD.

Potential misdiagnoses and diagnostic instability

This study shows that many young people in prison who have previous NDD diagnoses do not report having functional difficulties associated with that diagnosis. However, the majority of these individuals do report other functional difficulties. This raises the question of whether people are being incorrectly diagnosed — for example, are young men with ASD being misdiagnosed as having ADHD? However, it is also possible that these diagnoses were correct when they were given but that individuals' difficulties have waxed and waned over time, particularly during emerging adulthood. Although the majority of children with NDDs have lifelong symptoms, a significant minority of individuals (typically around 15-25 per cent, excepting in ASD and ID) do not continue to meet diagnostic criteria in adulthood[52].

Another possibile explanation is that adolescents and young adults with NDDs can present differently to children, resulting in them meeting diagnostic criteria in childhood but appearing not to later. This may occur due to improvement or maturation of skills, receipt of interventions in childhood, current medication status and/or greater ability to adapt or avoid situations and specific tasks they find challenging. However, these individuals may still exhibit difficulties when learning new skills, for example when an individual with DCD learns to drive[53].

A third possibility is that individuals with NDDs may have significant challenges but may not recognise this themselves. For example, adults with ADHD and adolescents and adults with TBI tend to under-report the severity of their symptoms[54]. Their diagnosis may stem from parent, teacher and/or assessor observation and assessment in childhood. This may not necessarily correspond with self-assessment of their difficulties,

48. Astle and Bathelt, "Remapping the Cognitive and Neural Profiles of Children Who Struggle at School."
49. Mickey Keenan et al., "The Experiences of Parents During Diagnosis and Forward Planning for Children with Autism Spectrum Disorder," *Journal of Applied Research in Intellectual Disabilities* 23 (2010): 390–397.
50. Cheryl Missiuna et al., "Mysteries and Mazes: Parents' Experiences of Children with Developmental Coordination Disorder.," *Canadian journal of occupational therapy* 73, no. 1 (2006): 7–17, http://www.ncbi.nlm.nih.gov/pubmed/16570837.
51. Gina Conti-Ramsden, Zoë Simkin, and Nicola Botting, "The Prevalence of Autistic Spectrum Disorders in Adolescents with a History of Specific Language Impairment (SLI)," *Journal of Child Psychology and Psychiatry and Allied Disciplines* 47, no. 6 (2006): 621–628; Jessica Leigh Green et al., "Autism Spectrum Disorder Symptoms in Children with ADHD: A Community-Based Study," *Research in Developmental Disabilities* 47 (2015): 175–184.
52. Cleaton and Kirby, "Why Do We Find It so Hard to Calculate the Burden of Neurodevelopmental Disorders?"
53. Amanda Kirby, Lisa Edwards, and David Sugden, "Emerging Adulthood in Developmental Co-Ordination Disorder: Parent and Young Adult Perspectives," *Research in Developmental Disabilities* 32, no. 4 (2011): 1351–1360.
54. Kooij et al., "Reliability, Validity, and Utility of Instruments for Self-Report and Informant Report Concerning Symptoms of ADHD in Adult Patients"; Leathem, Murphy, and Flett, "Self- and Informant-Ratings on the Patient Competency Rating Scale in Patients with Traumatic Brain Injury"; Wilson, Donders, and Nguyen, "Self and Parent Ratings of Executive Functioning after Adolescent Traumatic Brain Injury."

either in childhood or later. This emphasises the importance of collecting both self- and observer-reports of symptoms whenever possible and considering both when assessing support needs.

Potential misdiagnosis and psychosocial factors

The pattern of adversity reported in this study also demonstrates how incorrect assumptions may be made if a complete history is not taken. Of the young men with severe functional difficulties, nearly one-quarter reported experiencing at least one head injury and one-sixth reported experiencing at least one head injury with LOC. It is possible, therefore, that for some their difficulties are acquired rather than developmental. In particular, TBI may be associated with 'secondary' ADHD and may result in symptoms that mimic ASD and ID[55]. ACEs may also result in similar symptoms[56].

The finding that head injury was not significantly associated with severe functional difficulties in this cohort is unexpected. However, this may reflect the fact that head injury in young men is associated with particular combinations of severe functional difficulties — a possibility which is suggested by the data, but which could not be explored statistically due to the small numbers of young men reporting each combination of severe functional difficulties.

What are the potential consequences of a missed or misdiagnosis?

Missing or misdiagnosing NDDs has serious potential ramifications, particularly within the prison context. In particular, there is evidence that NDDs may make some individuals more vulnerable in a variety of ways — for example, to mental health difficulties, poor academic achievement and unemployment.

People with a variety of NDDs are at increased risk of various types of victimisation. Children and adults with ADHD[57], ASD[58], Dyslexia[59] and ID[60] are at increased risk of being victims of abuse and/or neglect. This association with victimisation may extend to offending. For example, people with ASD are at greater risk of being manipulated or exploited by others in order to commit crimes[61]. County Lines drug supply chains are often associated with 'cuckooing', a process whereby drug dealers take over and trade from a local person's home. This cuckooing often exploits people with ID[62].

NDDs may be associated with other types of vulnerability that affect offending, particularly when unrecognised and thus untreated. For example, individuals with ADHD are particularly vulnerable to illicit substance misuse, possibly as an attempt at self-medication[63]. However, this may result in substance use disorders, with consequences for offending and recidivism[64]. In this situation, treating the underlying ADHD is associated with reduced substance misuse

55. Babikian et al., "Chronic Aspects of Pediatric Traumatic Brain Injury: Review of the Literature"; Chang et al., "Traumatic Brain Injury in Early Childhood and Risk of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder: A Nationwide Longitudinal Study"; Compton et al., "Prevalence of Traumatic Brain Injury in Children with Attention-Deficit/Hyperactivity Disorder: A Cross-Sectional Study"; Keenan, Hall, and Marshall, "Early Head Injury and Attention-Deficit/Hyperactivity Disorder: Retrospective Cohort Study"; Yang et al., "Association of Traumatic Brain Injury in Childhood and Attention-Deficit/Hyperactivity Disorder: A Population-Based Study"; Max et al., "Predictors of Attention-Deficit/Hyperactivity Disorder Within 6 Months After Pediatric Traumatic Brain Injury"; Max et al., "Predictors of Secondary Attention-Deficit / Hyperactivity Disorder in Children and Adolescents 6 to 24 Months After Traumatic Brain Injury."
56. Van Der Kolk, "Developmental Trauma Disorder: A New Rational Diagnosis for Children with Complex Trauma Histories."
57. Adi Stern et al., "Associations between Abuse/Neglect and ADHD from Childhood to Young Adulthood: A Prospective Nationally-Representative Twin Study," Child Abuse and Neglect 81, no. January (2018): 274–285; Emel Sari Gokten et al., "Effects of Attention-Deficit/Hyperactivity Disorder on *Child Abuse and Neglect,*" *Child Abuse and Neglect* 62 (2016): 1–9, http://dx.doi.org/10.1016/j.chiabu.2016.10.007.
58. S M Brown-Lavoie, M A Viecili, and J A Weiss, "Sexual Knowledge and Victimization in Adults with Autism Spectrum Disorders," Journal of *Autism and Developmental Disorders* 44, no. 9 (2014): 2185–2196; David S Mandell et al., "The Prevalence and Correlates of Abuse among Children with Autism Served in Comprehensive Community-Based Mental Health Settings," *Child Abuse and Neglect* 29, no. 12 (2005): 1359–1372.
59. Esme Fuller-Thomson and S R Hooper, "The Association between Childhood Physical Abuse and Dyslexia: Findings from a Population-Based Study," *Journal of Interpersonal Violence* 30, no. 9 (2015): 1583–1592.
60. Gary Byrne, "Prevalence and Psychological Sequelae of Sexual Abuse among Individuals with an Intellectual Disability: A Review of the Recent Literature," *Journal of Intellectual Disabilities* 22, no. 3 (2018): 294–310, http://journals.sagepub.com/doi/10.1177/1744629517698844; Willi Horner-Johnson and Charles E Drum, "Prevalence of Maltreatment of People with Intellectual Disabilities: A Review of Recently Published Research," *Mental Retardation and Developmental Disabilities Research Reviews* 12 (2006): 57–69.
61. Payne, "Introducing Social Vulnerability and Compliance as Factors for Understanding Offending in Autism Spectrum Disorder."
62. Jack Spicer, Leah Moyle, and Ross Coomber, "The Variable and Evolving Nature of 'Cuckooing' as a Form of Criminal Exploitation in Street Level Drug Markets," *Trends in Organized Crime* (2019).
63. Gisli H Gudjonsson et al., "An Epidemiological Study of ADHD Symptoms among Young Persons and the Relationship with Cigarette Smoking, Alcohol Consumption and Illicit Drug Use," *Journal of Child Psychology and Psychiatry and Allied Disciplines* 53, no. 3 (2012): 304–312.
64. Carlos Knecht et al., "Attention-Deficit Hyperactivity Disorder (ADHD), Substance Use Disorders, and Criminality: A Difficult Problem with Complex Solutions," *International Journal of Adolescent Medicine and Health* 27, no. 2 (2015): 163–175.

relapses, improved housing status and increased employment rates[65]. These factors are also all associated with reduced recidivism[66]. It is possible that a similar approach may benefit individuals with TBI, as head injury is associated with increased risk of both developing and relapsing to substance misuse[67].

Conclusions and recommendations

In this study, the focus has been on Neurodevelopmental Disorders and Traumatic Brain Injury. However, expanding this approach and considering the interaction between multiple factors is likely to be key to equitable and effective service provision. A broader, biopsychosocial approach, rather than using a narrower, medical model, may be particularly important when working with vulnerable populations such as young people in prison, who have often experienced complex patterns of cumulative adversity. Once these factors are taken into consideration, it may be apparent that different formulations for support and intervention are required. For example, the optimal treatment of substance use disorders — a common problem among young people in prison — depends on whether the individual has co-occurring ADHD[68]. Identifying the neuropsychological components within an individual's difficulties is critical in order to understand how each component may influence a young person's presentation. In order to do this effectively and accurately, a broader and more holistic view is required, rather than the current system which separates LDDs, mental health and substance misuse and fails to consider either their interaction or additional factors.

The finding that such a high proportion of young men in prison report severe functional difficulties has implications for their management within the Justice Sector. As there are limited services and funding available, profiling and understanding patterns of cumulative adversity is essential. This will enable the right support to be targeted to those who are most vulnerable, resulting in the greatest impact on day-to-day functioning. Much discussion has focused on cause and effect, particularly the link to ACEs[69]. In reality, it is important to undertake a person-centred approach and consider the person holistically, including any potential NDDs, TBI, childhood factors and current factors. This type of approach may also save time and money in comparison to condition-specific approaches, which risk both duplicating work and missing potential support needs.

However, it is clear that screening and interventions in the Justice Sector must be combined with a whole-prison approach and greater awareness in schools and communities to maximise effectiveness. Early identification and timely, evidence-based support targeted to all functional difficulties experienced by a young person is essential to prevent cumulative adversity. In particular, there is a desperate need to comprehensively screen all LACYP and all children excluded from school, as these groups are both at increased risk of NDDs and TBI and at increased risk of offending. An integrated approach between community and forensic services is likely necessary. This will require greater in-reach of community Child and Adolescent Mental Health Services (CAMHS) into prisons to support the currently under-funded forensic CAMHS. Without these changes to both forensic and community practice, we risk leaving already vulnerable and marginalised young people at risk of further abuse, victimisation and exploitation, setting them up to fail in education, leaving them at increased risk of offending and letting them leave prison at high risk of further adversity and reoffending.

65. Berit Bihlar Muld et al., "Long-Term Outcomes of Pharmacologically Treated versus Non-Treated Adults with ADHD and Substance Use Disorder: A Naturalistic Study," *Journal of Substance Abuse Treatment* 51 (2015): 82–90, http://dx.doi.org/10.1016/j.jsat.2014.11.005.
66. Kathryn Hopkins, *The Pre-Custody Employment, Training and Education Status of Newly Sentenced Prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) Longitudinal Cohort Study of Prisoners* (London, UK, 2012); Andrew O'Hagan and Rachel Hardwick, "Behind Bars: The Truth about Drugs in Prisons," *Forensic Research & Criminology International Journal* 5, no. 3 (2017): 00158; Kim Williams, Jennifer Poyser, and Kathryn Hopkins, *Accommodation, Homelessness and Reoffending of Prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) Survey* (London, UK, 2012).
67. Steven F Merkel et al., "Factors Affecting Increased Risk for Substance Use Disorders Following Traumatic Brain Injury: What Can We Learn from Animal Models," *Neuroscience and Biobehavioral Reviews* 77 (2017): 209–218; James M Bjork and Steven J Grant, "Does Traumatic Brain Injury Increase Risk for Substance Abuse?," *Journal of Neurotrauma* 26, no. 7 (2009): 1077–1082.
68. Sean X Luo and Frances R Levin, "Towards Precision Addiction Treatment: New Findings in Co-Morbid Substance Use and Attention-Deficit Hyperactivity Disorders," *Current Psychiatry Reports* 19, no. 3 (2017): 14.
69. Baglivio et al., "The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders."

Ex-prisoners experiences of healthcare in prison and the community in Scotland

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Healthcare provision for prisoners presents unique challenges. Major health problems and behavioural-health issues linked to increased mortality and morbidity including blood borne viruses, circulatory disease, mental disorders, smoking, and substance misuse are over-represented in incarcerated groups [1] [2]. Healthcare provision has generally focussed on medical treatment of illness rather than on factors such as education, prevention, harm minimisation, sentencing diversion to avoid lengthy custodial sentences for non-violent crime, and childhood intervention to stop criminal development [3].

In Scotland, a commitment to move from a non-National Health Service (NHS), prison-based healthcare system and towards a shared Scottish Prison Service (SPS)/NHS-delivered model for incarcerated offenders was outlined in 2007[4].

The SPS and NHS now cooperate in the National Prison Health Network (NPHN), which was created with the signing of the 'National Memorandum of Understanding' document[5]. The main drivers and objectives for this partnership were to:

- reduce inequalities in health
- improve access for prisoners to NHS health care services
- provide a safe environment for the assessment and treatment of prisoners
- reduce harm and preserve life
- work with other organisations

This significant policy change, subsequently enacted in 2011, underpinned the study. Given the policy change described, and in that context, this study aimed to understand ex-prisoners' experiences of health and healthcare in prison and in the community.

The main objective and purpose of the study was to explore the healthcare experiences of males who had passed through the criminal justice system and re-joined the community in an effort to illuminate their experience of service provision from an insider perspective. The exploration and interpretation of prisoners' healthcare experiences were the focus of this study because the literature under represents works that reflect prisoners' own voices during the process of the legislative change. A desire to determine the perceived impact upon the participant group affected by policy change was a key concern underpinning this study. Failure to effectively incorporate service users' views and experiences may mean that any barriers to implementation remain unidentified and unaddressed. Any weaknesses or gaps arising from the conjunction of two large organisations, the NHS and SPS, may lead to the success of relevant policies being ultimately undermined.

Methodology

A qualitative, phenomenological study using interpretive phenomenology[6] was performed which utilised participants' narratives of their healthcare experiences as the source of data. Their stories were obtained using semi-structured interviews.

NHS Tayside serves a population a population of approximately 415,000 and is composed of the councils of Angus, the City of Dundee and Perth and Kinross[7]. It is a region which has urban and rural areas. The major population centres are the cities of Dundee and Perth. There are two prisons with Tayside; the closed secure prison at Perth (678 prisoners) and the only open prison in Scotland at Castle Huntly (285 prisoners) located

1. Tayler, F. (1997) 'Promoting health in prisons', Prison Service Journal., (November), pp. 18-19.
2. Graham, L. P. (2007) Prison health in Scotland: A health care needs assessment.. Edinburgh: Scottish Prison Service.
3. Marshall, T., Simpson, S. and Stevens, A. (2000) Health care in prisons: *A health care needs assessment*. University of Birmingham.
4. Scottish Government. (2007) *Potential transfer of enhanced primary healthcare services to the NHS. Report to cabinet secretaries for health and wellbeing, and justice.* Available at: http://www.scotland.gov.uk/Resource/Doc/924/0063020.pdf; (Accessed: 7 October 2019)
5. Scottish Government. (2011) National memorandum of understanding between the Scottish Ministers, acting through the Scottish Prison Service and NHS Scotland. Available at: http://www.scottish.parliament.uk/S4_JusticeCommittee/Inquiries/20130226__FINAL_revised_MOU_Prison_Healthcare_HIS_December_2012.pdf (Accessed: 7 October 2019)
6. Heidegger, M. (1962) Being and time. New York: Harper and Row.
7. NHS Tayside. (2017) Director of Public Health 2016/17 Annual Report. Available at: https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_284941&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1 (Accessed: 7 October 2019)

outside Dundee. While participants had served time in prisons across Scotland, all had been housed in one of the two in Tayside prior to their release.

Participants were recruited within the Tayside region via three centres; a GP practice in Perth and health centre and substance misuse service centre in Dundee. In this study a purposive sample with inclusion/exclusion criteria was utilised. This was appropriate as purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest; which in this study was the healthcare of ex-prisoners[8]. The inclusion criteria for participants were that they were males over the age of 18 years and had served a prison sentence greater than three months within a prison in Scotland. Excluded from the study were females, anyone under 18 years of age and those that had not served a sentence of at least three months within a Scottish prison.

It should be noted that all participants had served sentences in more than one prison within Scotland so had experienced healthcare within different prisons. All of them had also been convicted and served sentences before and after 2011 which, from their experiences, allowed grounds for making pre-post 2011 comparisons within the research.

Ethical approval to conduct the study was obtained from the ethics committees of Abertay University and East of Scotland Research Ethics Service (Part of NHS Scotland).

Participants' had to give written consent to participate, to record the interviews and for their quotations to be used pseudonymously within any related publications. Participants were also advised that they should not divulge any material about any criminal activities as this would be passed on to the relevant authorities.

Recruitment centre managers were given details of the study including inclusion criteria. Potential participants were identified in the GP practice and health centre by the GP personally using the NHS computerised patient's records system while the substance misuse service used their initial assessment process documents. Potentially eligible participants were provided with study information including a contact phone number for the researcher.

Semi-structured interviews were used for collecting data between April 2014 and April 2015. Prior to commencement, participants were given the opportunity to answer any remaining questions about the study and provided written informed consent. Interviews are most effective for qualitative research and questions were open-ended so that in-depth information was collected[9]. A semi- structured interview schedule was utilised with the main questions. The order of the questions varied depending upon the participant and their individual experiences. Interviews lasted approximately one hour.

Interviews were audio-recorded if consent was given to do so; and contemporary written notes taken where consent for audio-recording not given. Audio tapes were transcribed verbatim with the transcriptions creating the text for analysis together with written notes. Recordings and transcripts were kept securely on a password protected University computer drive.

Some of the participants experienced being treated like 'second class citizens.' Not only do the participants belong to a vulnerable group, but a number also expressed feeling isolated

The meaning of health.

The participants had all expected that the prison and community healthcare systems would provide the necessary care and help to maintain their health when required. However, their experiences did not correspond with their initial expectations. Participants experienced health predominantly as a physical phenomenon related to their ability to function physically in the world. Mental ill health had been experienced by participants and was spoken about in terms of stigma and ensuring/maintaining personal safety.

Some of the participants experienced being treated like 'second class citizens.' Not only do the participants belong to a vulnerable group, but a number also expressed feeling isolated, especially upon liberation, when they have to live with the effects of the labelling and stigma, which society places on ex-prisoners. This has affected their self-esteem.

Participants were very aware of the stigma that was attached to those who had served a prison sentence and felt that they were treated like second-class citizens, which also occurred within the healthcare

8. Lavrakas, P.J. (2008) Encyclopedia of Survey Research Methods. Thousand Oaks CA: Sage Publications.
9. Alshenqeeti, H. (2014) 'Interviewing as a Data Collection Method: A Critical Review', English Linguistics Research, 3(1), pp. 39-45.

establishments in the outside community. In particular, shortcomings from the Criminal Justice as well as the healthcare systems have not minimised the effects of labelling and stigma, which has exacerbated the barriers experienced in relation to accessing healthcare in the outside community following liberation. Contributing experiences include the use of handcuffs on participants while they were being escorted to healthcare facilities outside the prison during their time of incarceration, which not only enhanced stigma, but also caused pain and discomfort.

The care required is not being experienced as forthcoming by the participants. Participants experienced having little power, control or choice about their care within the prison. However, in the outside community they still perceived that they had limited control over certain situations; for example, when collecting their Methadone prescriptions from the pharmacy. This harms their self- esteem. As a result of exacerbated power dynamics, offenders struggle to assert choices in relation to their healthcare, as they face difficulties in negotiating care/treatment with healthcare professionals. It is interesting that the document Your health, your rights The Charter of Patient Rights and Responsibilities states: 'Communication and participation: the right to be informed, and involved in decisions, about health care and services '[10]. This document also detailed patients' rights to access of services, communication and participation in their care and treatment, confidentiality of personal health information, right to be treated as an individual with dignity and respect, the right to safe and effective care and to give feedback, make comments, or raise concerns or complaints about the health care they receive. This applies to all patients served by the NHS in Scotland regardless of their status in society and, therefore, should include those in prison. However, it would appear that prisoners are not involved in healthcare service decisions and it is with this point in mind that this study was performed.

Participants gave differing accounts of their experiences within the prison healthcare system, which may help to account for the mixed reactions and expectations towards the new SPS/NHS healthcare partnership and the impact that it could possibly make upon their health within the prison. The participants' had experiences of times when they had felt their health was poor and that their expectations of care and treatment had not been met. Consequently, many had made official complaints about their care. Many had experienced having had to make use of complaints procedures and indicated that this was a difficult to use. Hereafter, the complaints would not be dealt with seriously, as experienced by slow processing times and unsatisfactory replies/resolutions. In an effort to legitimise their complaints and bring about faster responses and satisfactory resolutions, many participants saw no other option than to have a lawyer to make the complaint on their behalf.

...being escorted to healthcare facilities outside the prison during their time of incarceration, which not only enhanced stigma, but also caused pain and discomfort.

Access to healthcare in prison and community.

Accessing healthcare services was a difficult experience for participants. There were problems with gaining access to healthcare services that caused participants to experience a lot of anger and frustration particularly with regard to waiting times.

Problems were experienced regarding medication and the prescribing practices of doctors, which were a source of discontent. Medication was talked of in terms of a currency and participants experienced difficulty in storing it in their cells along with the threat to their safety that was caused by bullying and the trade in medication. In order to prevent this, participants experienced various strategies such as supervised medications, medication checks and cell searches which were performed by staff, yet with limited effect.

Participants had experienced little health education/promotion within the prison. This is in contrast to the Scottish Governments plan presented in the document Your health, your rights The Charter of Patient Rights and Responsibilities[11] to build a 'Health Promoting Health Service' in which one of its purposes was to 'Help people to sustain and improve their health, especially in disadvantaged communities'. This was also meant to include offenders and ex-offenders as they are specifically mentioned in the document.

The participants also gave accounts that they had not experienced this within the outside community

10. Scottish Prison Service. (2012) Scottish Prison Service Corporate Plan 2012-15. Available at: http://www.sps.gov.uk/Corporate/Publications/Corporate6.aspx (Accessed: 7 October 2019)
11. ibid

either. Participants' also gave accounts that their experience of accessing healthcare services in prison was a difficult and frustrating process that was controlled by nurses whose attitudes and use of power were perceived as a major factor in prisoners being able to access and use the services available. All of the participants gave accounts of situations that reflected experience of a high level of mistrust in them and the issues surrounding their health status as a result of the phenomenon known as the credibility gap. This appears to have an impact upon their ability to access health care whilst in prison and the outside community.

The obfuscatory organisation.

Participants observed a lack of health service provision after office hours and they seemed to believe this had become more noticeable since the change in primary healthcare provision in November 2011. Out of hours healthcare is dependent upon the knowledge, skills and experience of the prison officer on duty. However, as the need for medical attention can arise at any time, this can result in inadequate handling of situations, especially when these occur outwith the general working hours of the more experienced and knowledgeable staff members. Due to this, participants have experienced mistakes having been made, which had resulted in unnecessary suffering for prisoners with painful conditions. Participants stated that serious conditions during 'out of hours' would see the prisoner transferred to a local hospital for assessment and appropriate treatment but delays can occur with this process. The transfer of prisoners to hospital appointments was a topic that aroused a lot of emotion amongst all the participants. Through their accounts, the ethical issues of privacy and confidentiality were highlighted when consulting with a specialist doctor at a hospital outpatient department. Participants voiced that G4S, the company responsible for all prisoner transfers (GEOAmey took over this function in January 2019), did not appear to have a proper assessment protocol or policy for the use of handcuffs during these consultations. Participants noticed that within the prison, the movement of prisoners to the health centre is the responsibility of the prison officers. As a result, participants seemed to believe that the officers are responsible for whether a prisoner attends their healthcare appointment or not.

Out of hours healthcare is dependent upon the knowledge, skills and experience of the prison officer on duty.

Prisoners' medication checks have been a feature of the prison routine for a number of years. Participants perceived a difference in this part of the prison routine following November 2011. This may be due to the different power and authority afforded to nurses within the prison. As nurses had their contracts of employment transferred to the NHS, they lost the authority they had under their previous SPS employment; namely the authority to check a prisoner's medication use and storage. Participants also voiced that the old process of accessing healthcare via the 'sick parade' had changed.

Participants expressed an awareness of access to health services becoming increasingly bureaucratic as it was now burdened with filling out forms. This disadvantaged and discouraged prisoners with literacy difficulties. Following November 2011, there were now separate complaints procedures for the SPS and NHS. Participants expressed the belief that these were not explained and appeared to be designed in a way to discourage and delay complaints being made.

Participants expressed that the access arrangements put in place to provide them with appointments appeared bureaucratic, slow and, it was reported that designed to discourage prisoners from accessing the healthcare services.

Vulnerability and hope.

There were a number of factors that participants had experienced, which they stated contributed to their feelings of vulnerability. The substance misuse services were explained to be inconsistent in their delivery of services. This was said to have an overall demotivating effect upon participants.

The role of the family and the support that they provide following liberation was stated to be important as it provided emotional support and helped to prevent relapsing into former health threatening behaviours. It could also help prevent men from becoming embroiled in the pattern of prison and liberty known as 'the revolving door,' which can be difficult to escape. The family was also a valuable resource as it provided accommodation and a permanent address, which was essential to access a number of healthcare services and benefits.

Participants voiced the importance of a job as a source of physical exercise and mental stimulation. However, it also provided them with an income, which helped prevent them from selling their medication in exchange for other goods or to pay off debts. Lack of an income within prison can lead to an accumulation of debt, which can have an impact upon the lives of

prisoners, including additional labelling practices which impede healthcare access.

Planned, consistent throughcare and opportunities, especially those from the third-party sector, were voiced as helpful. These opportunities equipped participants with new knowledge and skills which allowed them to explore their lives, gave them confidence to make choices and move forward in a healthy manner.

The men expressed hope for the future, not only for themselves but also for the future generations. They expressed genuine hopes and beliefs regarding the possibility that an integration of education, particularly health education, would help prevent the mistakes they had made in their lives from being repeated by the younger generations. Finally, it was found that effective healthcare provision can contribute to hope and successful reintegration into the outside community post liberation.

Discussion

In the UK, responsibility for secondary healthcare i.e., that requiring hospital facilities provision for prisoners has typically resided with the NHS, responsibility for primary care provision in Scottish prisons lay with the SPS until November 1, 2011 at which point the 'National Memorandum of Understanding' document brought the situation into line with the rest of the UK. This change of responsibility created a situation where two large organisations; the SPS and the NHS, are responsible for prisoners healthcare. It is worth noting that the SPS are responsible for custody as well as having a duty of care to prisoners within the SPS estate but the NHS has the responsibility for providing healthcare services for the offender, regardless of whether they are in prison or the community. In the context of the above national policy changes, the focus of this study was to explore prisoners' experiences of healthcare in and out of prison.

The SPS, established in 1993, is an agency of the Scottish Government. The SPS Corporate plan for 2012 to 2015[12] states that the priorities of the SPS are Custody, Order, Care and Opportunities. This serves to illustrate that the major discourse within the SPS is that of security which is in stark contrast to that of healthcare within the NHS. The exception to this being the forensic services within the NHS where there is a strong risk discourse and a dual care/containment focus The SPS now collaborates with the NHS in the NPHN, which was created with the signing of the 'National Memorandum of Understanding' document. The objectives for this partnership were:

- reducing inequalities in health
- improve access for prisoners to NHS health care services
- provide a safe environment for the assessment and treatment of prisoners
- reduce harm and preserve life
- work with other community and healthcare services.

This document was of considerable significance as it set out the particular roles of the SPS and the NHS Health Boards in Scotland in providing primary healthcare for prisoners within the SPS estates. However, with many partnerships, there are difficulties setting common goals such as which health issues to address, responsibilities for harm reduction, information gathering and environments for health assessment and treatment. This is more difficult when the two organisations involved have different agendas; the NHS being primarily focussed on health and illness while the SPS on security. Failure of this partnership to work effectively, theoretically means prisoners may receive less equitable care to that of the general population and potentially could defeat the purpose of the shift of responsibility for healthcare in the first place.

Finally, it was found that effective healthcare provision can contribute to hope and successful reintegration into the outside community post liberation.

A literature review identified that there is a dearth of relevant literature about male prisoners own views about their involvement in health services and they are rarely asked their opinion or given much choice regarding the services they require. To date there has been no study in Scotland that has explored ex-prisoners' healthcare experiences in prison and the community using their accounts. The study presented here was not interested in generalisations; rather, it was interested in gaining insights through accounts or versions of experience. The participants gave their experiential accounts that raised the themes presented. These themes help to illuminate the way the participants experienced the healthcare system.

12. Scottish Government. (2012) Your health, your rights The Charter of Patient Rights and Responsibilities. Edinburgh: Scottish Government. Available at: https://www.ohb.scot.nhs.uk/sites/default/files/publications/Charter%20of%20Patients%20Rights%20and%20Responsibilities.PDF (Accessed: 7 October 2019)

There were studies[13] [14] [15] that, while looking at specific service provision and outcomes, took patients' overall experiences of the healthcare system into account. Although these studies were conducted within the UK, they were all performed in England where the NHS responsibility for prisoner healthcare took place six years before it happened in Scotland. The vast majority of studies were conducted within the prison environment and looked at primary care provided by doctors and nurses, mental health or addiction services. However, only three studies interviewed offenders about their experiences inside and outside of the prison; the first looked at the resettlement needs of women offenders in the UK[16], the second explored the help seeking behaviour in men in UK[17] and the third studied the care given to those with HIV after liberation in the USA[18].

This study, specifically exploring offenders' healthcare experiences, is the first to have been performed in the UK since 2012 and certainly the only one that has taken a phenomenological approach. It is also the only study that explored the offenders' use and experience of other health services such as dentist, optician, chiropody and physiotherapy in the prison or community.

Conclusion

The NHS does not appear to be a flexible service and appears to be trying to fit the needs of prison patients into a service that is primarily designed for the wider public. The NHS is trying to get the 'patient to fit the service' rather than the 'service to fit the patient'. As a result, as a healthcare organisation it needs to look at the way it conducts its business within the secondary setting of prison.

While in prison there is opportunity for the health care services to do something different compared to the community. Prison healthcare can help those that are 'marginalised' if it 'engages with patients' as it can get them into treatment whether this is primary care, dental, mental, substance misuse, etc. There is also a need for a rapid response team in order to give easier access to care. This needs to be followed up with case conferences to review prisoners' care on a regular basis. In addition, Throughcare Support Officers are a new initiative which can provide valuable support for accommodation, continuity of healthcare upon liberation for example hospital and social work appointments. There is a need to link healthcare with social care to ensure a more holistic approach to care for the marginalised and disenfranchised.

Participants also raised the issues of their medication changing when they transferred between prisons, a lack of communication between the prison and community regarding medication at liberation and that different detoxification regimes were used at different prisons. There is a need for the National Prisoner Health Network to communicate and work with the SPS and NHS to address the varying care approaches and policies utilised within different prisons in an effort to try to minimise these issues.

One area that is in need of scrutiny is the complaints procedure within prison as prisoners are a litigious group and will complain when they are not listened to or informed about their care. At present, there are two systems, which are bureaucratic and confusing; one for the matters dealt with by the SPS and another for healthcare dealt with by the NHS. The NHS patient complaints system in particular needs reform. Complaints need to be dealt with by staff experienced in dealing with them as at present a lot of this burden is placed upon nurses. There is a need for a greater level of transparency of decision making in healthcare, for example, staff need to inform patients' why they are getting a certain treatment or not getting it, whatever the case may be.

Participants in this study frequently voiced difficulties that they had experienced with community healthcare services such as registering with GP surgeries and hostile attitudes with pharmacies. This implies that there needs to be a greater understanding and awareness of liberated prisoners' needs and the difficulties that they face within the community care services in an effort to minimise disruption to the continuity of their care. This could be facilitated by dissemination of information and educational strategies within each community health care trust.

The overriding conclusion to this study is that the participants' experiences of healthcare differ from the policy objectives of the UK and Scottish Governments19, NHS20 and SPS21 with particular reference to equity of service provision, health promotion and education, prisoner involvement with their care, and additionally links with the community and public sector.

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19. See note 4.
20. See note 10.
21. See note 5.

Reviews

Book Review

Life Imprisonment from Young Adulthood. Adaptation, Identity and Time

By Ben Crewe, Susie Hulley and Serena Wright

Publisher: Palgrave Macmillan
ISBN: 978-1-137-56600-3 (Hardback)
Price: £79.99 (Hardback) £63.99 (e-book)

As the above title suggests, *Life Imprisonment from Young Adulthood* is an account of the experiences of men and women who were given long life sentences at an early age. In particular it questions 'how they cope with its burdens, how they deal with issues of selfhood and meaning and how they establish a social lifeworld within a carceral environment' (p. 2). Written in an incredibly fluent and engaging way, the book, as stated in the Foreword by Erwin James, a man who has himself served 20 years in prison as part of his life sentence, challenges public perceptions of prison against the reality of life imprisonment. Rather than it being from an academic or practitioner viewpoint however, the book offers the voice of those who are currently serving the longest sentences in prisons in England and Wales.

The book starts with a useful introduction which provides not just an extensive literature review on the topic but also sets the contextual frame for what follows. So, for example in 1968 there were only 489 prisoners serving life or equivalent sentences in prison in England and Wales. In 1979 this had risen to 1,322, stood at nearly 2,000 by the end of the 1980s and had reached 7,046 by 2019. Time served in custody has also increased: in 2003 the average minimum term (excluding whole life) was 12.5 years with this increasing to 21.1 years just a decade later. The lifer population has therefore massively increased with many of these prisoners receiving such sentences when in young adulthood. For the purposes of the book, the voices of those found in the text are those who received a life sentence with a tariff of at least 15 years when they were aged 25 years or less. In chapter 2 we are told how at the time of the study there were 808 prisoners who met this criteria. Between February 2013 and December 2014, 309 men and 21 women, across 25 prisons took part in the study. The chapter also looks at a number of issues such as how access to the prisoners was achieved, issues relating to ethics, research design and details about the interviews and survey questions. In addition to introducing the research, chapter 2 is also an excellent resource for those carrying out similar research and I would especially recommend it to PhD students embarking on empirical projects.

Before embarking on sharing the generalised data, chapter 3 provides pen portraits of six individual participants. While there are many, many more voices in the book, this chapter is really interesting because it allows the reader to understand the life histories of these individuals. Selected to cover the range of participants in the study, taking into account sentence stage, gender, ethnicity and attitudes towards conviction, we learn how Seb (20s, early stage) was excluded from school, moved out of the family home in his late teens and had a history of drug-use. Gail (30s, late-stage) like many of the women in the book had a childhood marred with violence and abuse, while Campbell (30s, mid-stage) was convicted of murder under the principles of joint enterprise. Interestingly half of these individuals were convicted on the basis of joint enterprise, which is representative of the larger sample.

Chapters 4-8 then present the main findings of the research. Chapter 4 — the early years- talks about 'biographical rupture', where the 'sheer length of the sentence and the enormity of the offence compounded and intensified the standard 'pains' of imprisonment' (p. 79) resulting in 'some distinctive adaptive responses' (p. 79). The chapter through the voices of the participants talks about the initial entry shock, the acute stress reaction when they received a life sentence and the pains of serving a long indeterminate sentence. In sometimes harrowing detail, the participants talk about PTSD, recurring nightmares, losing contact with family and loved ones, how substances were used in the early years 'to kill reality' (p. 103) and their attempts at suicide, which were made to relieve not just themselves but also their families and friends. Chapter 5 — Coping and Adaption — then moves to describe how the participants change as they move through their life sentence. Rather than living with shock, denial and anger, the chapter, again through candid quotes, shows how the participants start to 'survive' and swim rather than sink. Coping strategies employed by some of the participants include becoming a Listener, completing accredited offending and education programmes and how life became a little easier when they were housed with other lifers. Others

speak about the 'emotional and spiritual journey' (p. 133) which helped them to come to terms with their situation and cope better with being imprisoned for such long periods of time. As time went by, more prisoners were thus reconciled with the 'permanence of their circumstances' (p. 136). However, even though at this mid-stage point many had come to terms with the sentence, they hadn't come to terms with what they had actually done. As one participant explains: 'I killed someone. How can anyone ever come to terms with that type of offence' (p.137). The chapter also touches on victim awareness activities and the therapeutic community at HMP Grendon. In short, the chapter shows how prisoners moved from 'coping survival' to 'coping-adaptation' (p. 154), with the latter achieved through the regaining of control, hope and purpose.

Chapter 6 — Social relations — looks at the changing nature of friendship and kinship relationships experienced by long term prisoners. Perhaps not surprisingly, 'separation from loved ones and close friends was among the most painful aspect of long-term imprisonment' (p. 210). This included missing people, worrying about people outside, worrying that you are losing contact with people and concerned that a loved one would die before release. The chapter, as with others, offers insightful quotes and interestingly shows a difference between men and women, especially in relation to women and their children and the desire to stay in contact with and have a meaningful say in their children's lives. For the men, it was more about being 'a better son' (p. 224). The chapter also explores friendship, with many participants experiencing the loss of good friends on the outside and for some the deepening of friendships on the inside. Chapter 7 looks at how identity and selfhood changes for those serving long-term imprisonment, including 'losing themselves' (p. 253), dealing with the label of 'murderer', a renarration of themselves and finally for some becoming 'a better and more 'authentic' person: the real me!' (p. 252). The final substantive chapter then looks at time and place and in particular, how the participants managed and defined these concepts during their sentence. This included 'temporal vertigo' (p. 291) for those at the beginning of their sentence with many expressing an inability to look much beyond today and a feeling that prison was 'dead time' (p. 302). There was also a need to 'kill time' (p. 302) whether that was done through sleeping, drugs, education, exercise or reading. As the sentence progressed, some participants began to see prison as home and were able to see time in bigger blocks whether that be in 'sport seasons' or 'seasonal patterns' (p. 305). Mid-late stage prisoners also used significant target points to map time such as the halfway stage or the sentence length being in 'single figures' (p. 306). The participants at this stage of their sentence also reported being involved in activities because of the desire to be involved, rather than just to kill time. Many also noted how they had matured while in prison, although also said how at the same time they had stood still when compared to friends and family on the outside. Time then took on a new urgency for those prisoners nearing release.

The book ends with an insightful and interesting conclusion chapter. Its thesis, I think, can be summed up in the following quote:

> *While prisoners in the early sentence stage were, in effect, treading water, being passively carried by the tide, or trying to swim against its flow, those who were further into their sentence accepted that they would not escape the water. Instead they submitted to the current, while at the same time seeking to use its energy to their advantage (p. 326).*

The book is highly recommended. I really enjoyed it and learnt a lot from the voices of the participants. It will be useful for academics, undergraduate and postgraduate students, penal practitioners and those interested in our penal system and in particular our prisons. It should also be mandatory reading for those who set minimum life sentence tariffs, politicians (especially the current government who seem to be keeping populist punitiveness ever more alive) and all those who think that our prisons are like holiday camps.

Professor Karen Harrison,
University of Lincoln.

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