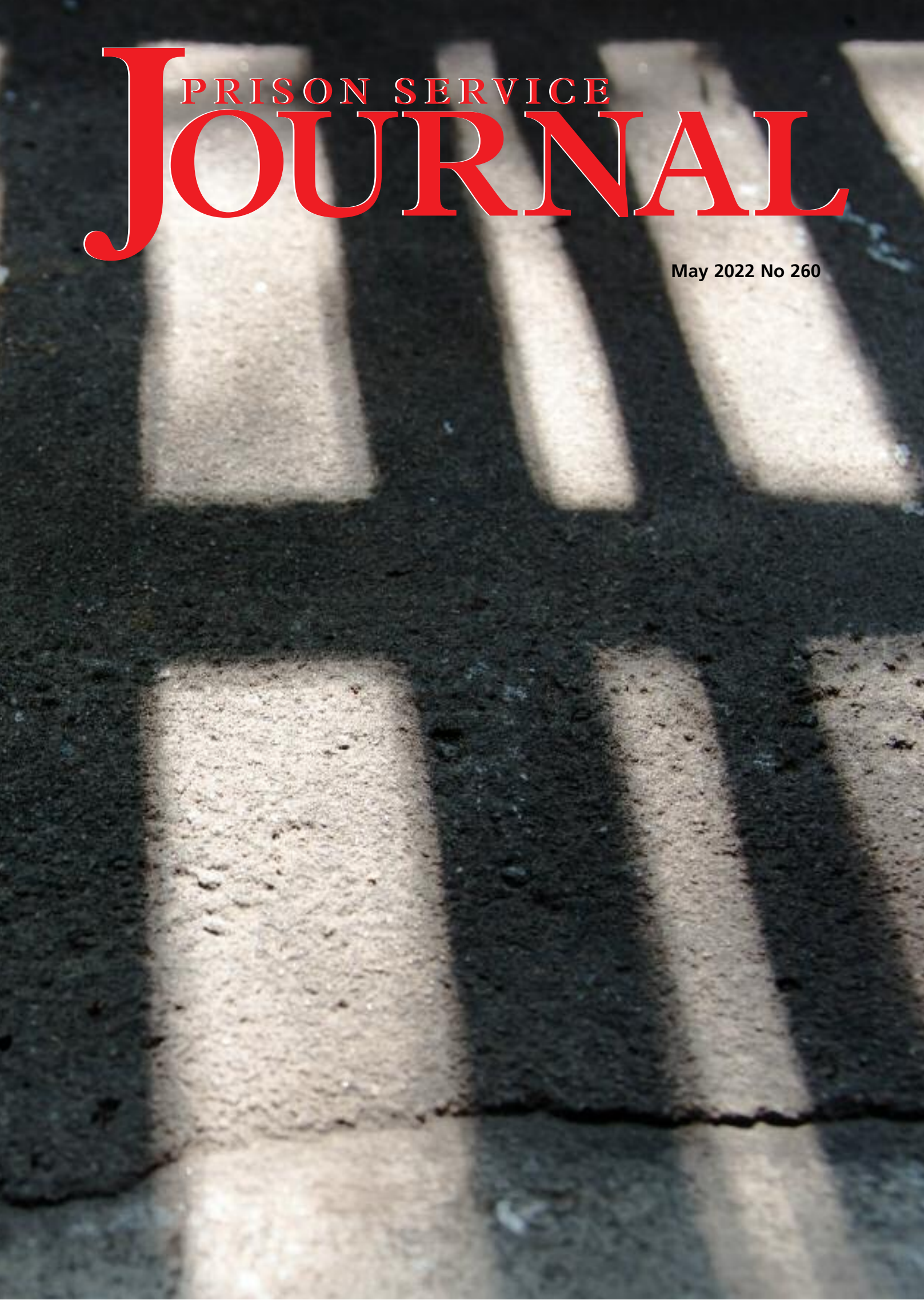

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Editorial Comment

This first edition of a new editorial era is typically full of articles that have already been expertly curated by the previous incumbent. As per usual they are diverse and offer much to our readership's interests in prisons and life through and beyond the prison gates.

We start this edition with an article by Professor Roy King and Doctor Lucy Willmott from the Institute of Criminology in Cambridge. They draw on an extensive array of interviews that they have conducted for their recently published book, 'The Honest Politicians guide to prisons and probation'.[1] Their subjects are those with influence from the time of the Strangeways riots and include Home and Justice secretaries; Junior ministers; Lord Chief Justices; Chief Executives of the various guises of the Prison and Probation Services; and a selection of Chief Inspectors of the same. King and Willmott concentrate this paper on the effects on prisons and pepper their way of explaining the 'truth' about prisons and probation with insightful quotes from their interviews.

The next three articles then all cover efforts to improve conditions in today's prisons. Doctor Katherine Doolin and Doctor Kate Gooch explore in depth the issues around the growing levels of prison violence directed at staff in the UK. Violence against prison staff is often overlooked in academic scrutiny, with violence directed at or between prisoners garnering more interest. However, staff cannot withdraw their presence to protect themselves, as absence in this way only increases the likelihood of more violence. Megan Georgiou examines mental healthcare delivery during the pandemic. Georgiou has closely reviewed forty-four inspections completed by Her Majesty's Inspectorate of Prisons during this period, which exposed new challenges, opportunities and existing inadequacies. On a similar theme of Healthcare in prisons, Mark Langridge and Sarah Bromley outline their study of the use of an easily dispersed buprenorphine medication for use in opioid substitution therapy in prisons. The trial they describe helps overcome the issues around using buprenorphine tablets that take time to dissolve and then can be easily diverted or the issuing of methadone or abstinence which are all less than ideal options.

The final two articles have a focus on experiences through the prison gate. Dr Helen Wakeling, firstly with colleagues, explores the risk factors for drug related deaths following release from prison and how those who care for prisoners on release may potentially intervene and encourage uptake of treatment post release. In the next article the prolific researcher Wakeling presents the results of a qualitative study with men who have sexually reoffended. Very little desistance research has focused on this group, who, despite public opinion, have a comparatively low reoffending rate. She highlights implications for practice and reintegration in society more widely.

This edition concludes with two interviews. Firstly, Carwyn Jones, the former First Minister of Wales is interviewed by Professor Karen Harrison. The interview covers the unique position Wales adopts in criminal justice both compared to the other countries of the United Kingdom besides England and in terms of the principality's unique needs in this respect. Secondly, Simon Shepherd, Director of the Butler Trust, is interviewed by Dr Jamie Bennett. Shepherd and the charity are advocates for all the good practice that goes on in prisons. The interview focuses primarily on the thoughts behind the newly formed Ruth Mann and Kathy Biggar Trophies and how the good practice of the winners is being disseminated.

This edition offers wide ranging material, intended to stimulate discussion and debate about contemporary penal practices and the wider criminal justice system.

1. King, R. D. and Willmott, L. (2022) *The Honest Politicians Guide to Prisons and Probation*, London, Routledge

The Truth about Prisons and Probation

Roy King *is Professor Emeritus (Wales) and Hon Senior Research Fellow, Institute of Criminology, Cambridge.*
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We trained hard—but it seemed that every time we were beginning to form up into teams we were reorganised. I was to learn later in life that we tend to meet any new situation by reorganising, and what a wonderful method it can be for creating the illusion of progress while actually producing confusion, inefficiency, and demoralisation.

Petronius.

Whether or not this was correctly attributed to Gaius Petronius Arbiter (there are other, more modern, attributions), it could be a conclusion with which the Directors of Prisons and Probation over the last 30 years would readily agree. Petronius, out of favour with Emperor Nero, anticipated his likely fate by committing suicide. Many Directors of Services and some ostensibly independent Chief Inspectors of Prisons, who spoke out, privately or publicly, about the effects of Government policies, were either sacked or forced to fall upon their metaphorical swords.

Over the last three years we have tried to understand how and why our prisons and probation services have lurched from one crisis to another since the roof-top protests and riots at Strangeways and elsewhere in 1990 until the General Election in 2019. In the research for our book *The Honest Politician's Guide to Prisons and Probation*[1] we interviewed all surviving Home Secretaries (David Waddington, who was Home Secretary at the time of the riots predeceased our research) and Justice Secretaries who had overall responsibility for prisons and probation in each of the governments: Conservatives from 1990 to 1997, New Labour until 2010, the Coalition until 2015 and the Conservatives again from 2015 to 2019. We also interviewed many of their Junior Ministers who had delegated responsibilities in these areas. Our aim was to discover, from their own words, what they thought they brought to the task, why they did what they did and their reflections on how and why it worked or failed to work. To find out about the effects on the prison and probation services we interviewed most of the Director Generals or Chief Executives of the Prison Service, the National Offender Management Service, and Her Majesty's Prison and Probation Service as well as several Chief Inspectors of Prisons and Probation. Finally, to enable us better to understand the sentencing policies in relation to prisons and probation, we interviewed the four most recently retired Lord Chief Justices.

In the limited confines of this paper we concentrate more on the effects on prisons, with the intention of writing more on the impact on probation elsewhere, and we can discuss just a few of the matters that have led us to our conclusions. All quotations, unless otherwise stated, are taken from our interviews.

Setting the Scene

Our story begins with the remarkable consensus among politicians, practitioners, penal reformers and academic commentators that had been generated around the report on the riots at Strangeways and elsewhere by Lord Woolf. Kenneth Baker, who had succeeded David Waddington as Home Secretary, embraced the report with enthusiasm. His White Paper *Custody, Care and Justice*[2] was intended to '*chart the direction of the prison service for the rest of the century and beyond*'[3]. Unfortunately, the White Paper failed to endorse Woolf's 7th recommendation — to create a rule '*that no establishment should hold more prisoners than is provided for in its certified normal level of occupation*'[4]. Joe Pilling, then the Director General of the Prison Service, told us that such a rule was '*an indispensable precondition of sustained and universal improvement in prison conditions*' — a view which we think was shared by all of his successors. Woolf's 6th recommendation for a national system of legally enforceable accredited standards, was also '*conveniently shelved*' according to Peter Dawson, now

1. King, R. D. and Willmott, L. (2022) *The Honest Politicians Guide to Prisons and Probation*, London, Routledge
2. Home Office (1991) *Custody, care and justice: the way ahead for the Prison Service in England and Wales* (Cm 1647) London, HMSO.
3. Hansard, HC 25.9.91
4. Woolf Report (1991) *Prison Disturbances April 1990*, Report of an Inquiry by the Rt. Hon. Lord Chief Justice (Parts. I and II) and His Honour Judge Stephen Tumim (Part II) Cm 1456, London, HMSO. Para 1.167

the Director of Prison Reform Trust following a distinguished career in the Home Office, including periods as an operational prison governor and sometime member of the Prisons Board. Richard Tilt, the first prison governor to become Director General of the service, told us that although senior managers argued '*long and hard*' for a code of standards they '*were always blocked by the Treasury*' for whom it offered too many hostages to fortune. The consensus did not last.

The killing of Jamie Bulger in February1993 by two ten-year old boys (shamefully tried in an adult court amid a blaze of publicity) was, in the words of Peter Lloyd, Junior Minister at the time, '*the shadow that eclipsed much of the Woolf agenda*'. Prime Minister John Major delivered himself of the statement that '*society needs to condemn a little more and understand a little less*' and future Prime Minister Tony Blair coined his mantra '*tough on crime ... tough on the causes of crime*'. But no Minister or Opposition spokesman made it clear that such events were extremely rare and that the risks of becoming victims of serious crime were low. Instead, as Ken Clarke who succeeded Baker as Home Secretary and was later in charge again as Lord Chancellor and Secretary of State for Justice, put it to us, ministers on both sides of the political spectrum '*played to the gallery*' and raised completely unrealistic expectations of what a criminal justice system could do. He particularly had in mind his own successor at the Home Office, Michael Howard, and David Blunkett, the second New Labour holder of the post — but there were certainly others. High profile crimes, especially if committed by offenders under supervision by the probation service, produced knee jerk responses to increase the length of sentences, reduce the time spent on parole, or to impose ever more stringent conditions attached to community sentences. Over the period covered by our review the prison population increased from some 42,000, which most well-informed observers regarded as already too high, to over 80,000 and the probation service was substantially changed from a helping profession to become an arm of law enforcement.

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Sentencing Policy, State Relations and the Ratchet Effect

The starting point for our attempt to understand the truth about prisons and probation is the interdependent relationships across the Executive, Parliament, the Judiciary and the Press. It is within this increasingly fragile constitutional milieu that sentencing policies are initiated, debated, enacted, brought into force, interpreted and amended *ad infinitum*. It is a process in which the executive, often responding to headlines in the tabloids, and sometimes to 'celebrity' victims, has sought to by-pass or ignore the other pillars of the state. At times the very basis of our democracy was put under stress. At times the Executive used so-called Henry VIIIth powers — clauses in an Act enabling Ministers to amend the legislation unilaterally through Statutory Instruments, making it much harder for Parliament to give effective scrutiny. At other times they failed to consult the Judiciary on constitutional changes, particularly under New Labour, regarding the role of the Lord Chancellor. Conservative Liz Truss, during her short time as Lord Chancellor in 2016-17, was slow to uphold judicial independence when Judges were attacked by the *Daily Mail* in banner headlines as 'ENEMIES OF THE PEOPLE'[5]. In the period under review we have seen both a marked decline in the restraining influence of expert career civil servants, as Ministers preferred to listen to the advice of their political special advisors (SpAds), and the loss of a more independent role of the old-style Lord Chancellor. What has emerged is not a criminal justice policy with a well thought through philosophical underpinning and based on evidence, but an ad hoc series of reactions to events. These have had a ratchet effect on sentencing and thus on the structure and size of the prison population, and on the nature of probation work and the size of their caseloads. Rather like global warming it will require a clear recognition of the folly of existing policies if it is to be reversed. As Peter Dawson put it in regard to the length of prison sentences '*you can push it up but it's very hard to pull it back down*'.

5. *Daily Mail* 4th November 2016. The occasion was when the Appeal Court, comprising LCJ Thomas, Master of the Rolls, Sir Terence Etherington, and Lord Justice Sales, had just upheld Gina Miller's contention that the consent of Parliament was necessary to trigger Article 50 to exit the European Union. The article was written by James Slack, later to become an official spokesman for Theresa May.

The last attempt at developing a coherent sentencing policy was initiated under Douglas Hurd who was Conservative Home Secretary from 1985 to 1989, after Home Office research had seriously called into question the effectiveness of deterrent sentencing. Hurd's Green Paper[6], which eventually led, in modified form, to the CJA 1991, was intended both to reduce the use of imprisonment and enhance the role of probation, albeit with what probation expert, Professor Peter Raynor, described to us as '*a bit of cosmetic rebranding*' as punishment in the community. It was also proposed to restore an effective system of fines, the use of which had declined dramatically, to be called *unit fines*, which would be linked to the ability to pay. It was anticipated that the proposals might reduce the prison population by some 4,500 to make it roughly consistent with the available accommodation. This was somewhat undermined during the passage from Bill to Act, by David Waddington's insistence that prisoners should serve at least half their sentence rather than a third before becoming eligible for parole. Ken Clarke's CJA 1993 further contributed to reversing the impact of the CJA1991, by his about turn which abolished unit fines, and his overturning of Hurd's policy that previous convictions should not be counted in the determination of the seriousness of the current offence — in both cases, it must be said, aided and abetted at that time by members of the judiciary.

However, it was Michael Howard who introduced the most radical changes of policy. He told us that the advice from his officials to manage expectations '*wasn't advice I was disposed to take*'. Nor did he take Peter Lloyd's advice, that trying to extend the sentences of Bulger's young killers '*would be overturned by the European Court of Human Rights*'. His '*Prison Works*' speech to the 1993 Tory Conference and his insistence on '*austere regimes*' and that '*prisoners should not enjoy privileges as a matter of right*' sent a quite different message to prison staff, from that offered by Woolf, though he told us '*that was never my intention*'. Howard's Criminal (Sentences) Act 1997 activated the ratchet effect by the introduction of automatic life sentences and mandatory minimum sentences — which were eventually brought into effect by Jack Straw, despite the large majority that New Labour had following the general election.

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Like Michael Howard, David Blunkett disdained the advice of his officials, whom he regarded as '*floating above things. It was never clear whether you're talking to people who have a clue.*' He told us that his mentor, Roy Jenkins, the Labour Home Secretary whose CJA 1967 introduced parole, told him '*don't believe you can have any influence over the level of crime ... I just didn't agree with that at all*'. He went on to make much the same mistakes that Michael Howard had done, albeit in spades. His CJA 2003 introduced indeterminate sentences of Imprisonment for Public Protection (IPP) which were to be imposed, ostensibly, on grounds of serious *future* risk regardless of the seriousness of the current offence, and with release dependent upon demonstration by the perpetrator that the risks had been reduced. Blunkett told us that this had been '*a blot on my copy book*' but he blamed the judiciary for the way in which they interpreted it, producing a thousand such prisoners in the first year when he had intended it to apply to only a few. After the House of Lords had overturned the Home Secretary's powers to set tariffs for lifers, Blunkett enshrined new minimum terms for different types of murder in legislation. These were set out in Schedule 21 of the Act and were very much higher than those proposed by Lord Woolf, then Lord Chief Justice. It was an even bigger blot on his copy book. Given his escalation of the length of prison sentences it is perhaps surprising that he was also committed to the idea of capping the prison population, and had an agreement with the Lord Chief Justice and the Lord Chancellor which he hoped would stabilise the prison population with a cap at 80,000 by tweaking the Sentencing Guidelines. This was to be enshrined in his Offender Management and Sentencing Bill, but the sentencing provisions were dropped by his successor Charles Clarke during the protracted journey through Parliament and was transformed into what eventually became just the Offender Management Act (OMA) 2007.

When Jack Straw, who had begun as New Labour's first Home Secretary, returned as Lord Chancellor in 2007 there were 6,740 lifers in prison, by far the highest number in Europe, plus 3,386 serving IPP sentences and it was clear that they could not receive the supposedly risk-reducing interventions required for them to be released on their tariff dates. His Criminal Justice and Immigration Act 2008 introduced a new

6. Home Office (1988) *Punishment, Custody and the Community* (Cm 424) London, HMSO

seriousness threshold for IPP sentences and stipulated that if the new conditions were met the Courts *may* rather than *must* impose the sentence. After the 2010 election Ken Clarke found himself again in command having been told by Cameron '*that he wanted a liberal Justice Secretary but he didn't want anybody to know that*'. Clarke was shocked that the prison population had doubled since he was last in charge and he was keen to try and reverse that situation. He planned to cope with the cuts imposed by Chancellor of the Exchequer, George Osborne, by reducing the prison population through his Legal Aid and Sentencing of Offenders Bill, and he worked closely with senior judges in drafting its provisions. He also signalled his intention to protect the independence of the Judiciary as Lord Chancellor. Clarke got his proposals for abolishing IPPs, reserving indeterminate sentences for those posing extreme risks, and the abolition of minimum sentences through the Cabinet Committee — but then Prime Minister Cameron got cold feet. According to Clarke, Cameron '*was terrified that we were going to be seen as soft on crime …and I'm afraid David got it all thrown out*'. Not quite all, in fact, because the proposal to abolish IPPs survived to become law — but it was not retrospective and large numbers of such prisoners were left in prison beyond their tariff dates. Cameron insisted on adding the word Punishment to the title of the Bill, and including *more* mandatory minimum sentences, the effect of which Clarke managed to neutralise by careful drafting.

Clarke was the last Minister prepared to argue an intelligent case for reducing the prison population, and during his time in office the numbers in prison were at least stabilised. His successor, Christopher Grayling, was not interested in reducing the prison population. His Offender Rehabilitation Act of 2014, however, which extended post release supervision for a period of 12 months to all prisoners, not only greatly increased the case-loads for probation officers but also put pressure on the prisons since many more offenders were potentially liable to recall for breaches of conditions. After the 2015 general election, Michael Gove became Lord Chancellor. He told us that whilst in office he '*swerved*' the inconvenient truth that we send too many people to prison — '*a far higher percentage of our population than similar developed nations*'. Liz Truss, who followed Michael Gove, thought it would take a '*brave politician*' to take those issues on board and both she, and the politicians who preceded and followed her, largely repeated a constant — but fanciful — refrain that the only way to bring the prison population down was through rehabilitation programmes which would reduce reoffending. David Gauke, the last of our politicians who held the office of Lord Chancellor during this period, and his Prisons Minister, Rory Stewart, were prepared to contemplate the possibility of legislation to limit the use of short sentences of imprisonment, but these would make very little difference to the size of the prison population.

When we discussed these matters with the Lord Chief Justices they were very nearly unanimous in their condemnation of much that had happened. Harry Woolf not only wrote the famous report but went on to become Lord Chief Justice from 2000 until 2005 during which time Jack Straw, David Blunkett and Charles Clarke were Home Secretaries. He subsequently campaigned to take the politics out of prisons. He was not consulted about the changes to the role of the Lord Chancellor which also meant that he and his successors became the Head of the Judiciary. He told us that '*sentence inflation has been the most serious problem*' in driving up the prison population '*without producing any corresponding benefit*'. Moreover, he was disappointed that '*the Sentencing Council* (which succeeded the Sentencing Guidelines Council) *is failing to realise that if you raise the sentence in one part of the system, you're going to raise it across the board*'. He had '*huge respect for David Blunkett*' but thought he had got things '*very sadly wrong*' over IPP sentences and again when he imposed mandatory minimum terms '*to stop the European Court from impinging upon his rights as Home Secretary*.' He was aghast at the way politicians '*had demoralised the probation service to a terrible extent*' but he thought that David Gauke and Rory Stewart '*had recognised that there is a crisis*' and he hoped that they might be able to do something about it.

Michael Gove told us that whilst in office he '*swerved*' the inconvenient truth that we send far too many people to prison.

Nicholas Phillips was Lord Chief Justice from 2005 until 2008 and he saw the transition from the Home Office to the Ministry of Justice, during which time Charlie Falconer, the last of the old-style Lord Chancellors was succeeded by the first of the new, Jack Straw. In 2017 Phillips opened a speech in the House of

Lords[7] as follows: '*My Lords …we send far too many people to prison for far too long; far longer than is necessary for rehabilitation and far longer than is needed for an effective deterrent*'. He went on to say we need *'leadership and courage on the part of Government. The aim should be, for a start, to halve the number of those in prison. IPP prisoners should be released. Old men who no longer pose a threat should not be held in expensive custody. Most importantly legislation should reverse the trend of requiring ever longer sentences.'* He told us that '*sentence length is not really critical in deterring crime. Basically, people commit crimes because they think they are not going to get caught. There is no point in locking up … youths who stab people … for 10 or 20 years for a two-minute loss of temper*'. He was completely opposed to the introduction of statutory minimum sentences and Blunkett's sentences of IPP and told us that '*It's never been our justice system that you keep someone in prison who has committed a comparatively minor offence if you decide he's a risk to society. Give them a chance to re-offend and then lock them up for their re-offending, or give them a chance not to re-offend and let them be free*.' Lord Phillips had famously donned the hi-vis jacket to do a day's incognito community payback to show that it was not a soft sentence, but he was also prepared to argue that what did it matter if it was soft '*so long as it worked*'.

Igor Judge served as Lord Chief Justice from 2008 until 2013 and overlapped with Jack Straw, Ken Clarke and Chris Grayling as Secretaries of State for Justice. He was critical of the sheer volume of criminal justice legislation, and especially '*the great Daddy of them all*' Blunkett's CJA 2003 which had no fewer than 1,169 paragraphs. Over the last few years '*something like 3,000 pages of primary legislation had been produced annually, and in addition laws are made by some 12,000 -13,000 pages of delegated legislation*' (Judge, 2017)[8]. How much, he wondered, '*has been read, just read, let alone scrutinised, by how many of us in Parliament in advance of the enactment coming into force?*' He was particularly scathing about the Henry VIIIth powers which empowered Ministers '*to amend, repeal, revoke or otherwise modify*' a Statute and which had become '*commonplace*'. In theory such Statutory Instruments are scrutinised by the Delegated Legislation Committee but the average length of DLC debates in 2013-14 was just 26 minutes and the shortest 22 seconds. However, he defended the right of judges to impose short sentences, and departed from his fellow Chief Justices, albeit in part playing the devil's advocate, by questioning whether there was any way to determine whether the number of people we sent to prison was too high or too low. He also told us '*we've got this difficult balance to strike, so that the court is not exercising private revenge*' whilst recognising that women victims may feel that what they '*have gone through isn't really worth very much*'.

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John Thomas succeeded Igor Judge as LCJ and served in that role until 2017 whilst Chris Grayling was still in office as Lord Chancellor to be followed by Michael Gove, Liz, Truss and David Lidington. He drew our attention to how little discussion there had been between the Home Office and the Judiciary at the time of Blunkett's CJA 2003 compared to the many exchanges with Ken Clarke at the time of what became the Legal Aid, Sentencing and Punishment of Offenders Act 2012. He told us that reducing the use of short sentences '*would address a bit of the problem but not very much of it ... the real problem is the great length of sentences and we have pointed this out, and pointed this out, and pointed this out*'. He singled out the CJA 2003 with its starting points for fixing minimum terms in mandatory life sentences for condemnation. But whereas minimum sentences usually leave the judge some discretion because of '*exceptional circumstances*,' the Sentencing Guidelines '*are driven by the statutory maxima … and the maxima are too high*'. He told us that '*politicians are unwilling to reduce maximum sentences*' or to deal with the residual IPP problem of reversing the burden of proof about risk before release on parole. This was on the ostensible ground that it would interfere with the independence of the Judiciary — a claim Thomas dismissed as '*absolute nonsense*'. The only way forward would be for a courageous Government '*to reduce maxima and be quite prepared to say this is our policy … bringing the sentence level down. My own view is that the prison population ought*

7. Hansard 7.9.17
8. Judge, Lord (2017) *A Judge's View on the Rule of Law*, Annual Bingham Lecture, 3rd May 2017.

to come down first to 60,000 and I hope …back to 40,000.

It is extraordinary that the Executive and the Judiciary in a democracy should be at such odds with each other.

The Problem of Ministerial Churn and Getting Proper Advice

Ministers spent an astonishingly short time in office — on average just 22 months, some 10 months shorter than the average served by ministers in the 30 years before 1990. Most had no prior experience of the field, although Jack Straw and Ken Clarke had two bites of the cherry — first as Home Secretary and later as Lord Chancellor and Secretary of State for Justice. This political churn need not have contributed to the crises had there been consistent support for well-planned policies — but that did not happen, although there was sometimes continuing support for ill-planned policies that left Directors of Prisons and Probation struggling to make them work. No Minister had a handover package from their predecessor nor passed one on to their successor. Most Ministers thought it would be desirable if they had the opportunity to spend longer in office to see things through, and if not, that there should be a systemic way of ensuring continuity. David Blunkett put it as follows: '*Ministers don't have a proper induction and they rarely speak to the person who has just done the job. The person who moves on has either just been sacked and is grumpy or has just been promoted and no longer cares. What we need is a proper portfolio with induction and handover every time someone changes — even when it is a change of Government.*' Andrew Selous, Junior Minister under both Chris Grayling and Michael Gove, thought that ensuring continuity of policy should be a responsibility of the Cabinet Office.

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As things were, new Ministers, like Chris Grayling, one of the longest serving Ministers, and Michael Gove, one of the shortest serving, felt free to pursue policies which they had applied in other settings, respectively in the work programme at Work and Pensions and academies at Education, regardless of their appropriateness to prisons or probation. Interesting innovations — such as problem-solving courts modelled on Red Hook in New York and judicial monitoring of sentences — hardly got past the pilot stage. Other Ministers — like Liz Truss or Rory Stewart — felt free to spend much of their time interfering in operational matters. Ministers sometimes had a specific brief from the Prime Minister, although under Tony Blair it was more a question, as one of our respondents put it, of '*always managing towards the Fuhrer … everybody knew what he wanted*'.

The short terms in office for Ministers were to some degree matched by the increased mobility of career civil servants between departments, which may have reduced their capacity to give sound advice based on their knowledge of departmental history. One shortcoming of our research has been that we did not manage to extend our interviews to include departmental career civil servants in policy rather than operational roles. However, there certainly seemed to be a process of life mirroring art as new Ministers approached their civil servants in much the same way as Jim Hacker regarded Sir Humphrey Appleby in the 1980s sit-com *Yes, Minister*. They often paid less attention to the advice of their officials preferring to listen to their so-called 'special advisors', who shared the same ideas and whose advice served mainly to enhance Ministerial hubris. David Faulkner, the distinguished senior civil servant who was widely regarded as the architect of Douglas Hurd's Green Paper that led to CJA 1991, late in his retirement, urged his successors to find their voices and speak out.

Organisational Change: Agency Status — HMPS, NOMS, HMPPS — and Austerity

Woolf's report made no recommendations on the organisation of the prison service because Waddington had already announced changes to the Prisons Board, the introduction of Area Managers, and a proposed move of Headquarters from London to the Midlands. Consideration was given as to whether the prison service should become a Next Steps Agency[9]. Next Steps Agencies[10] were intended to create an arms-length distance between Ministers, who were

9. Lygo Report (1991) *Management of the Prison Service*, London, Home Office
10. Fulton Report (1968) *The Civil Service*, Report of the Committee 1966-68, Vol. I, Cmnd 3638, London, HMSO; Ibbs Report (1988) *Improving Management in Government: The Next Steps, A Report to the Prime Minister*, London, HMSO.

accountable to Parliament for policy matters on the one hand, and operational managers who could be held responsible for any failures (though rarely in practice for operational successes). In return for carrying operational responsibility managers would have autonomy for running their operations within broad policy guidelines, but also the ability to speak out publicly when held to account for their activities. Woolf was critical of the many organisational changes that *had already taken place and concluded that 'the one thing that is not needed is more change'*[11]. But Woolf had identified that a lack of trust had developed between operational governors in the field and a remote headquarters organisation. He wanted to see the Director General of the Service having real operational experience and to show leadership by speaking out on behalf of the Service, which would fit very well within the agency model.

Woolf's hopes of an end to organisational change, however, were dashed and the next thirty years saw near perpetual change. Agency status was conferred first on the Prison Service (HMPS), by Ken Clarke in 1993, who in his desire for the involvement of the private sector preferred the outsider Derek Lewis over the incumbent Joe Pilling as Chief Executive. This was despite the fact that Pilling had successfully managed the service for two years, and bridged the gap between headquarters and the field with his 1992 Eve Saville Memorial Lecture *Back to Basics*[12] emphasising the need to treat prisoners with decency. He was also an advocate for Agency status and accepted the need for some privatisation. Pilling thus became the first to leave the job he '*most wanted to do*' unhappily. The second, of course, was Derek Lewis. Initially, Lewis, was able to run the agency largely as imagined under Ken Clarke, who was repeatedly singled out as '*a fantastic Secretary of State to work for*', someone prepared to share responsibility and accountability with his officials. But after the escapes of Category-A prisoners from Whitemoor and later from Parkhurst, Howard, according to his Prisons Minister, Anne Widdecombe, used the lamentable Learmont Report (1995) to '*get rid of Derek Lewis*'. Lewis was succeeded by Richard Tilt, who had spent a year as Acting Director General during a vain search for someone from the private sector to take the job on. He was the first Director General to have had operational experience as a governor, and he felt it to be his '*duty to do it*'. Tilt told us, that despite Howard's insistence on the distinction between accountability and responsibility '*Howard just couldn't cope with somebody doing something he didn't agree with… never mind the bloody Next Steps agency*'. He was the only one of our Directors, however, to leave happily and retire after three and a half years, at a time of his own choosing, having got things back more *'on an even keel'*.

Agencies were created to provide distance between Ministers, who were accountable to Parliament for policy matters, and operational managers who could be held responsible for any failures.

After the election in 1997 Jack Straw, having argued in opposition that Howard, '*takes the credit but is free of any responsibility*'[13], no longer allowed officials to account to Parliament and resumed that responsibility himself. He also began a push to bring the prisons and probation services closer together despite the fact that prisons were part of a large and very complex national system, whereas probation was locally based and part locally funded and managed by local committees largely composed of magistrates. The histories, purposes, philosophical underpinnings and ways of working of the two services were quite different, and indeed about the only thing that they had in common was that they dealt with some of the same offenders at different stages of their criminal careers. By the time Straw left office, the first Director of a notionally National Probation Service, Eithne Wallis, had been appointed and the number of local Probation Committees was reduced from 54 to 42 Probation Boards coterminous with police boundaries. The police and probation services were required to manage the risk of violent and sexual offenders through new Multi-Agency Public Protection Arrangements (MAPPA). According to Sonia Flynn (nee Crozier), who was Chief Officer of Probation at the time we interviewed her, these developments, together with the removal of the requirement for offenders to consent to probation, first

11. Woolf (1991) see n.4 para 12.6
12. Pilling, J. (1992) Back to basics: Relationships in the Prison Service. Eve Saville Memorial Lecture to the Institute for the Study and Treatment of Delinquency, reprinted in Perspectives on Prison: A Collection of Views on Prison Life, supplement to Annual Report of the Prison Service 1991–1992. London, HMSO.
13. Hansard HC 19.19.95

proposed by Howard, '*changed our purpose from 'advise, assist and befriend' to surveillance and protection*'.

David Blunkett, following the recommendations of the Carter Report[14] introduced the National Offender Management Service (NOMS) with the ambitious aim of establishing end-to-end management of offenders under ten Regional Offender Managers aligned with the existing prison regions rather than the recently reorganised 42 Probation Boards. Carter later told us that it had not been properly thought through: '*we didn't capture the technology or that culturally the difference between the probation service and the prison service was too great*'. It was a shotgun marriage and like many such marriages it was less than a total success — despite prodigious efforts to make it work. But ministers repeatedly blamed their officials for any failures. David Blunkett told us that '*the prison service didn't want it ... the probation service liked the idea but they weren't keen on engaging*'. Richard Tilt was broadly in favour of linking the two services together and had been impressed by what he saw in Canada where such a move had been successful — but, as he pointed out, it '*took them 25 years to achieve it*'.

By the end of the Blair era' Wheatley told us '*Ministers pushed very hard for prisons to pack all comers in like sardines*.'

Agency status remained with the prison service at this time and Martin Narey, who had succeeded Richard Tilt as Director General of prisons, was first made Commissioner of Corrections by David Blunkett and then Chief executive of NOMS, whilst Phil Wheatley became Director General of Prisons. Martin Narey had bought into what he regarded as three essential elements of NOMS — making probation officers the managers of prisoners in prisons, a commitment to driving up standards of decency and dignity in public sector prisons through competition, and the capping of the prison population. Moreover, with the rank of Permanent Secretary he had a say about the direction of policy as well being a member of the Sentencing Guidelines Council which was to deliver a stable prison population by tweaking the guidelines. But relations between Narey and Charles Clarke quickly deteriorated. According to Wheatley, Clarke did not like '*celebrity civil servants*'. When it became clear that Clarke was not going to try to cap the prison population, Narey became the third Director General to leave unhappily and resigned. NOMS was reorganised, and Narey's successors at the head of NOMS — Helen Edwards, Phil Wheatley and then Michael Spurr were not given the rank of Permanent Secretary, and the ability to speak out and make their voice heard publicly was lost.

When Jack Straw was back in charge as Lord Chancellor, now with prisons and probation under the Ministry of Justice, he took a much more 'hands-on' approach than when he had been at the Home Office. Eithne Wallis had been replaced briefly by Steve Murphy as Director of Probation (under David Blunkett) and then by Roger Hill who became the longest serving Probation Director. The OMA 2007 had redefined the relationship between probation and ministers and Probation Boards became Trusts with whom the minister *may* choose to contract services. Straw put increasing pressure on those Boards reluctant to change by threatening them with privatisation. In 2008 Agency status was transferred from the prison service to NOMS. It was a collaborative venture between Ministers and Directors, in a further attempt to make NOMS work. The separate roles of Director General of Prisons and of Probation soon ceased to exist. The new model was for the publicly run trusts or new functional Directors of Offender Management (DOMs) at a regional level, to commission services. Both Phil Wheatley and Michael Spurr believed it enabled them to get a managerialist grip on probation as they had on prisons under marketisation.

The new arrangements hardly had time to come into effect before a new era of austerity was dawning in the wake of the banking crisis. NOMS was required to make ever increasing savings. The situation with regard to the increasing prison population was already dire. John Reid who was, briefly, the last Home Secretary to have responsibility for prisons, and Charlie Falconer, even more briefly as a transitionary Lord Chancellor, told us they had to set up a special unit, working around the clock in shifts, trying to find places for the latest arrivals from the courts, whilst prison vans circled the M25 waiting for places to be found. '*By the end of the Blair era'* Wheatley told us '*Ministers pushed very hard for prisons to pack all comers in like sardines*.' When Phil Wheatley and Michael Spurr, then his Chief Operating Officer, told Straw that they had achieved all the economies they could, without endangering safety, Straw refused to accept that and effectively forced them into the first version of benchmarking. Wheatley

14. Carter Report (2003) *Managing Offenders, Reducing Crime*. The Strategy Unit.

told us this left the prisons '*in a very unstable place*'. When Wheatley thereafter took a firm line saying that '*HMPS would not hold more prisoners than we could safely accommodate*' he was given to understand that unless he became '*more corporate*' his contract would not be renewed and he resigned — the fourth to leave unhappily. Michael Spurr took over as the '*safest pair of hands*'.

When Ken Clarke was first to agree the 23 per cent cuts demanded by George Osborne he planned to make the savings through reducing the prison population — but that was scuppered by David Cameron's intervention. The immediate effects of the cuts which were based on a prediction of the future size of the prison population, were limited to reductions in central management. But they were enough to bring about the demolition of the collaboratively agreed regional model of NOMS. A revised model of NOMS removed the regional layer of management. Roger Hill, told us that when one saw the combined budget for the two services there was little room for manoeuvre as far as probation was concerned because most costs were already fixed. Hill was unable, for technical reasons concerning pensions, to apply for a post in the new arrangement and became the fifth Director to leave unhappily telling us it was '*one of the worst days'* of his life.

With the loss of experienced staff that safety issues started to go through the roof and that this was not due to poor performance by anyone but political decisions about resources.

Enter Chris Grayling. He began with what Crispin Blunt, who had been Ken Clarke's Prisons Minister, described to us as a '*Faustian pact*' with the POA to exchange the scrapping of Ken Clarke's proposal to put nine prisons out to tender in exchange for ever deeper benchmarking. Michael Spurr, forced to choose between the prospect of further privatisation and accepting more cuts chose the latter as the lesser of two evils. He oversaw the introduction of the Prison Unit Cost (PUC) programme and the Voluntary Early Departure Scheme (VEDS). Between them they delivered lower savings than privatisation but delivered them more quickly. Grayling told us that he was pleased to have closed more prisons than anyone else, but according to Michael Spurr these were small *'high-quality*' prisons and he replaced them with cheap prisons, larger and '*harder to run*'. His contracting out of highly complex facilities management was a policy earlier rejected under New Labour. Nick Hardwick, then Chief Inspector of Prisons, told us that it was only '*with the loss of experienced staff that safety issues started to go through the roof and that this was not due to poor performance by anyone but political decisions about resource*s.' Grayling made it clear to Hardwick that he would have to re-apply for his post at the end of his contract if he wanted to be reappointed — and that his chances were not good. Hardwick resigned rather than go through that process again. Grayling's impact on probation was in some ways even worse. Privatising aspects of probation work was based on an ill-founded notion of risk, with the National Probation Service dealing with high risks and 21 Community Rehabilitation Companies dealing with low risk cases. This split inevitably led to problems about organising contracts because it was difficult to predict how many offenders of each risk category would be coming through from the courts. But Grayling was deaf to the advice of his officials. The fact that it did not work was roundly condemned by Glenys Stacey in her role as HM Inspector of Probation. Wheatley, Spurr and Hill were agreed that a much better way of introducing privatisation in probation would have been to take one or two poor performing geographical areas and invite tenders for all, or most, of the services provided by probation officers.

Following the General Election of 2015 there was a growing recognition that cuts in resources had gone too far and tentative steps were taken to recruit new prison officers although staff numbers remained below those proposed under the PUC programme and far below those which had obtained in 2010. But still Ministers blamed their officials for failing to deliver the 'world class service' enshrined in Framework Documents. Things were made worse by the interventions of Ministers into operational matters. First, Michael Gove indulged in his so-called Reform Prisons, based on his experience with academies whilst Minister of Education, but he had no real conception of how prisons, unlike schools, were part of a highly complex national system. When Gove tried to insist on further reductions in staff, Spurr pushed back and '*refused to take any more cuts after 2015*'. Then Liz Truss, despite her lack of any apparent relevant experience, came to believe that she knew better than her officials how to run prisons. Perhaps the most telling example of how things had changed over the period under review is that whereas Joe Pilling had

meetings with Ministers 10 or 12 times a year Michael Spurr sometimes had that number in a week. He was summoned to '*bird table*' meetings in the morning to discuss a problem and expected to have a solution by the evening.

Liz Truss told us that she found Spurr to be too *'command and control'* but it became clear that what she really wanted was for command and control to reside firmly within the Ministry of Justice. Truss objected to all arms-length bodies (ALBs) like NOMS. She told us *'I wanted to get rid of NOMS and replace it with HMPPS… I wanted to embed it more within the Department so it was more directly accountable*.' This was in line with a 2016 Cabinet Office report on Public Bodies[15] which argued for the transformation of ALBs to reduce costs and increase accountability through a reduction in autonomy and closer relationships with departments. The reinvention of NOMS as HMPPS, was not discussed in her White Paper *Prison Safety and Reform*[16] but it reversed the model of agency that had aligned accountability to *greater* autonomy. The new model gradually removed the functions from the agency that enabled operational autonomy, including commissioning, future policy direction, setting standards and scrutinizing performance, HR, finance, procurement, IT and estates management. Spurr now had to seek '*permission to be able to run the organisation*'. Close observers, described the situation as '*wildly confusing*' with '*the Ministry of Justice... who don't really understand prisons… sucked into how can we make prisons safer*'.

A Cabinet Office report argued for the transformation of ALBs to reduce costs and increase accountability through a reduction in autonomy and closer relationships with departments.

Spurr told us that he was continually being required to '*brief up*' and even that his operational voice was undermined when governors were directly asked whether, '*what I was saying was right or wrong*'. Increased accountability did not translate into the power to speak out. At one point he was banned from '*engaging with the Treasury and with the Cabinet Office'*. Although technically Agency status had been transferred from NOMS to HMPPS, Anne Owers, former Chief Inspector of Prisons and now Chair of the Independent Monitoring Boards, told us '*it's not got what you would call agency status any longer*'.

The relationship between Spurr and David Lidington, who succeeded Liz Truss, was much more cordial, however Sam Gyimah his junior minister kept a '*a very, very close watch*'. Rory Stewart, Gyimah's replacement, told us that the crisis in HMPPS arose because of its '*failure to recognise that the world had changed since 2010*' and that in continuing its attempts to rehabilitate it had '*forgotten about the basics*'. He tried to argue that Spurr and others had failed to '*push back*' against the cuts. When we suggested that all Directors were committed to the 'decency agenda' and that some had lost their jobs for '*pushing back*', he finally acknowledged that the main problems had been brought about by the policy makers. He thought it likely that Spurr would outlast him because of the Government's delicate position over Brexit. But Spurr was effectively forced out, the latest in a long line of committed Directors to leave office unhappily.

Conclusions

What conclusions do we draw from this sorry history? Some truths which applied at the beginning are as applicable now. First, prisons are of necessity part of an interconnected system and need to be organised in a systemic way. This could either be a national system, or regional systems but with some functions, especially high security prisons, run as a national resource. Second that Probation is primarily a local service and, in our view, ought to be organised, and at least part funded, locally in close conjunction with the courts.

It should be obvious that prisons and probation are important public services and should be treated as such and not regarded as the playthings of here today and gone tomorrow ministers of whatever political persuasion. The proper function of ministers should be to ensure that the tasks set for those services are reasonable and achievable and that their operational officials have the resources they require to perform those tasks and to support them in so doing. There should be an enduring commitment between the Cabinet Office and the Treasury that prisons should not hold more prisoners than is provided in their certified normal accommodation. Expecting prisons or probation to bring about the rehabilitation of offenders and end reoffending is a holy grail the pursuit of which is doomed to failure. Prisons should strive not to make

15. Cabinet Office (2016) *Public Bodies 2016*, London, Williams Lea Tag.
16. Ministry of Justice (2016) *Prison Safety and Reform* (Cm 9350), London, Williams Lea Group for HMSO

prisoners worse, and to treat them with dignity and respect and where possible to provide educational and other services that can help repair the deficits that so many have suffered. Probation can certainly do much to help offenders with problems they experience either before or after they have been in prison but cannot be expected to undo many years of past experiences. The causes of crime lie elsewhere — in poverty, deprivation, poor education, housing, and life chances. In short giving them something to lose. Having something to lose keeps most of us straight.

We agree with our Lord Chief Justices, Lord Woolf, Lord Phillips and Lord Thomas that the prison population is far too high and that more discretion should be given to judges in sentencing. The provisions in Schedule 21 of the CJA 2003, which brought in 'starting points' for fixing the minimum term in mandatory life sentences, should be repealed as well as the mandatory minima, now enshrined in the Sentencing Act 2020, for drugs, residential burglary and other matters. The role of the Sentencing Council should be limited to helping to iron out disparities in sentencing between courts.

Both prisons and probation are primarily operational services, analogous to the NHS albeit on a much smaller scale, and they require a great deal of autonomy in order to fulfil their operational duties. They are therefore are well suited to the Agency model with its possibility of having a clearly identifiable leader who is both responsible and accountable for what goes on. We understand that since our research was completed some of the functions withdrawn to the centre under Liz Truss have been returned to the HMPPS agency, and that Jo Farrar, the current Chief Executive, has been given 2nd Permanent Secretary status, last held by Martin Narey. These are steps in the right direction. But we are concerned that Farrar is expected to cover not only HMPPS but also the Legal Aid Agency, which has a budget of £2 billions, as well as the Office for the Public Guardian, and Criminal Injuries Compensation, amongst possibly others. These seem likely to remove her from day to day operational matters and reduce both her ability to advise Ministers and to provide the dedicated leadership that prisons and probation so badly need.

Finally, there needs to be a carefully constructed cross party agreement as to the legitimate achievable aims of the prison and probation services which should be set out in primary legislation, together with a code of standards.

Preventing Prison Staff Assaults

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Introduction

In 2018, a new offence of 'assault on an emergency worker' was introduced in England and Wales, with the effect that common assault or battery of an emergency worker should be charged under section 1 of the Assaults on Emergency Workers (Offences) Act 2018. The offence of 'assaulting an emergency worker' carries a maximum term of imprisonment of one year — doubling the sentence available for offences of common assault or battery. In July 2020, the Government announced plans to double the maximum available sentence yet again to two years imprisonment.[1] In the House of Commons, Rory Stewart, Minister of State for the Ministry of Justice, described the principles underpinning the 2018 Act:

> *'They are that an assault on any individual or citizen in our society is a terrible thing, but that an assault on an emergency worker is an assault on us all. These people are our constituted representatives. They protect society and deliver services on our behalf. Therefore, an attack on them is an attack on us and on the state, and it should be punished more severely than an attack simply on an individual victim.'*[2]

The inclusion of prison staff[3] in the 2018 Act not only acknowledges their status as frontline workers providing critical services in an often complex and challenging environment, but also reflects the burgeoning concern about prison violence and prison safety. Prison staff face occupational risks to their health and safety, including assaults by prisoners, and studies have shown that prison staff can suffer from high levels of work-related stress, and poor physical and mental health.[4] A recent survey of nearly 600 prison officers in the UK found that the Covid-19 pandemic has led to elevated levels of anxiety and 'burnout', and a deterioration of physical and mental health.[5] The Prison Officers Association has also expressed growing concern regarding increased prison violence and disorder over the last decade.[6]

Such concern is not without foundation. During the period 2009-2019, there was a threefold increase in the number of assaults against staff per 1,000 prisoners.[7] The number of serious assaults against staff also increased fourfold between 2009-2018, reducing only slightly to nine per 1,000 prisoners in 2020, compared with three per 1,000 prisoners in 2009.[8] Although there was a slight reduction in the number of assaults in 2020, there were still 8,000 assaults and nearly 800 serious assaults against staff during a year in which all prisoners spent an unprecedented amount of time in their cells and where social interactions, and other activities such as work, employment and visits, were severely restricted during the global Covid-19 pandemic.[9] This increase in assaults on prison staff, however, is not consistent worldwide. Whilst some jurisdictions have noticed a similar upwards trend in prison violence,[10] countries such as Australia and

1. Ministry of Justice (2020) *Consultation Launched on Doubling Maximum Sentence for Assaulting An Emergency Worker*. 13 July. London: Ministry of Justice. Available Online: https://www.gov.uk/government/news/consultation-launched-on-doubling-maximum-sentence-for-assaulting-an-emergency-worker
2. Hansard, House of Commons. Vol 639 C1142, April 27 2018. Available Online: https://hansard.parliament.uk/Commons/2018-04-27/debates/0588597B-4425-4255-AAFA-7AE64BECF988/AssaultsOnEmergencyWorkers(Offences)Bill
3. Section 3 of the Assaults on Emergency Workers (Offences) Act 2018 includes as 'emergency worker' prison officers or persons employed or engaged to carry out functions in a custodial institution of a corresponding kind to those carried out by a prison officer.
4. See, for example, Liebling, A. Price, D. and Shefer, G. (2012) *The Prison Officer*. Abingdon: Routledge. 2nd ed, 65; Kinman, G., Clements, A.J. and Hart, J. (2017) 'Job demands, resources and mental health in UK prison officers', *Occupational Medicine* 67: 456-460; Carleton, R.N., Ricciardelli, R., Taillieu, T., Stelnicki, A.M., Groll, D. and Afifi, T.O. (2021) 'Provincial Correctional Workers: Suicidal Ideation, Plans and Attempts,' *Canadian Psychology*. Online First: http://dx.doi.org/10.1037/cap0000292.
5. Memon, A. and Hardwick, N. (2021) *Working in UK Prisons and Secure Hospitals During the Covid-19 Pandemic*. London: Centre for the Study of Emotion and Law, Royal Holloway University of London.
6. Prison Officers Association. (2018) 'National Chair: Violence Against Staff Must Be Stopped', December. Available Online: https://www.poauk.org.uk/news-events/news-room/posts/2018/december/national-chair-violence-against-staff-must-be-stopped/
7. Ministry of Justice (2021) *Safety in Custody Statistics*. London: Ministry of Justice.
8. Ibid.
9. For further analysis of the impact of the COVID-19 pandemic within prisons, see Issue 253 of the *Prison Service Journal* (March 2021).
10. Prison Reform International (2020) *Global Prison Trends 2020*. Available Online: https://cdn.penalreform.org/wp-content/uploads/2020/05/Global-Prison-Trends-2020-Penal-Reform-International-Second-Edition.pdf

Aotearoa New Zealand have historically maintained comparatively low rates of assaults on staff, although the number of prison staff assaults is now increasing in Aotearoa New Zealand.[11] By way of contrast, the increased use of weapons evident in England and Wales is not replicated in countries such as Australia and Aotearoa New Zealand.[12] Thus, there is something unique about the English and Welsh experience that merits attention.

Prison violence has consistently captured the attention of scholars.[13] However, there is frequently little, or no, distinction made between assaults on prisoners and assaults on staff, and it is the former that has attracted far more scholarly interest. Those studies that focus on assaults on prison staff typically originate from the United States and Canada (some of which are dated) and cannot simply be 'imported' into the prison context of England and Wales.[14] Moreover, much of the available research on prison violence relies on quantitative data,[15] giving some understanding of possible relationships between staff and prisoners but leaving the wider dynamics and narratives about assaults on prisoners and staff under-explored.

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Drawing on extensive ethnographic and qualitative research carried out since 2014, this article seeks to begin to address these gaps in our knowledge of assaults on prison staff in England and Wales. This article explores and sets out the differences in prisoner-on-prisoner assaults (prisoner assaults) and prisoner-on-staff assaults (staff assaults). We argue that there are fundamental differences in the aetiology of prisoner and staff assaults. At first glance, this would suggest that the prevention of violence against staff requires different measures or approaches to those required for prisoner-on-prisoner assaults. However, as we assert here, keeping staff safe starts with keeping prisoners safe. This is often apposite to the actions and strategies that are typically requested and campaigned for when staff feel unsafe, such as PAVA spray, tasers, enhanced security, more restricted regimes, body protection vests, and more severe sentencing options.[16] Typically, such measures can have a deleterious effect on relationships and alter organisational cultures in such a way as to exacerbate the problem of prisoner-on-staff violence, giving the illusion of control but without materially making prison staff any safer. Whilst legislative changes might communicate a welcome focus on the safety of our emergency workers, changing the penalty for staff assaults will not — in and of itself — deter prisoners from violence against staff. Instead, part of the solution to preventing staff assaults is to focus on the relational and cultural context. The

11. Gooch, K. and Doolin, K. (2020) *A Comparative Analysis of Prison Violence in England, Australia and Aotearoa New Zealand – An interim report*. Bath: University of Bath; Dennett, K. (2021) 'Calls for prison discipline overhaul amid increase in assaults on Corrections staff', *Stuff,* 14 March. Available Online: https://www.stuff.co.nz/national/crime/300251019/calls-for-prison-discipline-overhaul-amid-increase-in-assaults-on-corrections-staff
12. Treadwell, J., Gooch, K. and Barkham-Perry, G. (2019) *Crime in Prisons: Where now and where next?* Research report for external body. Office for the Police and Crime Commissioner, Staffordshire. Available Online: http://eprints.staffs.ac.uk/5438/1/OPCC%20-%20Plan-to-government-to-tackle-organised-crime-in-prisons.pdf; Gooch, K. and Doolin, K., ibid.
13. For an overview, see Bottoms, A. (1999) Interpersonal Violence and Social Order in Prisons. *Crime and Justice* 26: 205-281. In the English context, see Edgar, K., O'Donnell, I. and Martin, C. (2003) *Prison Violence: The Dynamics of Conflict, Fear and Power.* Cullompton: Willan; *Prison Service Journal* Issue 221 (September 2015).
14. See, for example, McNeeley, S. (2021) 'Situational Risk Factors for Inmate-on-Staff Assaults', *The Prison Journal* 101(3): 352-373; Konda, S., Reichard, A.A., and Tiesman, H.M. (2012) 'Occupational injuries among U.S. correctional officers, 1999-2008', *Journal of Safety Research* 43: 181-186; Sorenson, J.R., Cunningham, M.D., Vigen, M.P. and Woods, S.O. (2011) 'Serious assaults on prison staff: A descriptive analysis', *Journal of Criminal Justice* 39: 143-150; Lahm, K.F. (2009) 'Inmates Assaults on Prison Staff: A Multi-Level Examination of an Overlooked Form of Prison Violence', *The Prison Journal* 89(2): 131-150; Light, S.C. (1991) 'Assaults on prison officers: Interactional themes', Justice Quarterly 8(2): 243-261.
15. Note, by way of exception, in the English context, the qualitative research conducted by Edgar et al: Edgar, K., O'Donnell, I. and Martin, C., n 13 above. In the North American context, much of the qualitative research relies on formerly incarcerated individuals. See, for example, Trammell, R. (2012) *Enforcing the Convict Code: Violence and Prison Culture.* Boulder: Lynne Rienner Publishers; Levan, K. (2012) *Prison Violence: Causes, Consequences and Solutions.* London: Ashgate.
16. See, for example, Prison Officers Association, n 6 above; Bulman, M. (2017) 'Prison Officers 'need tasers and stab vests' to cope with rising violence in jails,' *The Independent,* 10 July. Available Online: https://www.independent.co.uk/news/uk/home-news/prison-officers-tasers-stab-vests-rising-violence-jails-uk-safety-wardens-a7832656.html; Hymas, C. (2019) 'Prison officers should be issued with tasers to combat violence, says union chief,' The Telegraph, 31 October. Available Online: https://www.telegraph.co.uk/politics/2019/10/31/prison-officers-should-issued-tasers-combat-violence-says-union/

safety of prison staff is much more likely to be secured when there are strong and good quality prisoner-staff relationships and where the use of power by staff is legitimate, fair, and just.

Researching Staff Assaults

Our interest in violence against prison staff arose from research projects focusing more broadly on prison violence in male prisons. This article is informed by three distinct but connected studies. The first is a comparative study of prison violence across different categories of prison in England and Wales, including: a Category C prison holding men convicted of sexual offences; a young offender institution (YOI) accommodating young men aged 18-21 years old; two Category B Local prisons; and a dual designated site Category C and YOI. This research began in October 2014 and remains ongoing. In each of the sites, long periods of immersive research (of at least six months) were carried out together with staff interviews, prisoner interviews, prisoner surveys, and the use of management information regarding incidents of assaults on staff and prisoners. The second is a longitudinal ethnographic study of the opening of a Category C prison in Wales. Whilst this study was focused on the opening and development of a new prison, issues of staff safety quickly arose, including, crucially, how to build and create a 'safe' prison. The third study focuses on prison homicide and involves interviewing perpetrators of murder, manslaughter and attempted murder committed within English prisons. The empirical research in all of these studies was paused during the period March 2020 — March 2021 owing to Covid-19 restrictions.

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When analysing staff assaults, and serious assaults more generally, the problem of consistent reporting and recording of incidents is quickly apparent. At first glance, it would appear to be relatively self-evident what constitutes 'assault' but in practice this could include a wide range of acts, including: punching, hitting, kicking, biting, throwing water, spitting, throwing unknown substances at staff and/or the use of weapons. If a prisoner lashes out during the use of force by staff, this could also be classified as 'assault' even if it was not necessarily deliberate. An increase in the number of 'potting' incidents, where urine and/or faeces is thrown at a prison officer, has led to novel legal solutions, namely the use of section 24 of the Offences Against the Person Act 1861 (administering a noxious substance) to prosecute actions that do not involve physical violence but nonetheless cause physical and psychological harm.[17] Such acts are primarily designed to humiliate or punish an officer, or to reassert the balance of power. Crucially, it is rare for prisoners themselves to be the victim of 'potting' incidents. This — and the narratives of prison violence we discuss here — illustrate that there are fundamental differences between prisoner and staff assaults.

Distinguishing Prisoner Assaults and Staff Assaults

The key mistake that is often made when discussing prison violence is to assume that violent incidents are irrational, unpredictable, or inexplicable. It is not uncommon for assaults to be interpreted by prison staff as 'unprovoked' or 'out of the blue'.[18] Yet all prison violence is rational to those who inflict it:

> *'You're not going to smack someone for no reason. Like you've always got a reason to do it.'* (YOI)

> *'I've seen someone like do a protest with [a potting] … a staff member is never potted or assaulted if there isn't a reason behind it. And that reason could be because they've not been decent, or they've been disrespectful.'* (Category C)

Fiske and Rai explain: 'When people hurt or kill someone, they usually do so because they feel they ought to: they feel that it is morally right or even obligatory to be violent.'[19] When viewed objectively, it may be difficult to appreciate that any act of unlawful violence may be judged to be rational or 'moral'. However, as Fiske and Rai argue, 'a person may be sincerely and truly morally motivated to do something

17. R v *Veysey* [2019] EWCA Crim 1332.
18. See also Fassin, D. (2017) *Prison Worlds: An Ethnography of the Carceral Condition.* Cambridge: Polity, 180.
19. Fiske, A.P. and Rai, T.S. (2015) *Virtuous Violence: Hurting and Killing to Create, Sustain, End and Honor Social Relationships.* Cambridge: Cambridge University Press, xxii.
20. Ibid, 9.

that many other people involved judge to be wrong.'[20] The argument here is not that prison violence is morally right, but that from the perspective of the perpetrator the violence has a rationality and conforms to a normative code. Staff assaults are 'rarely random occurrences.'[21] The critical difference between prisoner and staff assaults is the way in which the violence is explained and justified.

Whilst some prisoners will import, and/or develop behaviours arising from, individual factors such as mental health, substance misuse, histories of victimisation or perpetration of violence, which are likely to increase their propensity towards being violent, prison violence occurs within a relational and cultural context. Prisoner assaults tend to relate to 'prison politics' between prisoners. The normative code has long dictated that certain behaviour within prison, and prior to coming to prison, merits retribution.[22] This includes, for example, cell theft, 'grassing' or 'snitching,' homosexuality, and sexual offences against women and children. Physical violence is also perceived to be a legitimate response to perceived disrespect, threats to masculinity, attempts to extort or intimidate, and, in defence of property.[23] Indeed, physical violence is often perceived to be the only legitimate 'signal' that not only can ward off future victimisation but that can cement or establish a status and reputation.[24] In addition, one of the most critical shifts in prisoner assaults over the last decade is linked to increased economic activity within, and linked to, prison. Increased access to, and use of, contraband has led to an increase in prison violence related to the punishment of non-repayment of debt, the control of the illicit economy, and the punishment of the loss or consumption of contraband held for another.[25]

Whilst violence between prisoners may occur to establish or negotiate the balance of power between prisoners,[26] it does so without necessarily explicitly contesting the exercise of power by prison staff, although that is of course the consequence. Conversely, staff assaults are structured by a power differential. Staff have considerable formal and discretionary power. That exercise of power is not accepted unquestionably or unwaveringly, and prisoners draw conclusions as to the legitimacy and morality of the nature, extent, and exercise of penal power by prison staff and the terms of their confinement.[27] It is set against this background that staff assaults may occur and can be characterised in three ways: 1) the retaliatory assault; 2) the protest assault; and 3) the instrumental assault.

Retaliatory assaults are expressive acts designed to punish perceived transgressions by staff and are a way of prisoners showing dissatisfaction with the use of staff power (whether legitimate or not). They typically occurred in two scenarios. First, if an officer was perceived by prisoners to be 'power pissed' and on a 'power trip' this could invite physical reprisals, including serious acts of violence such as stabbings. Such assaults were primarily a product of the use of staff power that was viewed by prisoners as too heavy-handed and, therefore, perceived as illegitimate. Some prisoners were quick to ascribe such behaviour to inexperienced, young, or immature (regardless of length of service) officers who were unable to establish rapport and build strong relationships with the prisoners:

> *'Some of the young staff here are horrible bullies, they are, they do abuse their position.'* (Category C)

Prisoners were also particularly sensitive to verbal exchanges where officers were perceived to be 'disrespectful' and 'getting rude [and] getting cheeky,' particularly if this was accompanied by what was viewed as racist or inappropriate (and deliberately antagonistic) speech, including (as we observed) 'squaring up' to a prisoner or inviting them to hit them so they could restrain them. Some assaults against such

The critical difference between prisoner and staff assaults is the way in which the violence is explained and justified.

21. Fassin, D., n 18 above, 180.
22. See, for example, Edgar, K., O'Donnell, I. and Martin, C., n 13 above; Trammell, R., n 15 above.
23. Butler, M. and Drake, D.H. (2007) 'Reconsidering Respect: Its Role in Her Majesty's Prison Service,' *Howard Journal of Criminal Justice* 46(2): 115-127; Edgar, K., O'Donnell, I. and Martin, C., n 13 above.
24. Gambetta, D. (2009) *Codes of the Underworld: How Criminals Communicate.* Princeton: Princeton University Press.
25. Gooch, K. and Doolin, K., n 11 above; Gooch, K. and Treadwell, J. (2015) *Prison Bullying and Victimisation.* Birmingham: University of Birmingham. Available Online: birmingham.ac.uk/prisonbullying; Gooch, K. and Treadwell, J. (forthcoming) *Transforming the Violent Prison.* Palgrave.
26. Edgar, K., O'Donnell, I. and Martin, C., n 13 above; Gooch, K. and Treadwell, J. (forthcoming), ibid.
27. Sparks, R., Bottoms, A.E. and Hay W. (1996) *Prisons and the Problem of Order.* Oxford: Oxford University Press; Crewe, B., Liebling, A. and Hulley, S. (2014) 'Heavy-Light, Absent-Present: Rethinking the 'Weight' of Imprisonment,' *British Journal of Sociology* 65(3): 387-410; Liebling's, A. (2011) Distinctions and distinctiveness in the work of prison officers: legitimacy and authority revisited. *European Journal of Criminology* 8(6): 484-499.

staff were not met with surprise by other prisoners, nor indeed by prison staff colleagues who were often aware of those officers who were antagonistic towards prisoners. However, officers found it frustrating when they felt there was no objective basis for claims of illegitimacy, and it was the case that some prisoners were quicker to assess staff conduct as 'disrespectful' and illegitimate.[28]

Secondly, retaliatory assaults occurred where an officer(s) was perceived to use disproportionate or illegitimate force and some prisoners would intervene to either stop the perceived abuse of power or demonstrate their dissatisfaction. Such actions typically occurred spontaneously, with prisoners observing what they perceived to be the misuse of coercive force by an officer against another prisoner and then 'jumping in' to either obstruct the officer or deliberately indicate their dissatisfaction. This included hitting, punching, grabbing or kicking an officer as well as deploying whatever weapons were immediately to hand (for example, brooms). Such actions only served to escalate an incident and rarely prompted the desired (from the perspective of the prisoners concerned) reappraisal about the actions of prison staff, leading instead to the reprehension of the prisoner's behaviour.

Protest assaults are primarily the product of profound frustration by prisoners, which was no longer possible to contain. This form of assault typically occurred because of administrative difficulties, such as prisoners not getting answers to questions, applications or complaints, or from poor regimes, including too little time in cell and too little meaningful activity:

> *'With like the staff assaults, some of that happened because the staff don't understand the prisoners. Like we're banged up literally like 23 hours a day, there will be times we're meant to be out for association and they will just cancel it, they wouldn't give us an explanation or nothing so obviously people get frustrated and start banging their doors. Some people take it to the extreme and assault an officer, you know what I'm saying like?'* (YOI/Category C)

Frustration also stemmed from the arbitrary application of the rules. The 'rigid application of a rule that is usually interpreted more flexibly'[29] was particularly provocative and could easily escalate from heated verbal exchanges to a spontaneous or planned assault, especially when the arbitrary use of power was perceived to be discriminatory or personal. The inconsistent application of the rules was frustrating for its unpredictability since prisoners simply did not 'know where they stood' — something that Crewe describes more generally as the psychological pain of uncertainty.[30] The frustration on the part of these prisoners was that such staff were unnecessarily making prison time 'harder' than it needed to be.

Protest assaults are primarily the product of profound frustration by prisoners, which was no longer possible to contain. This form of assault typically occurred because of administrative difficulties

Instrumental assaults involve the use of violence by prisoners to bring about a desired purpose. They can occur when prisoners seek to reinforce or renegotiate the balance of power. For example, when prisoners had assumed a position of control on a particular wing(s) and there were attempts by individual officers to enforce the rules or (re)assert their authority. We repeatedly heard accounts from prisoners of incidences where the balance of power had shifted so that officers were largely physically or symbolically absent and under-using their power. For example:

> *'Frankly prisoners are running the prisons these days, it's not the staff running prisons. The prisoners are running prisons and they are getting more and more dangerous by the day because in a prison, like this, like I say we've got so many inexperienced staff that some of these very experienced inmate criminals, who can manipulate anything they want, are doing just that.' (Category C)*

If the culture amongst officers was to allow prisoners to self-police the wings, overlook rule

28. See also Quinn, A., Hardwick. N. and Meek, R. (2021) 'With Age Comes Respect? And for Whom Exactly? A Quantitative Examination of White and BAME Prisoner Experiences of Respect Elicited through HM Inspectorate of Prisons Survey Responses,' *Howard Journal of Criminal Justice* 60(2): 251-272.
29. Fassin, D., n 18 above, 181.
30. Crewe, B. (2011) 'Depth, weight, tightness: Revisiting the pains of imprisonment,' *Punishment and Society* 13(5): 509-529.

violations and allow inappropriate conduct, or simply to fail to enforce reasonable expectations about behaviour, power was assumed by more assertive and controlling prisoners. These attempts by prisoners to 'claim power from staff, rather than having it delegated to them'[31] became increasingly more common, particularly in some prisons/prison wings, owing to the loss of experienced staff from 2013, inconsistent staffing, and the presence of very inexperienced staff who were still developing their confidence and competence.[32] In such circumstances, prisoners' perceptions of respect became distorted. Officers being 'respectful' towards them was not only about decent treatment or the 'inherent dignity and value of the human person',[33] but — to those prisoners who had assumed a degree of power and control — it was also about recognising their status and deferring to their elevated positions (even if they had effectively usurped prison officer authority). The effect of this was that officers who sought to restore the balance of power in ways that would otherwise be considered appropriate, legal and legitimate, were perceived to be over-reaching and 'violating' prisoners who had adopted positions of 'extra-legal governance.'[34] It was these officers who quickly became the targets of organised assaults and 'potting' incidents.

Instrumental assaults also occurred when prisoners who were being threatened, assaulted, or coerced sometimes formed the belief that their only route to safety was to find 'sanctuary'[35] in segregation,[36] on another wing or in another prison. When officers were unavailable or unresponsive to initial attempts to report concerns, some prisoners decided that their only route to safety was to assault a member of staff. Here, such prisoners could not only predict the reaction of prison staff to assaults on staff but were indeed relying on that habitual response for their own safety and protection. Such assaults were instrumental, but they were also steeped in desperation and were preventable.

We found that prisoners' grievances towards staff and/or the 'system' more generally were primarily directed at staff rather than their peers. However, the overlap between a prisoner's grievances with other prisoners and grievances with staff occurred in two specific scenarios: 1) when a prisoner was in debt and was coerced by another prisoner to assault or 'pot' a member of staff; and 2) when a prisoner was seeking sanctuary or, conversely, seeking a transfer elsewhere and knew that assaulting a staff member would initiate the required action. For example:

> *'An officer got stabbed and got rushed to hospital, stabbed in the chest. … mostly it is they get paid to do it by others, if they're in debt, to clear the debt. … if someone's debted up to their eyeballs, and the guy he's debted up with says 'Oh if you wanna clear your debt, go and hit such and such.' So yeah, that's how it works.'* (Category C)

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As noted above, debt has become an increasingly common feature of prison life, often attracting very real threats to, and physical assaults of, the debtor or their family members. In such circumstances, the debtor can be susceptible to demands to assault or pot a staff member in order to expunge the debt. These targeted assaults defy traditional decisions about 'risk' since it is those who might appear least likely to pose a risk to prison staff, and/or who seem to be most vulnerable, who instigate the assault. It can also mean that the complicity of those who are orchestrating and demanding that the assault or 'potting' occurs goes unnoticed.

Preventing Staff Assaults

Research suggests that prison staff who are assaulted may experience post-traumatic stress disorder

31. Crewe, B. and Liebling, A. (2017) 'Reconfiguring Penal Power,' In: Liebling, A., Maruna, S. and McAra, L. (eds), *The Oxford Handbook of Criminology.* 6th Edn. Oxford: Oxford University Press, 889-913.
32. Gooch, K. and Treadwell, J. (2021) '"It doesn't stop at the prison gate": Understanding organised crime in prison,' *Prison Service Journal* 252: 15-30.
33. Liebling, A. (2004) *Prisons and their Moral Performance*: *A Study of values, Quality, and Prison Life* Oxford: Clarendon Press, 212.
34. Skarbek, D. (2014) *The Social Order of the Underworld: How Prison Gangs Govern the American Penal System.* Oxford: Oxford University Press; Gooch, K. and Treadwell, J., n 32 above.
35. Toch, H. (1977) *Living in Prison:* The Ecology of Survival. New York: Free Press, 165.
36. See also Laws, B. (2021) 'Segregation Seekers: An Alternative Perspective on Solitary Confinement Debate,' *British Journal of Criminology* Online First. Available Online: https://academic.oup.com/bjc/advance-article-abstract/doi/10.1093/bjc/azab032/6246111

(PTSD), secondary or vicarious trauma, 'burnout', and generalised feelings of stress and emotional detachment.[37] Thus, the impact of a staff assault extends far beyond any physical injury suffered. In addition, the fear of an assault, and increased anxiety about disorder, may have a more general effect on other staff members. This can often generate two distinct but related responses: 1) withdrawal and social distancing by staff from prisoners; and 2) the hardening of security measures and sentencing options (whether through adjudications or criminal prosecution). Whilst such responses are understandable and can seem to protect staff in the immediate or very short-term, they are ultimately counterproductive and can inadvertently increase, not decrease, the likelihood of further assaults. This is because such responses not only created or reinforced an 'us and them' culture but weakened staff-prisoner relationships. This risked indirectly allowing prisoners to claim greater power. Strong staff-prisoner relationships based on mutual respect and trust were the principal safeguard against staff assaults:

> *'It's much harder to attack someone you have respect for and you have good banter with.'* (YOI/Category C)

Thus, it is likely that creating further physical and social distance of staff from prisoners risks creating the fertile conditions for more, not less, violence. When staff are perceived to be unavailable, it encouraged the fashioning or storing of weapons amongst prisoners for 'protection' or self-defence if confronted by other prisoners. In some cases, these weapons would also be used against staff. Further, when staff withdraw, vulnerable prisoners were often left feeling more isolated with the effect that they simply withdrew from the regime or used whatever drugs were available to metaphorically escape. In the latter case, this only exacerbated problems of indebtedness and the possibility of the instrumental assaults detailed above.

The dangers of 'absent'[38] staff were not only apparent to prisoners[39] but (unsurprisingly) also to prison officers:

> *'There are some staff who we call them 'con shy.' I say some staff, but there is quite a lot of staff at the minute, and it is being brought up weekly, who you will just always find them in the office.'* (prison officer, Category C)

Social withdrawal and retreat of staff from prisoners, and tightening security measures or adopting more punitive approaches not only created or reinforced an 'us and them' culture but weakened staff-prisoner relationships.

For those officers who were prepared to remain on the landings, the absence of their colleagues contributed to the perception that the prison was unsafe and that staff assaults were not only possible, but likely. Such accounts and explanations by prison officers were consistent and repeated. When asked why he felt unsafe, another officer answered:

> *'I think lack of confidence in staff. Unsure of the rules. People, like, not having the awareness around them, I think, as well. I might be having an argument with one of the men [and the] officer's not clicking on to come and [has not] just make a presence or something and instead they might leave. I think it's just not experience. Yeah lack of experience in staff.'* (prison officer, Category C)

Prison officers were keenly aware of who the 'shit staff' (prison officer, Category C) were — those they described as failing to enforce the rules, who could not be relied upon, and/or who seemed to disappear when they were most needed. It was not uncommon for prison officers to form an assessment of how good the shift was likely to be after reviewing the 'detail' and discovering who they were working alongside. When describing what made him feel unsafe, one prison officer remarked:

> *'Now I am challenging lads all over the shop, saying, 'Right, you know you're not supposed*

37. See, for example, Boudoukha, A., Altintas, E., Rusinek, S., Fantini-Hauwel, C. and Hautekeete, M. (2013) 'Inmates-to-Staff Assaults, PTSD and Burnout: Profiles of Risk and Vulnerability', *Journal of Interpersonal Violence* 28(11): 2332-2350; King, A. and Oliver, C. (2020) 'A qualitative study exploring vicarious trauma in prison officers', *Prison Service Journal* 251: 38-45
38. Crewe, B., Liebling, A. and Hulley, S., n 27 above.
39. Ibid; Crewe, B. and Liebling, A., n 31 above.

to be here. […]. I am always challenging them every day. I had a confrontation the other day. He was right in my face. I said, 'Look. You know the score'. I had another officer with me and he backed down in the end. That's why it's unsafe. […] I think not consistent and not controlled with some staff not challenging [is why it's unsafe for staff].' (prison officer, Category C)

Overwhelmingly, on a day-to-day basis, such officers' perceptions of safety (or lack thereof) rested on who they were working with, not on what 'tools' they had at their disposal. This underscores the importance of having sufficient numbers of well-trained officers and investing in the ongoing training, mentoring and relationship building of prison staff who are working in often challenging and volatile environments.

Conclusion

Although the increase in the maximum penalties for assaulting prison officers — and their inclusion within the legislation regarding emergency workers — might be viewed as a welcome development, the extent to which it will serve a deterrent effect and reduce the incidence of staff assault is relatively limited. An abundance of research attests to the fallacy of increasing sentence severity in order to reduce crime — if anything, it is the certainty of being caught that deters individuals in the community from committing crime.[40] Whilst the certainty of being identified as a perpetrator is greatly increased within prison, violence serves a specific function in achieving justice, expressing grievances and frustration, retaliation, settling the balance of power, and, crucially and perversely, as a way of finding safety and sanctuary. In such circumstances, violence was commonly viewed by the prisoner as necessary, rational, and obligatory, even when faced with the possibility of 'added days' awarded by the Independent Adjudicator[41] or criminal prosecution for additional charges. Thus, the extent to which aggravated forms of assault and battery will serve as a deterrent and reduce staff assaults is limited.

Reducing and preventing staff assaults requires an environment where prisoners are safe and an investment in strong prisoner-staff relationships and staff-manager relationships. This investment requires sufficient numbers of well-trained staff, sufficient time to build relationships, smaller staff: prisoner ratios, well-supported and trained managers, the harnessing of dynamic security, and greater understanding of prisoner behaviour, including the ways in which harmful behaviour might be signalling concerns or distress that individuals cannot otherwise communicate in ways that are 'heard'. This is only part of the picture; some prisoners will import and/or develop norms and behaviours that may influence their propensity towards violence. Nevertheless, preventing staff assaults does not lie simply in expanding security measures, or in creating more forms of control, or in increasing legislative options. Whilst such action might make staff feel or be safer in the immediate or very short-term, preventing staff assaults and improving prison staff safety long-term will only happen with structural changes to the way we fund and use prisons.

40. von Hirsch, A., Bottoms, A.E., Burney, E. and Wikstrom, P-O. (1999) *Criminal Deterrence and Sentence Severity: An Analysis of Recent Research*. Cambridge: University of Cambridge.
41. Recent research suggests that prison adjudications generally do not prevent further rule-breaking for prisoners who experience their punishment immediately following an adjudication or those who experience confinement in their cell following adjudication: Fortescue, B., Fitzalan Howard, F., Howard, P., Kelly, G. and Elwan, M. (2021) *Examining the impact of sanctions on custodial misconduct following disciplinary adjudications.* Ministry of Justice and Her Majesty's Prison and Probation Service: London.

The state of secondary mental healthcare in prisons during a pandemic: an analysis of prison inspection reports from England and Wales

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The challenges facing mental healthcare provision in prisons are well established, however these have been amplified by the COVID-19 pandemic. The aim of this paper is to understand mental healthcare service delivery in prisons in the context of the pandemic. Forty-four inspection reports published by Her Majesty's Inspectorate of Prisons (HMIP) for England and Wales were analysed thematically, focusing solely on sections specific to secondary mental healthcare delivery. Conclusions highlight the need for greater resource and investment in prison mental health services, as well as action to maximise the opportunities to advance service delivery.

Introduction

> *The most disturbing effect of the restrictions was the decline in prisoners' emotional, psychological and physical well-being. They were chronically bored and exhausted by spending hours locked in their cells. They described being drained, depleted, lacking in purpose and sometimes resigned to their situation. Some said they were using unhealthy coping strategies, including self-harm and drugs, while others reported using mundane routines to pass the time and cope with their confinement and associated anxieties. They frequently compared themselves to caged animals.*[1]

The public health response to the COVID-19 pandemic translated into restrictions on daily life and targeted measures to reduce the spread of the infection and save lives[2]. Shortly after the pandemic took hold in England and Wales, HM Prison and Probation Service (HMPPS) and Public Health England (PHE) conducted modelling to anticipate the impact of COVID-19 on people in prisons. It suggested that over 2,000 people in prison might die if no action was taken to reduce the spread. As a result, severe regime restrictions were imposed for the safety of both those working and living in prisons[3]. The restrictions led to increased time in cells (up to 23 hours a day for many people), little or no contact with other people imprisoned, little or no meaningful activity, and termination of social visits with family and friends[4]. Over the course of the pandemic, greater attention has been given to its effects on prison healthcare services and the health and wellbeing of people in prison[5 6 7 8 9].

1. HMIP (2021) What happens to prisoners in a pandemic? A thematic review by HM Inspectorate of Prisons. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/02/What-happens-to-prisoners-in-a-pandemic.pdf
2. Beaudry, G., Zhong, S., Whiting, D., Javid, B., Frater, J. & Fazel, S. (2020) Managing outbreaks of highly contagious diseases in prisons: a systematic review. BMJ Global Health, 5(11): 3201. http://dx.doi.org/10.1136/bmjgh-2020-003201
3. HMIP (2021) What happens to prisoners in a pandemic? A thematic review by HM Inspectorate of Prisons. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/02/What-happens-to-prisoners-in-a-pandemic.pdf
4. Hewson, T., Shepherd, A., Hard, J. & Shaw, J. (2020) Effects of the COVID-19 pandemic on the mental health of prisoners. The Lancet Psychiatry, 7(7): 568-570. https://dx.doi.org/10.1016%2FS2215-0366(20)30241-8
5. Kothari, R., Forrester, A., Greenberg, N., Sarkissian, N. & Tracy, D. (2020) COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff. Medicine, Science and the Law, 60(3): 165-168. https://doi.org/10.1177%2F0025802420929799
6. Hewson, T., Shepherd, A., Hard, J. & Shaw, J. (2020) Effects of the COVID-19 pandemic on the mental health of prisoners. The Lancet Psychiatry, 7(7): 568-570. https://dx.doi.org/10.1016%2FS2215-0366(20)30241-8
7. Beaudry, G., Zhong, S., Whiting, D., Javid, B., Frater, J. & Fazel, S. (2020) Managing outbreaks of highly contagious diseases in prisons: a systematic review. BMJ Global Health, 5(11): 3201. http://dx.doi.org/10.1136/bmjgh-2020-003201
8. Parliament UK (2020) Coronavirus (Covid-19): The impact on prisons: Government Response to the Committee's Fourth Report of Session 2019–21. https://publications.parliament.uk/pa/cm5801/cmselect/cmjust/1065/106502.htm
9. Prison Reform Trust (2021) CAPPTIVE: How prisons are responding to COVID-19. www.prisonreformtrust.org.uk

Whilst the measures introduced to minimise the spread of COVID-19 are necessary to save lives, the long-term impact of quarantine on the mental health, wellbeing and rehabilitation of people in prison are of grave concern[10]. A rapid review of the psychological impact of quarantine conditions, conducted in a range of settings, reported several negative effects, including post-traumatic stress symptoms, confusion, and anger. These were aggravated by quarantine duration, fear of infection, boredom, and inadequate supplies and information. The authors warn that individuals should not be quarantined for longer than required and there should be a clear rationale, and access to information and sufficient supplies[11].

Within prison settings, these findings are of great importance due to the vulnerability of the people detained and the likely harmful consequences of such conditions. Prevalence studies have identified high rates of mental health conditions among this population, as well as record levels of suicide and self-harm in recent years[12 13 14]. People in prison are among the most marginalised in society; they have multiple and complex health issues at rates far greater than the general population[15 16]. The impact of such restrictions on mental health and wellbeing has been published in a recent report capturing the views and experiences of people in prison during COVID-19, with respondents describing aggravation of diagnosed mental health conditions, and increased anger, anxiety and depression[17]. The adverse mental health effects are affecting previously healthy people, as well as people with pre-existing mental health conditions[18].

The challenges experienced by prison mental health services were well documented prior to the pandemic, including limited resource, variability between prisons, a lack of integrated working, and shortcomings in ensuring continuity of care, to name a few[19 20 21 22]. Concerns have also been raised in other areas, such as: mental health awareness among prison staff; the appropriateness of the environment for clinical practice; a lack of information available on mental healthcare and related services; limited patient involvement in care planning; and inadequate staff support systems[23]. The existing challenges of providing healthcare in prisons were amplified by COVID-19 and services quickly shifted to prioritising clinical need and suspending non-essential services[24]. The impact of the pandemic on mental health services will vary across the prison estate, with differing populations, environments, and health and custodial resource. However, there has been evidence of some innovative practice to support service delivery during this period, such as the increasing use of telemedicine whilst face-to-face assessments are not possible[25].

This paper analyses data from 44 reports of prison inspections conducted between May 2020 and April

10. Parliament UK (2020) Coronavirus (Covid-19): The impact on prisons: Government Response to the Committee's Fourth Report of Session 2019–21.
11. Brooks, S. K., Webster, R., Smith, L., Woodland, L., Wessely, S., Greenberg, N., & Gideon, J. (2020) The psychological impact of quarantine and how to reduce it: rapid review of the evidence. The Lancet, 395(10227): 912-920. https://doi.org/10.1016/S0140-6736(20)30460-8
12. Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998) ONS Psychiatric morbidity among prisoners: Summary report. Office for National Statistics.
13. Fazel, S., Hayes, A., Bartellas, K., Clerici, M. & Trestman, R. (2016) Mental health of prisoners: prevalence, adverse outcomes, and interventions. The Lancet Psychiatry, 3(9): 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0
14. Prisons & Probation Ombudsman (2016) Prisoner mental health. http://www.ppo.gov.uk/app/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf
15. Ismail, N. & Forrester, A. (2020) The state of English prisons and the urgent need for reform. The Lancet Public Health, 5(7): E368-E369. https://doi.org/10.1016/S2468-2667(20)30142-0
16. Public Health England (2016) Health and Justice Annual Review 2015/16. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565232/health_and_justice_annual_review_2015_to_2016.pdf
17. Prison Reform Trust (2021) CAPPTIVE: How prisons are responding to COVID-19. www.prisonreformtrust.org.uk
18. Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., Cannon, M., Correll, C., Byrne, L., Carr, S., Chen, E., Gorwood, P., Johnson, S., Kärkkäinen, H., Krystal, J., Lee, J., Lieberman, J., López-Jaramillo, C., Männikkö, M., … (2020) How mental health care should change as a consequence of the COVID-19 pandemic. The Lancet Psychiatry, 7(9): 813-824. https://doi.org/10.1016/S2215-0366(20)30307-2
19. Forrester, A., Exworthy, T., Olumoroti, O., Sessay, M., Parrott, J., Spencer, S., & Whyte, S. (2013) Variations in prison mental health services in England and Wales. International Journal of Law and Psychiatry, 36(3–4): 326–332. https://doi.org/10.1016/j.ijlp.2013.04.007
20. Centre for Mental Health (2014) The Bradley report five years on: an independent review of progress to date and priorities for further development. https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/bradley5years.pdf.
21. National Audit Office (2017) Mental Health in Prisons. https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf
22. Ismail, N. & Forrester, A. (2020) The state of English prisons and the urgent need for reform. The Lancet Public Health, 5(7): E368-E369. https://doi.org/10.1016/S2468-2667(20)30142-0
23. Georgiou, M. & Townsend, K. (2019) Quality Network for Prison Mental Health Services: reviewing the quality of mental health provision in prisons. Journal of Forensic Psychiatry and Psychology, 30(5): 794-806. https://doi.org/10.1080/14789949.2019.1637918
24. Kothari, R., Forrester, A., Greenberg, N., Sarkissian, N. & Tracy, D. (2020) COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff. Medicine, Science and the Law, 60(3): 165-168. https://doi.org/10.1177%2F0025802420929799
25. Hewson, T., Robinson, L., Khalifa, N., Hard, J. & Shaw, J. (2021) Remote consultations in prison mental healthcare in England: impacts of COVID-19. BJPsych Open, 7(2): e49. https://doi.org/10.1192/bjo.2021.13

2021 with the purpose of understanding secondary mental healthcare service delivery in the context of the pandemic. It aims to recognise key themes and learning that can contribute to service improvements and enhancement of patient experience as prison mental health services focus on restoration and recovery from COVID-19. This paper is important given the growing concerns that have been raised regarding mental health and wellbeing in prisons and the challenges posed by the COVID-19 pandemic. The analysis focuses solely on the section within each inspection report that describes secondary mental health provision.

Method

This qualitative study analyses HM Inspectorate of Prisons (HMIP) reports from inspections published in England and Wales during the COVID-19 pandemic. The analysis includes all 44 published reports for prisons (including privately run prisons) and young offender institutions inspected between May 2020 and April 2021. The reports consist of both individual site-based scrutiny visit reports (n=37) and multi-site short scrutiny visit reports (n=7). The study does not include reports on secure training centres, immigration detention facilities, police and court custody or military detention as the settings differ from prison establishments in purpose and service delivery. As this paper is focused on secondary mental healthcare, analysis has been restricted to sections within the report specifically relating to this provision. Though, it is important to highlight that some primary and secondary mental health services are integrated, and the reports have been presented in this manner. This paper reports on the summations and judgements provided by the inspectors only; the full data collected from the inspections was not observed. The study also presents data from a survey collected as part of the HMIP site-based visits for adult prisons and includes responses from 34 prisons. The survey was distributed to a random sample of the prisoner population at each prison and the response rate varied between prisons. The total number sampled was 5166. The survey posed questions on the experiences of people imprisoned during the COVID-19 pandemic. It included a question 'Is it easy or difficult to see mental health workers?' and a yes/no question on self-reported mental health problems — 'Do you have mental health problems?'.

Report on short scrutiny visits	**Prisons inspected**
Category C Prisons	HMP Maidstone HMP Onley HMP/YOI Brinsford
Local Prisons	HMP Leeds HMP Thameside HMP Winchester
Long-term and High Security Prisons	HMP Belmarsh HMP Manchester HMP Woodhill
Category D Open Prisons	HMP/YOI Thorn Cross HMP Ford HMP Sudbury
Prisons holding prisoners convicted of sexual offences	HMP Littlehey HMP Rye Hill HMP Stafford
Prisons holding women	HMP Send HMPYOI Downview
Young offender institutions holding children	HMYOI Feltham A HMYOI Werrington

Table 1 Description of Short Scrutiny Visit reports reviewed, and the prisons included in each report.

Prison type	Site reports	Mean percentage of prisoners who self-reported a mental health condition (range)	Mean percentage of prisoners who reported easy access to mental health workers (range)
Category A	2	43 (42-43 per cent)	26 (22-30 per cent)
Category B	14	59 (37-79 per cent)	23 (8-49 per cent)
Category C	11	46 (31-62 per cent)	24 (11-35 per cent)
Category D	5	30 (22-36 per cent)	43 (36-56 per cent)
Women	2	67 (59-75 per cent)	19 (15-23 per cent)
YOI	3	No data	No data
Total	37*		

Table 2 Description of prisons reviewed under the Scrutiny Visit model, including HM Inspectorate of Prisons (HMIP) data on self-reported mental health conditions among prisoners and reported ease of access to mental health workers by prisoners.

*Five prisons were managed by a private company as contracted by HM Prison and Probation Service.

The prison inspection reports, published on the HMIP website, are within the public domain and free-to-access. HMIP are an independent, statutory organisation which reports on the treatments and conditions of those detained in prisons and other places of detention. The COVID-19 pandemic has prevented HMIP from conducting full inspections against their standard criteria. Therefore, from April 2020, a reduced methodology known as the 'short scrutiny visit' (SSV) model was developed. These visits occurred over one day in an establishment and inspecting teams consisted of two or three inspectors, including one healthcare inspector[26]. Thematic summary reports were published highlighting key themes from a series of visits across a sector of the prison estate (e.g. the youth estate, male local prisons, etc.). A full list of prisons that were included in the SSV thematic summary reports is presented in Table 1. In August 2020, inspections were replaced with 'scrutiny visits' (SV), an updated approach considering the changing circumstances around COVID-19 at the time (see Table 2 for a description of the prisons reviewed). The purpose of the SVs were to report on individual prison establishments. SV inspecting teams consisted of five inspectors, including one healthcare inspector[27]. Each report offers findings into the operation of the prison(s) and the services that are provided.

This study applies a systematic procedure for reviewing organisational and institutional reports, known as document analysis, to generate key themes, categories, and case examples[28]. The approach enables the researcher to rely on the description and interpretation of data within published documents, such as excerpts, quotations, and surveys, rather than analysing raw data[29 30]. Utilising this method in prison research offers valuable insight and understanding of how mental healthcare in prisons is delivered[31 32 33]. In the current climate of the coronavirus pandemic, this method offers greater utility whilst external scrutiny is reduced, and research activity suspended.

An inductive approach was taken to analyse the texts and generate categories[34]. The data was analysed using NVivo 12, a computer-assisted qualitative data analysis software. NVivo is a useful tool for managing large datasets and supports the researcher in ensuring and demonstrating rigor in the

26. HMIP (2020a) Alternative approach to scrutiny during the COVID-19 pandemic. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Short-scrutiny-visit-briefing-document-for-website-1.pdf
27. HMIP (2020b) Developing HMI Prisons scrutiny during recovery from the COVID-19 pandemic. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/08/SV-methodology-for-website-1.pdf
28. Bowen, G. A. (2009) Document analysis as a qualitative research method. Qualitative Research Journal, 9(2): 27–40. https://doi.org/10.3316/QRJ0902027
29. Bowen, G. A. (2009) Document analysis as a qualitative research method. Qualitative Research Journal, 9(2): 27–40. https://doi.org/10.3316/QRJ0902027
30. Labuschagne, A. (2003) Qualitative Research - Airy Fairy or Fundamental?. The Qualitative Report, 8(1), 100-103. https://doi.org/10.46743/2160-3715/2003.1901
31. Woodall, J. & Freeman, C. (2019) Promoting health and well-being in prisons: an analysis of one year's prison inspection reports. Critical Public Health, 30(5): 555-566. https://doi.org/10.1080/09581596.2019.1612516
32. Woodall, J. & Freeman, C. (2021) Developing health and wellbeing in prisons: an analysis of prison inspection reports in Scotland. BMC Health Services Research, 21:314. https://doi.org/10.1186/s12913-021-06337-z
33. Patel, R., Harvey, J. & Forrester, A. (2018) Systemic limitations in the delivery of mental health care in prisons in England. International Journal of Law and Psychiatry, 60: 17-25. https://doi.org/10.1016/j.ijlp.2018.06.003
34. Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2): 77–101. https://doi.org/10.1191/1478088706qp063oa

analytical process[35]. Each report was uploaded into NVivo and coding functions were used to create categories and code date accordingly.

Results

This section reports the key themes derived from 44 HMIP inspection reports that were published during the first year of the COVID-19 pandemic, as well as survey data relating to mental health and mental healthcare from 34 adult prisons. The prisons have not been identified in the reporting. The results have been presented under six headings: reduced service provision; prevalence; treatment and interventions; management of suicide and self-harm; use of technology; transfers to hospital under the Mental Health Act.

Reduced service provision

The COVID-19 pandemic and its impact on health provision is described in each report. In relation to secondary mental health provision, 84 per cent of reports stated that the support available had reduced during the pandemic. Many teams were reported to be prioritising support on clinical risk and vulnerability and there were concerns that in some locations routine referrals were not being assessed or were taking much longer. In one location, services were withdrawn from the prison in the first part of the pandemic:

> *The secondary mental health in-reach team had been working remotely during the pandemic. On-site face-to-face appointments had restarted in mid-August with a caseload of 23 prisoners. There was evidence of unmet need.*

In relation to secondary mental health provision, 84 per cent of reports stated that the support available had reduced during the pandemic.

Six reports described healthcare staff conducting welfare checks for the most vulnerable or to support people not on their caseload with general wellbeing issues due to increased demand.

Several reports described staffing shortages which led to increased waiting times. In some cases, the limited resources prior to the pandemic were mentioned and these challenges were further exacerbated due to shielding, isolating and social distancing.

> *… prisoners did not have access to evidence-based psychological therapies, and waiting lists for treatment were extensive.*

Table 2 displays the mean percentage of people in prison who reported easy access to mental health workers (by prison type) during the pandemic. There was little qualitative feedback directly from patients in the reports, however at one site it was stated that patients had reported having to wait for long periods for treatment, but that the care they received was good once they were able to access the service.

One service was able to mitigate the effects of the pandemic on service delivery by adapting their approach:

> *Despite some curtailment to the service during the pandemic, mental health staff had been flexible in providing ongoing support. They visited the units and had altered their working hours to fit in with exercise times on the playing field, to see their patients and anyone else who wanted to speak to them about their mental health and wellbeing.*

Prevalence

Several reports described an increase in people in prison requiring support since the regime restrictions commenced. Table 2 displays the percentage mean and range of self-reported mental health problems from individuals surveyed across different prison types.

At one prison, staff raised concerns about the impact of the restricted regime on health and wellbeing:

> *Staff had serious concerns that the long periods confined to their cells would affect these patients' well-being, and cause boredom, low mood and sleep inversion, leading to increased prescribing.*

35. Spencer, L., Ritchie, J. & O'Connor, W. (2003) Analysis: Practices, principles and processes, in Ritchie, J. and Lewis, J. (eds) Qualitative Research Practice (pp. 199–218). Sage.

Interestingly, one site had seen diminished demand although there was no supporting information to explain the reduction:

> *Referrals were low and had in fact decreased since the beginning of the period of restrictions.*

There was variability in the size of caseloads of secondary mental health services, ranging from one patient to over 200. One mental health service was reported as having a combined primary and secondary mental health caseload of 450 patients.

Treatment and interventions

Face-to-face contact and therapeutic groups were greatly reduced or unavailable in most prisons during the restricted regime.

However, some teams were able to continue with individual sessions and one service managed to make improvements:

> *The team offered a variety of interventions including interventions based on cognitive behavioural therapy, sleep hygiene and an extensive range of in-cell guided workbooks.*

> *Services had improved with a more diverse range of psychological therapies, wider competences among staff and a developing neuro-disability pathway.*

Many mental health teams developed in-cell workbooks and self-help materials to mitigate the reduced service provision.

> *A range of mental health information was available, including specific COVID-19 anxiety management information in an easy-read format, and distraction and in-cell activity resources.*

> *A particularly helpful booklet entitled 'Living with Lockdown' which had been translated into Albanian, Romanian, Spanish and Polish provided useful coping strategies.*

In some cases, there were insufficient spaces to conduct one-to-one and group interventions:

> *There were not enough rooms in the prison to deliver high intensity one-to-one therapy, and therapeutic groups had been curtailed because of social distancing restrictions.*

For patients subject to the Care Programme Approach and due for transfer or release, two reports acknowledged the challenge in engaging external mental health services during the restrictions.

Psychiatry provision was available in most cases, either via telephone or face-to-face. Psychology input was much more variable with some sites continuing with therapy individually, although in other locations psychological therapies were not available. One prison upskilled nursing staff enabling them to offer patients interventions to address their psychological needs.

Psychology input was much more variable with some sites continuing with therapy individually, although in other locations psychological therapies were not available.

Management of suicide and self-harm

Almost half of reports acknowledged the mental health teams' involvement in Assessment, Care in Custody and Teamwork (ACCT) reviews for people at risk of suicide or self-harm. Of these, all the services were actively involved in the process however their input varied.

> *… ACCT records suggested that multidisciplinary input was not always consistent.*

Some teams attended all reviews in person, whereas others provided written contributions where it was not possible to attend. Furthermore, most teams attended initial ACCT reviews only and a couple of teams were reported as attending all ACCT reviews.

Use of technology

Just over one-quarter of reports stated telephony as a means for mental health practitioners to maintain contact with patients throughout the pandemic. Only five reports indicated that video calling was utilised to undertake some consultations and assessments for mental health purposes.

Clinicians had made more use of technology to treat patients in the last six months, including telephone consultations with hospital specialists and the use of electronic tablets to allow the psychiatrist to observe the patient while undertaking an assessment.

One prison was reported to be planning to adopt video-conferencing and electronic handheld devices in the near future.

Transfers to hospital under the Mental Health Act

26 reports recorded activity in relation to Mental Health Act transfers to hospital. Of these, 15 reports identified concerns whereby patients were experiencing delays beyond the national guidance and waiting too long for transfer:

All five patients on the transfer waiting list at the time of our visit were beyond the transfer time target (14 days), one of whom had waited more than 100 days and one more than 250 days. This was unacceptable.

In one prison, two people awaiting transfer did not have a care plan.

Eight reports stated that there had been no reported (significant) delays or the transfers had taken place within specified timescales.

One prison was commended for reductions in waiting time:

[Provider] had developed a new approach to transferring patients to hospital under the Mental Health Act, which included weekly monitoring with service commissioners and specialist commissioners. This had proved very effective with only two patients awaiting transfer (compared to 16 in April) and waiting times, while still beyond target, reduced.

Discussion

The purpose of this study was to understand how mental healthcare was delivered in prisons during the first year of COVID-19 and identify learning that could be applied throughout the remainder of the pandemic and beyond. This is particularly important as external scrutiny has been lessened during the period of regime restrictions and service delivery is so variable. Whilst COVID-19 has presented unique challenges to the prison estate and measures are required to reduce the spread of infection within prisons, the effect on mental healthcare and the mental health and wellbeing of people in prison are profound.

In most cases, service delivery has been restricted, there has been an observed rise in people requiring support, and the health of people in prison has been compromised.

Mental healthcare in prisons was under pressure prior to the pandemic. The data contained within the inspection reports demonstrates the substantial impact COVID-19 has had on mental health services in prisons. In most cases, service delivery has been restricted, there has been an observed rise in people requiring support, and the health of people in prison has been compromised. Mental health practitioners have had to quickly adapt to new ways of working and navigate through a shifting landscape and increased risk[36].

The variability of mental health service provision identified in pre-pandemic accounts continue to be problematic, with services not able to provide equivalent care to that provided in the community[37]. COVID-19 exacerbated these challenges, with services suffering reduced resource because of vacancies, sickness and shielding arrangements. Many teams were constrained to prioritising need by clinical risk and vulnerability, despite increasing demand. Of most concern are the accounts where mental health services withdrew from the prison and only provided support remotely, resulting in unmet need. Moreover, the figures in Table 2 demonstrate the difficulties people in prison experienced in accessing mental health workers during this time. Four of the five prison types reported a mean below 26 per cent for the question relating to how easy respondents experienced accessing mental health workers.

Prior to the pandemic concerns were raised regarding the range of services available to people in

36. Kothari, R., Forrester, A., Greenberg, N., Sarkissian, N. & Tracy, D. (2020) COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff. Medicine, Science and the Law, 60(3): 165-168. https://doi.org/10.1177%2F0025802420929799
37. Forrester, A., Exworthy, T., Olumoroti, O., Sessay, M., Parrott, J., Spencer, S., & Whyte, S. (2013) Variations in prison mental health services in England and Wales. International Journal of Law and Psychiatry, 36(3–4): 326–332. https://doi.org/10.1016/j.ijlp.2013.04.007

prison[38]. The restricted regime limited the available interventions further, with face-to-face contact and group work being reduced or unavailable in most prisons. Mental health practitioners were quick to put alternatives in place, such as self-help materials and in-cell packs. One of the few positives of the pandemic was the implementation of technology to support the delivery of healthcare services using telemedicine. Around 40 per cent of prisons in England and Wales lacked sufficient internet connectivity for videoconferencing prior to the pandemic, however following COVID-19 new legislation has permitted the use of 4G enabled tablets for this purpose and all prisons in England now have telemedicine capability[39]. However, only five prison inspection reports mentioned the use of videoconferencing to undertake consultations and assessments. A greater number mentioned the use of telephones to maintain contact with their patients. Beyond the pandemic, opportunities to modernise healthcare delivery in prisons is welcomed. Telemedicine offers a range of potential advances, including improvements in accessing health services, reductions in waiting times, enhancement of the transfer process under the Mental Health Act, and improved health outcomes[40]. Although, further exploration is required to ensure remote working does not risk poorer health outcomes and compromise patient safety and experience[41].

Across the prisons included in this study, it is apparent that people are still waiting unacceptably long periods of time to be transferred to hospital under the Mental Health Act. This is particularly concerning as delays in transferring individuals with a severe mental illness is detrimental to health and is associated with increased risk of harm to self and others[42 43 44]. Existing guidance states that the transfer should occur within 14 days after the first assessment has taken place[45]; however, figures indicate that only 34 per cent of people were transferred in time[46]. New proposals as part of the Reforming the Mental Health Act White Paper suggest extending the timeframe to 28 days, despite the known harms associated with doing so[47]. The findings from this study illustrate the scale of the issue, and most alarmingly, that patients awaiting transfer are not always receiving a personalised plan to appropriately manage their health and ongoing care.

The study's findings highlight the importance of prison reform and greater investment in prison mental health services to improve health outcomes and rehabilitation for people in prison. Standards consistently fall short of the minimum requirements for mental healthcare in prisons and there remains much work to make improvements[48]. Mental health teams should be of a sufficient size and skill-mix to appropriately cater for the mental healthcare needs of people in prison[49]. Improvements in multi-agency working is also paramount to ensure people involved with the criminal justice system receive ongoing support across the care pathway, rather than the current fragmented approach[50].

In normal conditions the experience of imprisonment can have detrimental effects on health

38. Patel, R., Harvey, J. & Forrester, A. (2018) Systemic limitations in the delivery of mental health care in prisons in England. International Journal of Law and Psychiatry, 60: 17-25. https://doi.org/10.1016/j.ijlp.2018.06.003
39. Hewson, T., Robinson, L., Khalifa, N., Hard, J. & Shaw, J. (2021) Remote consultations in prison mental healthcare in England: impacts of COVID-19. BJPsych Open, 7(2): e49. https://doi.org/10.1192/bjo.2021.13
40. Edge, C., Hayward, A., Whitfield, A. & Hard, J. (2020) COVID-19: digital equivalence of health care in English prisons. The Lancet Digital Health, 2(9): E450-E452. https://doi.org/10.1016/S2589-7500(20)30164-3
41. Hewson, T., Robinson, L., Khalifa, N., Hard, J. & Shaw, J. (2021) Remote consultations in prison mental healthcare in England: impacts of COVID-19. BJPsych Open, 7(2): e49. https://doi.org/10.1192/bjo.2021.13
42. Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P., & Croudace, T. (2005) Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: A systematic review. Archives of General Psychiatry, 62(9): 975–983. https://doi:10.1001/archpsyc.62.9.975
43. Leonard, S. (2018) A comparative study of people transferred from prison to hospital under the Mental Health Act (1983): their pathways and outcomes. University of Manchester, PhD Thesis.
44. Forrester, A., Till, A., Simpson, A. & Shaw, J. (2018) Mental illness and the provision of mental health services in prisons. British Medical Bulletin, 127(1): 101–109. https://doi.org/10.1093/bmb/ldy027
45. Department of Health (2011) Good Practice Procedure Guide: The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act. https://www.gov.uk/government/publications/the-transfer-and-remission-of-adult-prisoners-under-s47-and-s48-of-the-mental-health-act
46. National Audit Office (2017) Mental Health in Prisons. https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf
47. DHSC (2021) Reforming the Mental Health Act White Paper. https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act
48. Glorney, E., Ullah, H. & Brooker, C. (2020) Standards of Mental Health Care in Prisons in England and Wales: A Qualitative Study of Reports from Her Majesty's Inspectorate of Prisons. International Journal of Forensic Mental Health. Routledge, 19(3): 283–296. https://doi.org/10.1080/14999013.2020.1743389
49. Forrester, A., Exworthy, T., Olumoroti, O., Sessay, M., Parrott, J., Spencer, S., & Whyte, S. (2013) Variations in prison mental health services in England and Wales. International Journal of Law and Psychiatry, 36(3–4): 326–332. https://doi.org/10.1016/j.ijlp.2013.04.007
50. Forrester, A. & Hopkin, G. (2019) Mental health in the criminal justice system: A pathways approach to service and research design. Criminal Behaviour and Mental Health, 29(4): 207-217. https://doi.org/10.1002/cbm.2128

and wellbeing, therefore it is vital that people in prison can access high quality care[51]. For those experiencing imprisonment during a pandemic, access to these services is even more important to mitigate the psychological impact of quarantine conditions.

Whilst this study has drawn together the key results from more than 40 inspection reports, identifying a number of key commonalities across the prison estate around mental health provision during the first year of the COVID-19 pandemic, it is limited in a number of key ways. In particular, the inspection reports lack detail as they were not produced for research purposes. This paper focuses on one section of the prison inspection reports whereby concise and factual accounts of mental healthcare provision are provided. It is possible that some areas of service provision were not recorded by inspectors. As a result, the depth of the analysis was restricted. Reports offering more in-depth analysis, such as the peer-review reports offered by the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services, may glean a richer picture. This paper is further limited by the argument that inspection reports offer a negative picture of healthcare delivery in prisons and may not capture good practice[52 53]. Lastly, this paper focuses on secondary mental healthcare only as it forms part of a wider project on this topic. The impact of COVID-19 on primary mental healthcare in prisons would also be an important consideration for future research.

Conclusion

This study summarises the key themes and learning from 44 prison inspection reports, offering a broad understanding of the delivery of mental healthcare in prisons during the first year of the COVID-19 pandemic. The pandemic posed new challenges for prison healthcare, whilst also exposing existing inadequacies. The regime restrictions have led to increased demand for mental health services, however with curtailed service delivery the support provided to people in prison has diminished, resulting in unmet need. The severe reduction in access and range of mental healthcare opposes the notion that the highest attainable standard of health is a fundamental right of every human being and that imprisonment should not adversely affect this[54 55]. Services require greater investment and resources to ensure people in prison receive equivalent services to that received in the community. Conversely, whilst presenting substantial challenges to the prison estate, the COVID-19 pandemic has offered the opportunity to modernise and improve some aspects of health and justice services. Action is now required to maximise these opportunities for advancement, such as improved technology and connectivity within prisons, to enhance prison healthcare services, improve health outcomes and support rehabilitation. With the return to full prison inspections from May 2021 it is vital that greater scrutiny is given to mental health provision, as services focus on recovering from COVID-19, to monitor progress and developments[56].

51. Patel, R., Harvey, J. & Forrester, A. (2018) Systemic limitations in the delivery of mental health care in prisons in England. International Journal of Law and Psychiatry, 60: 17-25. https://doi.org/10.1016/j.ijlp.2018.06.003
52. Walsh, E. (2009) Prison health care: it's time to "water the flowers". British Journal of Nursing, 18(4): 218. https://doi.org/10.12968/bjon.2009.18.4.39617
53. Woodall, J. & Freeman, C. (2021) Developing health and wellbeing in prisons: an analysis of prison inspection reports in Scotland. BMC Health Services Research, 21:314. https://doi.org/10.1186/s12913-021-06337-z
54. World Health Organisation (2017) Human rights and health. https://www.who.int/en/news-room/fact-sheets/detail/human-rights-and-health
55. Forrester, A., Till, A., Simpson, A. & Shaw, J. (2018) Mental illness and the provision of mental health services in prisons. British Medical Bulletin, 127(1): 101–109. https://doi.org/10.1093/bmb/ldy027
56. HMIP (2021b) Chief Inspector announces return to full inspections. https://www.justiceinspectorates.gov.uk/hmiprisons/2021/05/chief-inspector-announces-return-to-full-inspections/

Impact of introducing an alternative buprenorphine formulation on opioid substitution therapy supervision within UK prison settings

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Background

Opioid substitution therapy (OST) involves the prescribing and administration of pharmaceutical opioids for the treatment of dependence. OST is designed to reduce illicit opioid use and drug-related harms, reduce and prevent withdrawal symptoms, promote changes in lifestyle, and ultimately abstinence where this is an attainable outcome[1].

The National Drug Treatment Monitoring System estimated that there were 140,599 adults in England who were in contact with drug and alcohol treatment services for opiate dependency in 2019—2020[2]; of these, approximately 1 in 5 were in a prison setting[3]. The most commonly prescribed opioids used for OST in prisons are methadone and buprenorphine. However, buprenorphine sublingual tablets (whole or broken into granules) can take between 5 to 10 minutes to dissolve, providing opportunities for diversion of prescribed buprenorphine in prison settings[4]. Historically, this has meant that the offer of buprenorphine has been discouraged or limited in UK prisons. This impacts on both equivalence and continuity of care versus the community offering.

Where buprenorphine is not a standard offering in prison, patients entering these establishments have the option to move to methadone maintenance or undergo detoxification; both options are suboptimal and not always the best choice for the patient. For prisons that offer buprenorphine for OST, the current process for supervision of buprenorphine administration can be challenging for the staff involved and for patients and can lead to confrontation.

Buprenorphine oral lyophilisate (Espranor®) is an innovative form of buprenorphine that is designed to rapidly disperse on the tongue. One study found 96.3 per cent of buprenorphine oral lyophilisate administrations achieved partial disintegration on the tongue in ≤15 seconds, with over 58.0 per cent of administrations completely dissolving within 2 minutes[9]. By comparison, only 71.8 per cent of sublingual buprenorphine administrations achieved partial disintegration in ≤15 seconds and 5.1 per cent completely dissolved within 2 minutes, with a median time of 10 minutes for the tablets to completely dissolve.[8,9]

Evidence on the impact of switching to buprenorphine oral lyophilisate from buprenorphine

1. National Institute for Health and Care Excellence. (2007) *Methadone and buprenorphine for the management of opioid dependence* (TA114). Available at: https://www.nice.org.uk/guidance/ta114 (Accessed: 2 July 2021).
2. Public Health England. (2020) *Substance misuse treatment for adults: statistics 2019 to 2020*. Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020 (Accessed: 2 July 2021).
3. Public Health England. (2021) *Substance misuse treatment in secure settings: statistics 2019 to 2020.* Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-2019-to-2020 (Accessed: 2 July 2021).
4. European Medicines Compendium. (2021) *Buprenorphine 8mg Sublingual Tablets Summary of Product Characteristics*. Available at: https://www.medicines.org.uk/emc/product/4163/smpc (Accessed: 17 September 2021).
5. Reimer, J. et al. (2016) 'The Impact of Misuse and Diversion of Opioid Substitution Treatment Medicines: Evidence Review and Expert Consensus', *European Addiction Research*, 22(2), pp. 99–106. Available at: https://www.karger.com/Article/Fulltext/438988 (Accessed: 3 November 2021).
6. Wright, N. et al. (2011) 'Comparison of methadone and buprenorphine for opiate detoxification (LEEDS trial): a randomised controlled trial', *British Journal of General Practice*, 61(593), pp. e772–e780. Available at: https://pubmed.ncbi.nlm.nih.gov/22137413/ (Accessed: 3 November 2021).
7. Wright, N. et al. (2016) 'Addressing misuse and diversion of opioid substitution medication: guidance based on systematic evidence review and real-world experience', *Journal of Public Health*, 38(3): pp. e368–e374. Available at: https://pubmed.ncbi.nlm.nih.gov/26508767/ (Accessed: 3 November 2021).
8. European Medicines Compendium. (2020) *Espranor 8 mg oral lyophilisate Summary of Product Characteristics.* Available at: https://www.medicines.org.uk/emc/product/2317/smpc (Accessed: 2 July 2021).
9. Strang, J. et al. (2017) 'Randomised Comparison of a Novel Buprenorphine Oral Lyophilisate versus Existing Buprenorphine Sublingual Tablets in Opioid-Dependent Patients: A First-in-Patient Phase II Randomised Open Label Safety Study', *European Addiction Research,* 23(2), pp. 61–70. Available at: https://www.karger.com/Article/Abstract/456612 (Accessed: 3 November 2021).

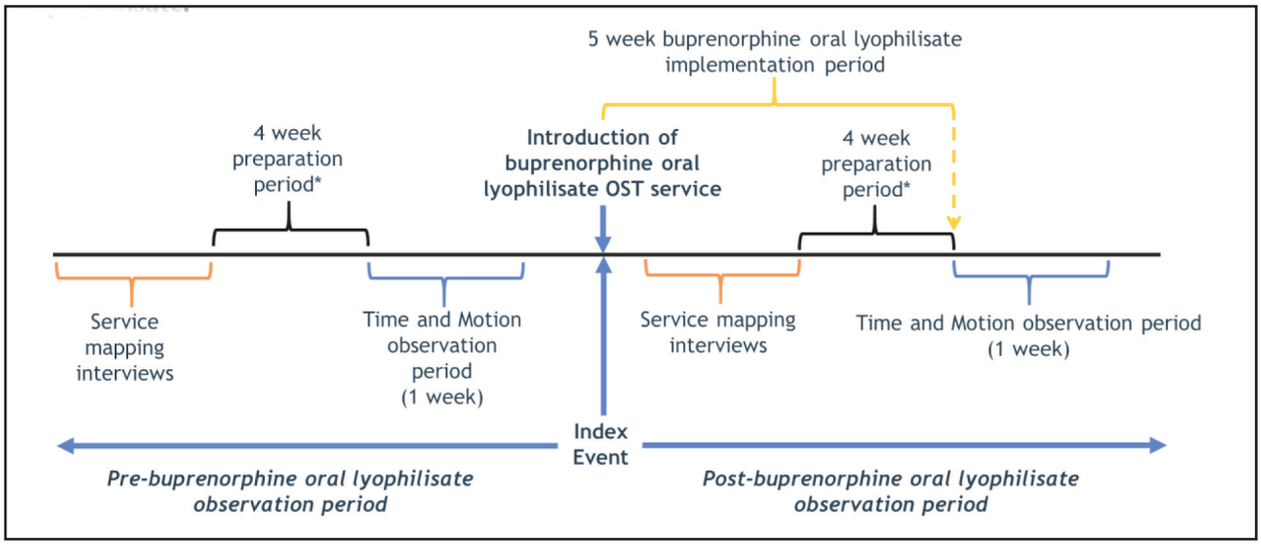
sublingual tablets in the prison setting is lacking. The aim of this study was to assess the benefits of adopting buprenorphine oral lyophilisate on the OST supervision process in two Practice Plus Group prisons. It is hoped that this change in OST service will provide benefits to patients and staff and may also reduce the misuse of OST in this setting.

Methods

This was a prospective, time and motion study carried out at two UK prisons, HMP Leeds and HMP Pentonville, receiving OST services through Practice Plus Group. The study included two observation periods of one week prior to and one week following the adoption of buprenorphine oral lyophilisate. The time and motion observer was trained prior to the commencement of the study to enable uniform data recording procedures, and attended a minimum of three OST supervision sessions during each observation period. Observers recorded data on specifically designed paper case report forms. The total supervision schedule was then compared between the two observation periods (Figure 1).

Figure 1. Study design. The study included a time and motion observation periods of one week prior to the adoption to buprenorphine oral lyophilisate and one week following the adoption of buprenorphine oral lyophilisate, with a five week implementation period to enable the Practice Plus Group staff and patients to become familiar with the supervision of buprenorphine oral lyophilisate.

Patients included in the study were aged 18 years and over and were treated with buprenorphine formulations for



**A period of 4 weeks was allowed between completion of the service mapping interviews and the start of the time and motion observation period, to enable preparation of the time and motion CRF (which was informed by the outcome of the interviews).*

OST (in receipt of a stable dose of buprenorphine for at least 4 days prior to evaluation) in a Practice Plus Group prison during the pre- and/or post-buprenorphine oral lyophilisate observation period. Patients unwilling or unable to provide written informed consent to be observed during OST administration visits were excluded.

The primary endpoint was the time required for supervision of OST administration visits pre- and post-adoption of buprenorphine oral lyophilisate. Secondary endpoints included changes in cost to the OST service, prescribed dose, and patient and staff experiences associated with the change from tablets to buprenorphine oral lyophilisate. To gain a better understanding of patients' and staff experiences of the OST service following the introduction of buprenorphine oral lyophilisate, semi-structured interviews were held by telephone with the first 12 consenting patients and 6—10 nurse/pharmacy technicians across the two participating sites. Patient interviews covered areas related to: perceptions of the OST supervision process, subjective dose equivalence (number of past buprenorphine treatments including maximum dosage), the acceptability of buprenorphine oral lyophilisate and the risks associated with diverted OST medication in prison (number of instances when caught for buprenorphine diversion, drug debts, intimidation and violence) following the introduction of buprenorphine oral lyophilisate. Staff interviews covered areas related to perceived changes in working practice, personal safety and level of confrontation related to OST administration following the introduction of buprenorphine oral lyophilisate.

Comparative statistical analysis and appropriate statistical tests for significance were used. The study was approved by Her Majesty's Prison and Probation Service's National Research Committee.

Results

Time and motion

A total of 120 OST administration episodes were observed across the two prison sites; 50 episodes were observed in the pre-buprenorphine oral lyophilisate observation period and 70 episodes in the post-buprenorphine oral lyophilisate observation period.

The overall OST administration time per episode (from presenting identification to when the patient leaves the hatch) was lower in the post-buprenorphine oral lyophilisate observation period (median [IQR] of 2.8 [2.2—3.6] minutes) compared to the pre-buprenorphine oral lyophilisate observation period (median [IQR] of 7.3 [5.9—8.2] minutes, p<0.001). Similarly, other aspects of OST supervision, including time to present identification, time to prepare medication, time to administer medication, supervision time, and time for checking medication had dissolved, were all significantly lower in the post-buprenorphine oral lyophilisate observation period than in the pre-buprenorphine oral lyophilisate observation period (Table 1). Assuming a patient has a daily episode of buprenorphine oral lyophilisate administration over the course of a year, on average, there could be a potential staff cost saving for administration of OST of £514.65 per patient.

Table 1. Impact of introducing buprenorphine oral lyophilisate on OST supervision.

	Pre-buprenorphine oral lyophilisate (n=50)	Post-buprenorphine oral lyophilisate (n=70)	P value*
Overall OST administration time per episode (mins)†	7.3 (5.9—8.2)	2.8 (2.2—3.6)	<0.001
Time to present identification (secs)	11.5 (5.0—30.0)	5.0 (4.0—20.0)	0.004
Time to prepare medication (secs)	47.5 (30.0—78.5)	30.0 (20.0—46.5)	<0.001
Time to administer medication (secs)	10.0 (7.0—14.3)	15.0 (10.0—55.5)	<0.001
Supervision time (mins)	4.7 (3.5—5.7)	1.5 (0.8—2.3)	<0.001
Time for checking medication has dissolved (secs)	8.5 (5.0—15.0)	4.0 (3.0—10.0)	<0.001

All values stated are median (IQR).
*Mann-Whitney Test. †Primary endpoint.
n/a, not available; IQR, interquartile range; OST, opioid substitution therapy.

Cost

The median (IQR) cost of drug administered per episode was £2.76 (£2.01—£3.92) in the pre-buprenorphine oral lyophilisate observation period vs £1.79 (£1.29—£2.57) in the post-buprenorphine oral lyophilisate observation period. Drug costs were based on those paid by Practice Plus Group at the time of study. There was no change in prescribed dose of buprenorphine per episode between the pre- and post-buprenorphine oral lyophilisate observation periods (median [IQR] 10.0 [6.5—13.5] mg vs 10.0 [8.0—14.0] mg, respectively).

Patient and staff interviews

Semi-structured interviews with patients and staff indicated that buprenorphine oral lyophilisate resulted in less diversion in comparison to other OSTs. However, patients were able to find ways to conceal and divert buprenorphine oral lyophilisate, something that will require further monitoring. Some staff members stated that it took some time to educate patients in how buprenorphine oral lyophilisate is administered but suggested that the introduction of buprenorphine oral lyophilisate had positively impacted the daily routine and resource management in aspects such as reduced medication queues, which ultimately saved time and prison resources (supplementary table 1 and 2). Some patient and staff quotes on the topic were:

> *Patient quote: 'It [diversion] does happen, but they are not getting as much out whereas before they could get loads out because you spit it out after a few minutes whereas with Espranor® it is just like that. With Espranor® you can't do that so it is a good thing.'*

> *Patient quote: 'No, there is a difference [between buprenorphine oral lyophilisate and sublingual tablets]. I would be lying if I said otherwise. There is a difference. If you are getting bullied for it, you can say, 'Look, I am on the Espranor®, mate. I tried my*

hardest, but she makes me...' and they have to back off because everybody knows the way it works.'

Staff quote: '..with patients trying to conceal it, there's not much they can do about it because it dissolves quicker. Whereas previously when we used to crush them, they used to swap white powder to a paracetamol or another tablet in a different pot, to say that, 'Oh', whereas that doesn't happen now.'

Adverse events

Buprenorphine oral lyophilisate was well tolerated during the study. A total of 7 patients experienced non-serious adverse events during the time and motion study or during interviews. Of these, 2 patients recovered, while 5 patients had not made a full recovery at the time of data collection. The 7 patients' AEs were described as: rash; sleep disturbance, sweating, cramping; vomiting, sleep disturbance, appetite reduction, snappiness; hot flushes, lethargic, blackouts, deteriorating eyesight; pain in knees; diarrhoea, vomiting, appetite loss, sleeplessness; flu-like symptoms.

Discussion

The current supervision process of buprenorphine in prison settings can be challenging for staff and patients, involve long waiting times, and can lead to confrontation. Recent studies have noted that the routine diversion of opiate substitutes to other prisoners is a key concern[10]. Streamlining administration using new OST formulations — including fast-dissolving buprenorphine oral lyophilisate or long-acting depot style injections — has been highlighted as a positive development[10,11].

This is the first study to evaluate the impact of introducing a new buprenorphine product on OST supervision within a UK prison setting. The results show that the overall time required for OST administration was significantly lower in the post-buprenorphine oral lyophilisate observation period than in the pre-buprenorphine oral lyophilisate observation period. There was also a significant reduction in time spent on supervision of the OST process following the adoption of buprenorphine oral lyophilisate, potentially freeing up time for staff to focus on patient care.

The new supervision regime has the potential to be more patient friendly, less intimidating and providing greater dignity. The change to buprenorphine oral lyophilisate was acceptable to staff, who suggested the positive impact on resource management. Also, both patients and staff agreed that buprenorphine oral lyophilisate resulted in less diversion in comparison to other OSTs.

The change to buprenorphine oral lyophilisate was acceptable to staff, who suggested the positive impact on resource management.

The arrival of a rapidly dissolving form of buprenorphine may allow for continuity of care and patients to be offered the same form of OST that they had in the community, avoiding the need for unnecessary detoxes or conversions to methadone. Practice Plus Group have moved the majority of patients across all their prisons to buprenorphine oral lyophilisate. This may allow for more accurate financial forecasting, which could release funds to be redirected to additional services. This may be accompanied by cost savings if buprenorphine oral lyophilisate were more widely rolled out in other prisons.

The study has several limitations. First, participant consent was a requirement of the study, which may have introduced selection bias and result in a study sample that may not be representative of the wider patient population who switch to buprenorphine oral lyophilisate. Second, data obtained from participant-reported outcomes rely on the completeness of the answers provided by participants, which may be subject to reporting bias. Finally, insufficient quantitative data on OST diversion was available to compare incidences of OST diversion before and after introduction of buprenorphine oral lyophilisate treatment.

Despite these limitations, our findings suggest that buprenorphine oral lyophilisate was associated with a significantly lower overall time required for OST

10. Alam, F. et al. (2019) 'Optimising opioid substitution therapy in the prison environment', *International Journal of Prisoner Health*, 15(4), pp. 293–307. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6761913/ (Accessed: 3 November 2021).
11. Neale, J. et al. (2019) 'Prolonged-release opioid agonist therapy: qualitative study exploring patients' views of 1-week, 1-month, and 6-month buprenorphine formulations', *Harm Reduction Journal,* 16(1), pp. 1–9. Available at: https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-019-0296-4 (Accessed: 3 November 2021).

administration and time spent on supervision of the OST process in the UK prison setting.

Conclusion

This change in OST service may provide benefits to patients and staff, including better staff and patient experience of supervision, release of staff capacity due to reduced supervision time, cost savings, and also reductions in the rates of the diversion and misuse of OST in this setting.

Acknowledgement

The authors would like to thank Daniella Harris (Principal Pharmacist, HMP Pentonville) and Parminder Singh (Pharmacist, HMP Leeds) for their support in conducting the research. Writing support was provided by Havas Lynx.

Supplementary materials

Supplementary material associated with this article can be found in the online version.

Supplementary material

Supplementary table 1. Patient interviews.

Theme	Summarised patients' views
Acceptability of buprenorphine oral lyophilisate to patients	● There were highly divergent views on the effectiveness of buprenorphine oral lyophilisate in terms of managing symptoms ● Whilst some patients described limited negative symptoms, others described a range of side effects, some that were akin to withdrawal symptoms. Some explicitly identified their symptoms as withdrawal symptoms using terms such as 'rattling' and 'clucking' ● For some the switch from Subutex took place with minimum impact on their physical symptoms, whilst others described several days of feeling unwell whilst they adjusted to the new medication. Some described a period of experimentation with dosage that took place over several weeks ● In general, the speed with which the medication dissolves was viewed by patients as a positive factor ● Size of dosage was linked to speed of dissolution ● Some associated the speed of dissolution with lack of efficacy in terms of the medication 'not holding' them, leading to withdrawal symptoms ● There were mixed opinions about the formulation of the tablet in terms of texture and taste; dependent on personal preference for the 'minty' taste
Impact on emotional wellbeing and relationships	● Some patients reflected that they were feeling more emotional since the switch to buprenorphine oral lyophilisate but were unsure if this was due to the change in medication, coming off opiates in general, or changes in other psychiatric medication. Some attributed poorer emotional wellbeing with experiencing the severe side effects whilst on buprenorphine oral lyophilisate ● Most patients did not describe any changes in their relationships with friends, family and other prisoners as a result of the change in medication
Supervision process	● Most patients did not think there were any major changes in the logistics of the supervision process apart from the speed, due to the fast dissolution of the medication ● Patients from both prisons described an initial period of confusion [of the administration process] whilst the staff came to terms with the correct administration period. This appeared to be linked with the administration of water to aid the dissolution process ● All patients described a process of constant surveillance during the administration process in order to ensure they were not concealing their medication

The problem of diversion	● Some patients provided details of how peers were able to divert the medication ● In general, patients in Leeds felt it was more difficult to divert buprenorphine oral lyophilisate in comparison to Subutex ● Some patients spoke about the ongoing pressures to divert their medication ● One patient stated the pressure to divert their medication was less with buprenorphine oral lyophilisate, and that this was due to the general awareness about the different formulation
Prison environment	● Patients held different beliefs about the reasons why the prison had adopted buprenorphine oral lyophilisate to reduce diversion of Subutex and faster administration process ● In Leeds, the patients were of the opinion that it was difficult to get access to buprenorphine oral lyophilisate, and therefore only a handful of people were using it ● Some patients described feeling the stigma that comes with having an addiction problem, complaining that there was a lack of understanding and compassion among staff, both medical professionals and prison staff
Preference for opiate substitution treatment	● Methadone was viewed as being particularly difficult to come off and therefore buprenorphine oral lyophilisate was viewed as being more congruent with treatment goals ● When asked about their preference for OST, a strong theme identified in the responses was the positive views about buprenorphine in general, rather than buprenorphine oral lyophilisate in particular ● There appeared to be differing views between the two prisons. Whilst in Pentonville there appeared to be a preference for Subutex, in Leeds patients overwhelmingly said they would recommend buprenorphine oral lyophilisate. Preference was associated with the effectiveness of either medication to manage symptoms

OST, opioid substitution therapy.

Supplementary table 2. Staff interviews.

Theme	Staff views
Clinical experience with OST medications	● Staff saw between 13—17 patients a day with the principal medications consisting of methadone or buprenorphine
Staff views of OST medications	● No side effects were identified by the staff interviewed, with the exception of one staff member who had noticed patients experiencing a rash ● Staff were of the general view there were less diversions with buprenorphine oral lyophilisate in comparison to other OST medications, but that some patients were still finding ways to conceal ● Concerns were expressed about the minimum level of dose available for buprenorphine oral lyophilisate (2mg) which is high in comparison to Subutex, and which makes detoxing a challenge
Preferences for OST medications	● In general staff at Pentonville expressed a preference for buprenorphine oral lyophilisate because it dissolves quickly, stops craving, gives the full amount of the prescribed medication to the patient. Some staff in Leeds preferred methadone, namely because it is easier to manage, and they thought it led to less diversions ● Staff believed patients preferred buprenorphine because it is easier to detox from than methadone

Supervision of buprenorphine oral lyophilisate	• Staff discussed how patients found buprenorphine oral lyophilisate more acceptable once they understood more about the medication, suggesting the importance of patient education and awareness raising to aid transition • A few members of staff stated that it took some time to educate the patients in how buprenorphine oral lyophilisate will be administered • Staff identified improvements in the administration of buprenorphine oral lyophilisate compared to other buprenorphine preparations: no need to crush the tablet, fast speed of tablet dissolution, less people to observe at any one time, and the ability to have several staff observe a patient at any one time • Staff expressed continued concerns about the ability of patients to divert buprenorphine oral lyophilisate. Some staff expressed concern that they did not have sufficient understanding of how to carry out appropriate checks • Some staff felt the logistics of accompanying patients between the pharmacy and the accommodation wing by the prison officers could be better coordinated • Staff felt the speed of dissolution of the tablets differed between patients, and this was not necessarily linked to the dose
Behavioural impacts of changing medications	• There were mixed views as to whether prisoner intimidation had reduced as a result of the switch to buprenorphine oral lyophilisate. • Some staff reported fewer challenges once patients understood the medication and the administration process • Other staff described ongoing kick-back from patients when trying to challenge any suspected concealment or diversion
Impact on staff—patient relationship	• Several members of staff stated that there had been no impact on their relationship with the patients since the switch • Other staff reported that their relationships had improved once they had been through the process of confronting the patient about suspected concealment, and had explained their reasons for doing so and their role as 'observer' in the supervision process
Impact on quality of life/work	• There were mixed opinions on the impact of the switch to buprenorphine oral lyophilisate on quality of life or work • Whilst some staff noted no changes, others felt their job was easier because the administration process was shorter and there was less time spent dealing with concealment issues
Satisfaction with buprenorphine oral lyophilisate	• In general, staff expressed satisfaction with buprenorphine oral lyophilisate mainly due to the reasons expressed above • One staff member suggested they had only experienced minimal impact of buprenorphine oral lyophilisate because only a few patients were being prescribed it
Change in illicit activities	• Some staff discussed the ongoing challenges of patients misusing (any) drugs and how some staff are not fully knowledgeable of how buprenorphine can be abused • In general staff believed there was less diversion/concealment with buprenorphine oral lyophilisate, but that it is still taking place
Change in criminality among patients	• Some members of staff said there had been no changes in criminality and others stated that it is too early to tell
Impact on overall safety	• There was no mention of any observed impacts on the overall safety of the prisoners • The majority of the staff did discuss an overall impact on the safety of their colleagues due to less time spent at the medication hatch, a decrease in

	aggressive and intimidating behaviour and fewer patients diverting/palming their medications
Staff regime and resource management	• Staff suggested that the introduction of Espranor® had positively impacted the daily routine and resource management. For example, one member of staff discussed the reduction in the medication queues, which ultimately saves money and time

OST, opioid substitution therapy.

Understanding and Preventing Drug-related Deaths, and Encouraging Treatment Uptake, after Release from Prison

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High rates of mortality after release from prison, many times higher than the death rates for the general population, have been recorded in many countries, including the UK.[1] In England and Wales the number of people who died under post-release supervision reached a record high of 526 in 2018/2019, falling to 458 in 2019/20.[2] In both of these years, 32-35 per cent of the deaths were self-inflicted (a definition which includes drug-related deaths), and 9-11 per cent were in the first two weeks post release. Definitions and recording of drug-related death (DRD) however vary across jurisdictions, so official figures may be underestimating the scale of the problem, and comparisons between countries can be problematic. The risk of DRD, especially opiate-related, is a particular concern. Restricted access to illicit substances while in custody can reduce physical tolerance, leading to greater risk of accidental death if the person relapses once back in the community. The risk is especially high, and the leading cause of death, in the first few days and weeks after release, after which this risk appears to gradually decrease.[3]

It is important to understand what factors are related to increased risk of DRD in the early days post-release, and the ways we can intervene to reduce this risk, including helping people enter into drug treatment upon release back into the community. Officially recorded data indicates that uptake of community treatment post-release is as low as 30 per cent in some areas.[4] The empirical evidence in this area is somewhat hampered by primarily relying on officially recorded data, which means we know less about people's circumstances and experiences leading up to their deaths, which could help us to better intervene. To date, there has been more focus on suicide in prisons and less focus on deaths immediately post-release.

Within this paper we aim to summarise the peer reviewed published literature on the risk factors related to DRD, as well as the literature around uptake of treatment post-release. A comprehensive literature search was conducted, primarily using EBSCO and Google Scholar. Approximately 140 published articles were sourced and read, and this paper summarises the findings from these. Not all papers are cited as we prioritised the more rigorous and most recent studies. The themes from this review have been grouped under the following sections: who is most at risk of DRD post-release, pharmacological interventions to reduce DRD, and continuity of care.

Who is at greatest risk of DRD post-release?

Whilst some factors associated with being at greater risk of DRD after release from prison have been identified, our understanding is far from comprehensive or complete. Factors that are more easily recorded (e.g. demographics) have been studied more than social, psychological or lifestyle factors. And within the existing evidence base there are some suggestions of different patterns relating specifically to different groups (to men

1. Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage. European Journal of Public Health, 25, 879- 885.
2. Ministry of Justice. (2020). *Deaths of Offenders in the Community, England and Wales, 2019/20.*
3. For example see: Zlodre, J., & Fazel, S. (2012). All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis. *American Journal of Public Health,* 102, 67-75; Merrall, E. L. C., Kariminia, A. Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. Addiction, 105, 1545–1554.
4. Public Health England (2021). Alcohol and drug treatment in secure settings 2019 to 2020: report. Found at: Alcohol and drug treatment in secure settings 2019 to 2020: report - GOV.UK (www.gov.uk)

or to women, for instance, or to people in different ethnic groups) that need further study.

Prior history of substance misuse

An assessment indicating a substance misuse disorder, problems with opioids/sedatives, a history of injection drug use, poly drug use, previous drug overdose, and pre-sentence daily opioid use have all been linked to significant greater risk of DRD.[5] Not using drugs in prison has also been found to be associated with increased risk; possibly due to decreases in drug tolerance while in custody.

Sentence length and conviction type

Spending longer in custody appears to be associated with lower risk of DRD immediately after release.[6] However, evidence is not currently available as to the sentence length thresholds that constitute a lower risk. Having more periods of incarceration, and multiple short periods, appears to be associated with higher risk.[7] Evidence relating to conviction type and DRD risk is sparse and often conflicting in its conclusions.[8]

Demographic variables

While increasing age is associated with increasing all-cause mortality rates for people leaving prison, a different pattern is found for DRD specifically.[9] Although there are some differences in research findings, multiple studies suggest that people in their late 20s and early 30s are at greater risk than those who are younger. The research is not clear about when (age-wise) risk declines. There is an unclear picture in relation to gender, and while differences in risk have been identified for different ethnic groups, the pattern is, again, not consistent within the current literature.

Mental health

Being treated for mental illness, prescribed psychiatric medication pre-release, and being hospitalised for mental illness while in custody, have all been associated with higher post-release DRD risk.[10]

Social and lifestyle factors

While some studies in this area are robust and use large samples, the number of studies is not high, and therefore findings should be considered tentatively.[11] Being single, having no qualifications, lacking social support, and living off crime were identified as significant predictors of DRD post-imprisonment in a UK study. Being married or in a common-law partnership was identified as protective in a Scottish sample. Factors such as disruption of social networks, interrupted medical care, poverty and stigma have also been associated with increased DRD risk. Qualitative research indicates the potential importance of family. For example, some family members report wanting to receive overdose prevention training, but in other cases family members may use drugs or alcohol and so heighten the presence of triggers for the released person. Family members may also have attitudes towards pharmacological treatment options that could influence help-seeking and treatment uptake.[12]

5. For example see: Binswanger, I. A., Nguyen, A. P., Morenoff, J. D., Xu, S., & Harding, D. J. (2020). The association of criminal justice supervision setting with overdose mortality: a longitudinal cohort study. *Addiction, 115*, 2329–2338; Spittal, M. J., Forsyth, S., Borschmann, R., Young, J.T., & Kinner, S. A. (2019). Modifiable risk factors for external cause mortality after release from prison: a nested case–control study. *Epidemiology and Psychiatric Sciences*, 28, 224–233; Leach, D., & Oliver, P. (2011). Drug-Related Death Following Release from Prison: A Brief Review of the Literature with Recommendations for Practice. *Current Drug Abuse Reviews*, 4, 292-297; Singleton, N., Pendry, N., Taylor, C., Farrell, M., & Marsden, J. (2003). Drug-related mortality among newly-released offenders. *Home Office Online Report, 16/03*.
6. For example see: Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage. *European Journal of Public Health,* 25, 879-885.
7. For example see: Bukten, A., Riksheim Stavseth, M., Skurtveit, S., Tverdal, A., Strang, J., & Clausen, T. (2017). High risk of overdose death following release from prison: variations in mortality during a 15-year observation period. *Addiction, 112*, 1432–1439.
8. For example see: See Binswanger, et al. (2020).
9. For example see: Binswanger, I. A., Blatchford, P. J., Lindsayd, R. G., & Sterne, M. F. (2011a). Risk factors for all-cause, overdose and early deaths after release from prison in Washington state. *Drug and Alcohol Dependence,* 117, 1– 6; Kariminia, A., Butler, T. G., Corben, S. P., Levy, M. H., Grant, L., Kaldor, J. M., & Law, M.G. (2007a). Extreme cause-specific mortality in a cohort of adult prisoners – 1988 to 2002: a data-linkage study. *International Journal of Epidemiology*, 36, 310-316.
10. For example see: Binswanger, I. A., Stern, M. F., Yamashita, T. E., Mueller, S. R., Baggett, T. P., & Blatchford, P. J. (2015). Clinical risk factors for death after release from prison in Washington State: a nested case–control study. *Addiction, 111*, 499–510; Leach, D., & Oliver, P. (2011). Drug-Related Death Following Release from Prison: A Brief Review of the Literature with Recommendations for Practice. *Current Drug Abuse Reviews*, 4, 292-297.
11. For example see: Joudrey, P. J., Khan, M. R., Wang, E.A., Scheidell, J. D., Edelman, E. J., McInness, D. K., & Fox, A. D. (2019). A conceptual model for understanding post-release opioid-related overdose risk. *Addiction, Science and Clinical Practice*, 14, 17; Singleton, N., Pendry, N., Taylor, C., Farrell, M., & Marsden, J. (2003). Drug-related mortality among newly-released offenders. *Home Office Online Report, 16/03*; Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage. *European Journal of Public Health*, 25, 879-885.
12. For example see: Strang, J. (2015). Death matters: understanding heroin/opiate overdose risk and testing potential to prevent deaths. *Addiction, 110*, 27–3; Millings, M., Taylor, S., Burke, L., & Ragonese, E. (2019). Through the Gate: The implementation, management and delivery of resettlement service provision for short term prisoners. *Probation Journal, 66*, 77–95; Bunting, A. M., Oser, C. B., Staton, M., Eddens, K. S., & Knudsen, H. (2018). Clinician identified barriers to treatment for individuals in Appalachia with opioid use disorder following release from prison: a social ecological approach. *Addiction Science & Clinical Practice, 13,* 23-33.

Drug-misuse pharmacological interventions

A summary of the different types of pharmacological treatments used in prisons worldwide can be seen in Table 1.

Table 1: Types of pharmacological treatments

Opioid substitution therapy (OST)	Methadone and buprenorphine are synthetic opioids, usually taken orally and daily, to alleviate withdrawal symptoms and cravings. Methadone is a full 'agonist', which means it binds to and activates the same receptors which opioids do, creating an opioid-like effect, but more slowly and not leading to the same euphoric feeling. Buprenorphone is a partial opioid 'agonist' which attaches itself to receptors of the brain. It works as an opiod maintenance treatment because of its pharmacological properties of high affinity and slow dissociation from the receptor. There is a new preparation of buprenorphine (new prolonged-release formulation) that is injected by a nurse or doctor once a week or monthly, and further types are in development.
Relapse prevention	Naltrexone is an 'opioid receptor antagonist' which means that any use of an opioid doesn't produce the expected 'rewarding' effect. It is taken daily or every few days and is recommended for people who were formerly dependent on opioids, have completed withdrawal (at least 7 days) and are motivated to not revert to using. Another version of naltrexone is 'extended-release naltrexone' (ERN) and its effects last for weeks, usually delivered via injection or implant. The use of naltrexone isn't common in England and Wales, and currently ERN is not supported under NICE Guidelines.
Overdose reversal/treatment	Naloxone is another form of antagonist which blocks the effects of opioids, but it acts very fast. It is administered by injection or nasally and can be used by anyone in an emergency to reverse respiratory depression caused by overdose and can thus prevent death. 'Take home naloxone' programmes train people how to use naloxone and respond to someone else having an overdose, so there is no need to wait for emergency service responders to provide treatment.

Impact of OST

Several large studies from the US, UK and Australia have found methadone and buprenorphine treatment in prison to be associated with significantly fewer DRDs on release compared with rates for people not receiving treatment. Reported reductions in DRDs from these studies range from 61 per cent to 85 per cent.[13]

The evidence suggests that OST is most beneficial if started in prison and continued on release. In one study comparisons were made between three groups: those who did not receive OST, those who received OST in prison only, and those who received OST in prison and on release. Mortality rates were highest for those not receiving OST; remaining in treatment post-release was associated with significantly lower DRD rates than those who received only prison-based OST.[14] The impact of OST was found to be broadly similar for people with different demographic and criminogenic characteristics, suggesting this is an effective treatment option for most people.

However, it is important to note that prescribing OST does not mean people are risk-free from DRD. Also there are differences in toxicity between methadone and buprenorphine, with the result that the latter may be safer for those with an opioid use disorder. As the dose of methadone increases, so can its effect on respiratory depression, whereas with buprenorphine,

13. For example see: Green, T. C., Clarke, J., Brinkely-Rubinstein, L., Marshall, R. D. L., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Post incarceration fatal overdoses after implementing medications for addiction treatment in a state-wide correctional system. *JAMA Psychiatry,* 75, 405-407; Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., Lowden, T., Maddelena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does exposure to opioid substitution in prison reduce the risk of death after release? A national prospective observational study in England. *Society for the Study of Addiction, 112*, 1408-1418; Bird, S. M., Fischbacher, C. M., Graham, L., & Fraser, A. (2015). Impact of opioid substitution therapy for Scotland's prisoners on drug-related deaths soon after prisoner release. *Addiction, 110,* 1617–1624; Degenhardt, L., et al. (2014). The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study. *Addiction, 109*, 1306-1317.
14. Gordon, M. S., et al. (2014). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. Drug and Alcohol Dependence, 142, 33-40.

there is a ceiling effect - during clinical pharmacological studies in opiate-dependent subjects, buprenorphine demonstrated a ceiling effect on a number of parameters, including positive mood, ''good effect" and respiratory depression.

Impact of Naltrexone

Whilst not licensed for use in the UK, extended-release injectable naltrexone (ERN) has been found effective at reducing drug use on release from prison. However, evidence of the effect of ERN on DRDs is currently an evidence gap.[16] There are particular issues with the use of this treatment, including the need for 7-10 days of abstinence before commencement, people discontinuing treatment prematurely, and risk of opioid overdose (if individuals try to challenge the opioid blockage associated with naltrexone by taking more opioids).[17] However, there appears to be a receptiveness to ERN, in principle at least, amongst prison residents.[18]

Impact of Naloxone

There is some evidence that naloxone use can reduce DRD. A naloxone programme, including training, launched in Scotland in 2011 aimed to make this available to anyone at risk of opioid overdose. The initial two years saw a 36 per cent reduction in DRDs in the first month after release.[19] This was consistent across gender and age groups. With around 12,000 naloxone kits issued between 2011 and 2013 the scheme may have prevented 42 deaths in the first month post-release. In a US study, of 637 prisoners who received an overdose kit and education programme, 32 per cent reported reversing an overdose and 44 per cent received refills from community-based programs.[20]

Continuity of care

In England and Wales the Advisory Council on the Misuse of Drugs has repeatedly called for greater care provision for people leaving prison to reduce their risk of relapse and DRD, and to facilitate treatment uptake. Good communication and collaboration between prisons, health and community service providers to deliver coordinated and continuous care has been identified as vital to this work.[21] Actively involving prison residents in their care plans is also important,[22] so they know about the community services available and they can help shape services to best meet their needs. The following interventions have been found to improve continuity of care relating to substance misuse services.

> Buprenorphine also provides a more consistent 'blockade' effect meaning that using illicit opiates 'on top' of OST is less likely to result in overdose.

Pharmacological interventions

Pharmacological treatment can increase recovery treatment uptake and is therefore a potential means of reducing the risk of DRD in the most risky days and weeks after release. In a large UK study residents exposed to OST in prison were twice as likely to enter drug misuse treatment in the first month post-release.[23] In a series of randomised controlled trials (RCT) in the US, the

15. Whelan, P. J., & Remski, K. (2012). Buprenorphine vs methadone treatment: A review of evidence in both developed and developing worlds. *Journal of Neurosciences in Rural Practice,* 3, 45-50.
16. For example see: Jarvis, B. P., Holtyn, A. F., Subramaniam, S., Tompkins, D. A., Oga, E. A., Bigelow, G. E., & Silverman, K. (2018). Extended-release injectable naltrexone for opioid use disorder: a systematic review. *Society for the Study of Addiction*, 113, 1188-1209.
17. For example see: Binswanger, I. A., & Glanz, J. M. (2018). Potential Risk Window for Opioid Overdose Related to Treatment with Extended Release Injectable Naltrexone. Drug Safety, 41, 979-980; Velasquez, M., Flannery, M., Badolatol, R., Vittitow, A., McDonald, R.D., Togihil, B., Garment, A.R., Giftos, J., & Lee, J.D. (2019). Perceptions of extended release naltrexone, methadone, and buprenorphine treatments following release from jail. *Addiction Science & Clinical Practice*. 14, 1-12.
18. Murphy, P. N., Mohammed, F., Wareing, M., Cotton, A., McNeille, J., Irving, P., Jones, S., Sharples, L., & Monkg, P.E. (2018). High drug related mortality rates following prison release: Assessing the acceptance likelihood of a naltrexone injection and related concerns. *Journal of Substance Abuse Treatment,* 92, 91–9.
19. Bird, S. M., McAuley, A., Perry, S., & Hunter, C. (2016). Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006–10) versus after (2011–13) comparison. *Addiction, 111*, 883–91.
20. Wenger, L. D., Showalter, D., Lambdin, B., Leiva, D., Wheeler, E., Davidson, P. J., Coffin, P. O., Binswanger, I. A., & Kral, A. H. (2019). Overdose Education and Naloxone Distribution in the San Francisco County Jail. *Journal of Correctional Health Care,* 25, 394-404.
21. Stöver, H., Jamin, D., Sys, O., Vanderplasschen, W., Jauffret-Roustide, M., Michel, L., Trouiller, P., Homem, M., Mendes, V., & Nisa, A. (2019). Continuity of care for drug users in prisons and beyond in four European countries final report. *Frankfurt am Main*.
22. MacDonald, M., Williams, J., & Kane, D. (2012). Barriers to implementing throughcare for problematic drug users in European prisons. *International Journal of Prisoner Health*, 8, 68-84
23. Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., Lowden, T., Maddelena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does exposure to opioid substitution in prison reduce the risk of death after release? A national prospective observational study in England. Society for the Study of Addiction, 112, 1408-1418.

percentage of people entering treatment within a month of release was 8 per cent for those receiving only counselling in prison, 50 per cent for those receiving prison counselling and transfer to methadone treatment after release, and 69 per cent for those having prison-based counselling and methadone treatment which was continued on release.[24] Similarly, another US RCT reported initiating methadone treatment in prison to significantly increase treatment uptake in the community, and significantly reduce the time taken to enter treatment, compared to people simply referred to treatment post-release.[25]

Similar positive treatment uptake outcomes have been reported in a robust study of buprenorphine compared with counselling for men and women in prison.[26] Buprenorphine, compared to methadone, may be more effective in impacting treatment uptake in the community because it has less stigma associated with it, and milder withdrawal symptoms and side effects.[27] In Scotland, the recent roll out of prolonged-release buprenorphine where clinically appropriate (as a contingency measure in response to COVID-19), has been received well by prisoners and may lead to improvements in the health and wellbeing of patients, and whilst there is no evidence as yet on its impact on DRD or uptake of treatment in the community it is a promising treatment option worthy of further research.[28]

Buprenorphine, compared to methadone, may be more effective in impacting treatment uptake in the community because it has less stigma associated with it

And the same results have been found with the use of ERN (although not licensed for use in the UK). Those who receive ERN before release have greater treatment retention four weeks post-release than those who receive ERN only after release, most importantly in the first two weeks which is the riskiest time for DRD.[29]

Community and throughcare support

A recent systematic review found that interventions which increase treatment uptake in the community include those which enhance support after release using case management, and those which focus on health service provision.[30]

Programmes or services which connect those released from prison with support in the community can be particularly beneficial. In a systematic review of international qualitative evaluations of re-entry programmes, the key factors relevant to successful community re-entry (reduced substance use and increased treatment uptake) included: case worker interpersonal skills, housing and employment, continuity of case worker relationships throughout pre- and post-release periods, and access to social support.[31] There has been little research on such programmes in the UK to-date, although pilots are underway.[32]

Other research has stressed how important it is for re-entry programmes to focus on multiple domains (e.g. employment, education, health, housing and recidivism), recognising that many people on the CJS caseload have multiple needs and issues that will be best met through improving partnerships across multiple agencies.[33]

24. Kinlock, T. W., Gordon, M. S., Schwartz, R. P., O'Grady, K., Fitzgerald, T. T., & Wilson, M. (2007). A randomized clinical trial of methadone maintenance for prisoners: Results at 1-month post-release. *Drug and Alcohol Dependence,* 91, 220-227.
25. McKenzie, M., Zaller, N., Dickman, S. L., Green, T. C., Parihk, A., Friedmann, P. D., & Rich, J. D. (2012). A Randomized Trial of Methadone Initiation Prior to Release from Incarceration. *Substance Abuse*, 33, 19–29.
26. Gordon, M. S., et al. (2014). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. *Drug and Alcohol Dependence,* 142, 33-40.
27. Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug and Alcohol Dependence*, 99, 222-230.
28. Scottish Government (2021). Coronavirus (COVID-19) opioid substitution treatment in prisons – evaluation: patient experience follow-up report. Health and Social Care. Found at: Coronavirus (COVID-19) opioid substitution treatment in prisons - evaluation: patient experience follow-up report - gov.scot (www.gov.scot)
29. Lincoln, T., Johnson, B. D., McCarthy, P., & Alexander, E. (2018). Extended-release naltrexone for opioid use disorder started during or following incarceration. *Journal of Substance Abuse Treatment,* 85, 97-100.
30. Kouhoumdjian, F. G., MsIsaac, K. E., Liauw, J., Green, S., Karachiwalla, F., Siu, W., Burkholder, K., Binswanger, I., Kiefer, L., Kinner, S. A., Korchinski, M., Matheson, F. I., Young, P., & Whang, S. W. (2015). A Systematic Review of Randomized Controlled Trials of Interventions to Improve the Health of Persons During Imprisonment and in the Year after Release. *American Journal of Public Health,* 105.
31. Kendall, S., Redshaw, S., Ward, S., Wayland, S., & Sullivan, E. (2018). Systematic review of qualitative evaluations of re-entry programs addressing problematic drug use and mental health disorders amongst people transitioning from prison to communities. *Health and Justice,* 6, 4.
32. See NHS England » RECONNECT – Care After Custody.
33. Lattimore, P. K., & Visher, C. A. (2013). The Impact of Prison Reentry Services on Short-Term Outcomes: Evidence from a Multisite *Evaluation. Evaluation Review*, 37, 274-313.

Capability, opportunity and motivation of people post-release

Research confirms that capability, opportunity and motivation are three key conditions for behaviour change.[34] For opportunity and motivation, one study in the US interviewed 122 people released from custody and found that when given the opportunity, many chose to take part in programmes aimed at helping them transition more successfully into society even if they were not required to as a condition of parole. Of the people who used substances during the programme, 61.8 per cent voluntarily participated in treatment. However, 47 per cent continued to use drugs throughout the programme, highlighting the challenges faced of continuing drug use when returning to the community.[35] It is unlikely that motivation and opportunity on their own are enough.

Capability is also key but hampered when people are balancing many needs, as demonstrated in a study of 577 people with substance misuse issues released from prison in Azerbaijan, Kyrgyzstan, and Ukraine. Researchers found respondents prioritised finding a source of income, reconnecting with family, and staying out of prison over receiving treatment for substance use disorders, general health conditions, or initiating methadone treatment.[36]

Health record transfer and treatment referrals

In 2018 Public Health England found the 'transfer' or 'referral' stage from prison to community substance misuse treatment services was the highest point of treatment attrition.[37] Treatment engagement rates appeared to increase when community workers visited residents in custody to support release planning. Lack of information sharing and joined up IT systems between prisons and the community is a frequently identified barrier to joint planning, alongside data/record sharing issues.[38]

Navigating and accessing healthcare

Difficulty accessing SMS services or getting GP appointments, and accessing the right medication at the right time, have been reported by people after release from prison.[39] These delays are particularly problematic for medication continuity, as often only a short supply (usually 7 days) is provided and a GP appointment is needed to renew the prescription.

A study with US criminal justice employed clinicians in the community flagged available treatment and staffing as problematic.[40] These professionals identified insufficiently resourced specialist treatment, few appropriate self-help groups, long waiting lists, high caseloads, and lack of knowledge (or misunderstanding) of treatment needs and options amongst parole and probation officers to impede referrals to evidence-based treatment. The complexity and resourcing of the management of prison health generally might also be a contributing factor to the difficulties of accessing the right healthcare in prison and on release.

Accessing support for multiple complex needs

Interviews with men and women with substance use difficulties in a number of countries (including the UK) highlight the range of inter-related challenges and barriers experienced as they moved from custody to community settings.[41] These made successful resettlement more challenging, and influenced their risk of, and triggers for, substance use: These included: difficulties with social support, safe and stable

34. Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6, 1-11.
35. Morani, N. M., Wikoff, N., Linhorst, D. M., & Bratton, S. (2011). A Description of the Self- Identified Needs, Service Expenditures, and Social Outcomes of Participants of a Prisoner-Reentry Program. *The Prison Journal*, 91, 347 –365.
36. Rozanova, J. Morozova, O., Azbel, L., Bachireddy, C., Izenberg, J. M., Kiriazova, T., Dvoryak, S., & Altice, F. L. (2018). Perceptions of Health-Related Community Reentry Challenges among Incarcerated Drug Users in Azerbaijan, Kyrgyzstan, and Ukraine. *Journal of Urban Health*, 95, 508–522.
37. Public Health England. (2018). Continuity of care for adult prisoners with a substance misuse need Report on the London 'deep dive'.
38. Millings, M., Taylor, S., Burke, L., & Ragonese, E. (2019). Through the Gate: The implementation, management and delivery of resettlement service provision for short term prisoners. Probation Journal, 66, 77–95; MacDonald, M., Williams, J., & Kane, D. (2012). Barriers to implementing throughcare for problematic drug users in European prisons. *International Journal of Prisoner Health*, 8, 68-84.
39. For example see: Binswanger, I. A., Nowels, C., Corsi, K. F., Glanz, J., Long, J., Booth, R. E., & Steiner, J. F. (2012). Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. *Addiction Science & Clinical Practice*, 7, 3-12; Carswell, C., Noble, H., & Farrow, D. (2017). Barriers between offenders and primary health care after release from prison: A case study. *Practice Nursing,* 28, 386-389.
40. Bunting, A. M., Oser, C. B., Staton, M., Eddens, K. S., & Knudsen, H. (2018). Clinician identified barriers to treatment for individuals in Appalachia with opioid use disorder following release from prison: a social ecological approach. *Addiction Science & Clinical Practice*, 13, 23-33.
41. For example see: Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). "From the prison door right to the sidewalk, everything went downhill." A qualitative study of the health experiences of recently released inmates. I*nternational Journal of Law and Psychiatry,* 34, 249–255; Cepeda, J. A., Vetrova, M. V., Lyubimova, A. I., Levina, O. S., Heimer, R., & Niccolai, L. M. (2015). Community reentry challenges after release from prison among people who inject drugs in St. Petersburg, Russia. *International Journal of Prison Health*, 11, 183–192.

accommodation, finances, employment, and physical and mental health. Many reported not knowing how to access needed support, and that they felt insufficient support was offered or available. People described feeling 'dumped', frightened, despairing and hopeless. Factors perceived to be protective included: avoidance of old neighbourhoods, strong family relationships, religion and spirituality, housing, support from friends, a highly structured residential treatment program, a patient navigator, community-based organisations and programmes, and self-help groups.

Release timing

The day of the week people are released from custody can affect treatment continuity.[42] More than a third of people leaving custody in England and Wales are released on a Friday. People may have long distances to travel to the area they are being resettled to, leaving them limited amount of time before many services close for the weekend (and exacerbated further on bank holidays).

Conclusions

DRD is a significant risk for people with opioid use disorders released from prison, particularly in the first few weeks. Getting people in contact with the right services and treatment within that period is critically important. This review has drawn together evidence around who is most at risk of DRD, which includes those with a substance misuse disorder, those serving short or more frequent times in prison, those who are younger, and those with a history of mental illness. It is important that such factors, and others not yet fully understood, are identified so that we are able to identify who most needs specific and timely support. However, further research is needed to bring this evidence together to help practitioners do this in a meaningful way, such as through the development of a screening tool.

Many reported not knowing how to access needed support, and that they felt insufficient support was offered or available. People described feeling 'dumped', frightened, despairing and hopeless.

This review has also found good evidence around the effectiveness of pharmacological treatment, including use of methadone and buprenorphine, started in prison and continued on release, on reducing DRD and improving uptake of treatment post-release. However, OST requires adequate funding and support. In the UK OST has been shown to be cost-effective for the treatment of opioid use disorders.[43] The savings associated with OST were between £14,000 and £17,000 over one year (based on 2016 cost/prices), primarily driven by a reduction in victim costs, and healthcare resource use. This approximation is based on a one-year timeframe meaning that true costs are likely much greater when longer term costs and benefits are included. Although ERN has some advantages over methadone or buprenorphine, including the fact that it gives prison residents 'protected time' after release, it has been shown to be significantly more expensive than treatment-as-usual opioid substitutes in a randomised trial in the US.[44] No economic analysis for naltrexone or naloxone have yet been done in the UK.

Services which connect those released from prison with support in the community and which target multiple domains (e.g. employment, education, health, and housing), are also critical. Continuity of care can be improved by ensuring health records are transferred, treatment referrals are made, health services are accessible, and support for additional and complex needs are provided. This needs a partnership approach. The recent review by Dame Carol Black highlights many of the continuing issues around transition and drug treatment uptake.[45] With political interest in this topic and the healthcare integration agenda, we are optimistic that now is the time where we can strive forward with making positive changes.

Based on this review we have made some recommendations for ways which may help to reduce the risk of DRD in the early post-custody period and

42. NACRO (2018). *Barriers to effective resettlement: Friday prison releases.* Policy Briefing. Policy Analysis from NACRO.
43. Kenworthy, J., Yi, Y., Wright, A., Brown, J., Madrigal, A. M., & Dunlop, W. C. N. (2017). Use of opioid substitution therapies in the treatment of opioid use disorder: results of a UK cost-effectiveness modelling study. *Journal of Medicine Economics*, 20, 740-748.
44. Murphy, S.M., Polsky, D., Lee, J.D., Friedmann, P.D., Kinlock, T.W., Nunes, E.V., Bonnie, R.J., Gordon, M., Chen, D.T., Boney, T.Y., & O'Brien, C.P. Cost-effectiveness of extended release naltrexone to prevent relapse among criminal justice-involved individuals with a history of opioid use disorder. *Addiction,* 112, 1440–1450.
45. Black, C. (2021). Independent report. Review of drugs part two: prevention, treatment and recovery. Found at: Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)

enhance the provision and take-up of services to bring better outcomes for many in the longer term (see table 2). All of these recommendations are grounded within the empirical evidence. Further research that follows people over time, both in and out of custody, and brings in more reliable data from a wider range of sources would help build the picture of effective practice in this area.

Table 2: Evidence-informed recommendations

Increase rates of diversion away from prison and into community treatment[46]	Work across the CJS to develop knowledge and practices for diversion to treatment (Community Service Treatment Requirements) and other support services, recognising this may bring better outcomes than imprisonment for some (especially for people in scope for a short prison sentence, or serving multiple short prison sentences). Develop public trust in diversion schemes and community options through education and knowledge about drug treatment, and their efficacy and value for money.
Provide and support people into evidence-based treatment[47]	Improve screening and data capture for substance misuse needs on entry into prison (and on transfer), ensuring this is recorded and treatment options discussed. Judicious use of the evidence-base on who is most at risk of DRD to identify people for support (but with the careful understanding there are likely factors that increase risk that we don't yet properly understand).
	Facilitate conversations about substance related needs, treatment options, and provide support for referrals during routine stages or meetings during someone's sentence.
	Increase funding and deliver OST, starting in prison and continuing into the community. Where possible try to link these programmes so people can move from one to another on release.
	The provision of prolonged-release buprenorphine should be made more widely available in the UK.
	Consider the expansion of naloxone programmes, in prison and in the community, for service users and their families/support networks.
	Prior to release, set up community treatment/assessment appointments for all people in prison with ongoing substance misuse needs. The new telemedicine SMS project to be launched in England and Wales has great potential in helping link people up with community treatment teams pre-release.
	Make every effort to avoid failure to attend the first community treatment appointment post-release, but if this does happen establish pro-active follow up contact and appointment procedures.
Improve the collection, monitoring and publication of data[48]	Record specific causes of death after release (in this case, DRD), rather than using umbrella terms or broader categories.
	Record and publish group-based risk, need and responsivity profiles of people with drug use disorders in custody and the community, enabling services to tailor their support and resources.

46. For example see: Spittal, M. J., Forsyth, S., Borschmann, R., Young, J.T., & Kinner, S. A. (2019). Modifiable risk factors for external cause mortality after release from prison: a nested case–control study. *Epidemiology and Psychiatric Sciences*, 28, 224–233.
47. For example see: Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., Lowden, T., Maddelena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does exposure to opioid substitution in prison reduce the risk of death after release? A national prospective observational study in England. *Society for the Study of Addiction*, 112, 1408-1418.
48. For example see: Canzater, S. L., & LaBelle, R.M. (2020). Championing change to save lives: A call to action to implement reforms to increase use of medications to treat opioid use disorder in correctional settings. *Criminal Justice Review*, 1-9.

	Routinely monitor changes in the data being recorded, in light of the evidence-base around who is most at risk of DRD, and what helps to reduce this.
Improve healthcare and drug treatment referrals from custody to community[49]	Establish alert systems or communication channels so release numbers and dates are provided to local treatment services in sufficient time to enable treatment place offers, or alternative support to be put in place if there are waiting lists.
	Create a referral process collaboratively with local authorities and drug treatment services. Monitor this often, to check people do not fall through the cracks.
	Continue to improve GP pre-registration systems and/or provide clear information for people in prison about how to register with a GP after release, and confirm this with local surgeries.
	Where appropriate, issue sufficiently long prescriptions pre-release, to minimise risk of delays in getting repeats authorised.
	Ensure consistency in prescriptions from prison into the community (ensuring that access to different medication is equivalent in both settings).
Reduce potential barriers that may interfere with planning and support delivery[50]	Identify and share contact details for at least two points of contact within each relevant partner organisation, enabling faster communication about referrals, assessments and releases, and ensure there is cover during absences from work.
	Avoid releasing people from custody on Fridays whenever possible, or if on a Friday early in the day.
Improve continuity of care during transition, prioritisation of need/support[51]	On release from prison, a focus on planning and responding to people's physical, practical, psychological and social needs, will mean treatment take-up becomes more likely, and risk of DRD reduced.
	Extend services for additional needs, such as housing, employment, and financial support into prison for people pre-release. Implement face-to-face meetings before release with services and key actors involved in the person's re-entry. In conjunction with the service user, agree a realistic release plan, ensuring they have a good understanding of their plan.
	Include people's families and support networks in pre-release planning. Consider the value of peer mentors, who have experience of transition, to support, reassure, encourage and guide people pre/post their release.
	Collaborate with partner agencies, enabling multi-disciplinary planning and support provision, share risk and need assessments, and facilitate support/treatment referrals.
	With all parties, establish very clear roles and responsibilities, so that actions are not missed, everyone understands what is needed, when and why, and people in prison and on re-entry do not fall through the cracks.

49. For example see: Public Health England (2018). Continuity of care for adult prisoners with a substance misuse need report on the London 'deep dive'. Found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/760266/ContinuityofCareinLondon.pdf
50. For example see: NACRO (2018). *Barriers to effective resettlement: Friday prison releases.* Policy Briefing. Policy Analysis from NACRO.
51. For example see: Kendall, S., Redshaw, S., Ward, S., Wayland, S., & Sullivan, E. (2018). Systematic review of qualitative evaluations of re-entry programs addressing problematic drug use and mental health disorders amongst people transitioning from prison to communities. *Health and Justice*, 6, 4.

Improve education on overdose, services and treatment options[52]	Provide information on treatment services in each prison, and the local area people are returning to, including: different treatment options, referral processes and contact details for treatment providers.
	Provide information for individuals, their families/support networks, prison and probation staff on the different treatments available, their effectiveness to enhance motivation and support to engage, and also to counter myths/stigma associated with some treatments.
	Provide education on risk of DRD, harm reduction methods, overdose symptom recognition and prevention, and first aid techniques. This should include education for people who have been abstinent in prison, as well as those with ongoing drug use difficulties, and families.
Continue to build the evidence base[53]	Building the evidence base requires first and foremost better coding and recording of meaningful and reportable data.
	Conduct robust quantitative trials of interventions, including in the analyses risk, need, responsivity and demographic variables, to develop the evidence base for what works, for whom, and when.
	Conduct up-to-date economic analyses also for different treatment options, to help policy makers make good quality cost-effectiveness decisions.
	Conduct qualitative research to understand how people can be helped into treatment services, and how to deliver effective continuous care between custody and the community.
	Conduct case study research when someone dies from DRD soon after release from prison, to help us get a better understanding of the circumstances, and learn about opportunities to improve our care.
Promote and strengthen the recovery agenda[54]	Develop strong leadership and vision, to bring people on board, create trust, and determine shared direction and priorities.
	Engage staff in all relevant organisations in understanding recovery, treatment options and how they can play a part, thereby overcoming potential conflict between security, enforcement or rehabilitative staff orientations.
	Openly discuss and tackle stigma and philosophical opposition to pharmacological treatment, in order to bring people on board with encouraging delivery and uptake of evidence-based interventions.
	Create and routinely review a local drug strategy that clearly and explicitly communicates to all staff how they contribute to it, and why this is important. Collaborate with people living in prison, those who have left, and staff in prisons, probation and partner agencies, in shaping this and suggesting practical and innovative solutions and ideas.

52. For example see: Wenger, L. D., Showalter, D., Lambdin, B., Leiva, D., Wheeler, E., Davidson, P. J., Coffin, P. O., Binswanger, I. A., & Kral, A. H. (2019). Overdose Education and Naloxone Distribution in the San Francisco County Jail. *Journal of Correctional Health Care,* 25, 394-404.
53. For example see: World Health Organisation (2010). Prevention of acute drug-related mortality in prison populations during the immediate post-release period.
54. For example see: Public Health England (2018). Continuity of care for adult prisoners with a substance misuse need report on the London 'deep dive'. Found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/760266/ContinuityofCareinLondon.pdf.

Relapses and challenges of desistance: Hearing the voices of men convicted of sexual offences on release from prison

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In this article I present the key findings from a qualitative study exploring the experiences of men who sexually reoffended.[1] These findings will also be linked with the latest evidence and research on desistance, and the wider support structures which may be helpful for men in their desistance from sexual offending. The article will conclude with some suggestions for how we can learn from this evidence and improve services for this group of people.

Introduction

Desistance is a change process[2], and describes the process of slowing down or ceasing to offend, and can be marked by lapses, relapses and recovery.[3] There has been an increased focus on desistance from crime in the last decade. For some crimes (particularly street crime), offending rates peak in early adulthood, after which they fall off steadily and then drop sharply at around 30.[4] It is likely that this maturation out of crime, is encouraged by social capital or the presence of particular societal roles (e.g. becoming a father/mother, getting married, or gaining employment). However, research has also indicated that desistance from crime can be facilitated by cognitive transformations; that is by the formation of a new 'non-criminal' identity and the shedding of the old 'offender' identity[5], through the power of personal agency or the re-evaluation of a negative experience into a growth-promoting one.[6] Other factors also need to be in place for individuals to successfully desist, including having a belief in the possibility of change, actively contributing to their communities, having stable employment, maintaining abstinence from substance use, having positive and pro-social relationships, having positive future goals, and having the necessary skills and strategies in place to desist from offending, and to cope with their risk factors.[7] It is a complex process, and even if people are motivated to change, the social, psychological and economic circumstances they face on release from prison, may make desistance difficult.

There are currently around 13,000 MCSOs serving custodial sentences in England and Wales[8], the majority of whom will be released back into the community. In general, people who have committed crime and served time in prison face significant obstacles in reintegrating into society following release from prison. However those who have been convicted of sexual offences may have even greater difficulty due to the nature of their offence. Whilst the reoffending rates of MCSOs are consistently low (typically around 8-12 per cent)[9], and most MCSOs, do not go on to commit another, the fact that this group are often viewed negatively by society, and that the harms caused by the offences are significant, together confirm the need to examine desistance from sexual offending.

1. Wakeling, H., & Saloo, F. (2018). An exploratory study of the experiences of a small sample of men convicted of sexual offences who have reoffended after participating in prison-based treatment. *HM Prison and Probation Service Analytical Summary*.
2. Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives.* American Psychological Association Books.
3. Farmer, M., Beech, A. R., & Ward, T. (2012). Assessing desistance in child molesters: a qualitative analysis. *Journal of Interpersonal Violence,* 27, 1-21.
4. van Mastrigt, S. B. and Farrington, D. P. (2009) 'Co-offending, age, gender and crime type: implications for criminal justice policy', *British Journal of Criminology,* 49, 552-573.
5. Giordano, P. C., Cernkovich, S. A., & Rudolph, J. L. (2002). Gender, crime, and desistance: Toward a theory of cognitive transformation. *American Journal of Sociology*, 107, 990–1064.
6. Serin, R. C., & Lloyd, C. D. (2009). Examining the process of offender change: the transition to crime desistance. *Psychology, Crime and Law,* 15¸ 347-364.
7. Mann, R. E., & Thornton, D. (1998). The Evolution of a multisite sexual offender program. In W. L. Marshall,Y. M. Fernandez, S. M. Hudson,&T.Ward (Eds.)., *Sourcebook of treatment programs for men convicted of a sexual offence* (pp. 47-57). New York: Plenum.
8. Office for National Statistics. (2020). *Offender management statistics quarterly: October to December 2019 and annual 2019.* ONS.
9. Barnett, G. D., Wakeling, H. C., & Howard, P. D. (2010). An examination of the predictive validity of the Risk Matrix 2000 in England and Wales. *Sexual Abuse*, 22, 443-470.

Much of the research around desistance has not focused on MCSOs, although more recently attention has been given specifically to this group.[10] Recent studies which have explored desistance amongst MCSOs indicate that those who desist tend to be optimistic about their future, have an enhanced sense of personal agency, an internalized locus of control, and have found connection with the community.[11] Further research suggests there may be three groups of individuals in the early desistance phase: survivors, strivers and thrivers.[12] The survivors characterised by identifying as a 'sexual offender', having low hope and optimism, being socially isolated, and feeling highly stigmatised. The thrivers, on the other hand, characterised by the presence of cognitive transformation, having high levels of hope and optimism, a high internal locus of control, feeling socially connected, and having better problem-solving skills. Other research has found that the barriers to achieving goals of meaningful work, building positive relationships and being able to generate a non-offending identity seem greater for MCSOs compared to those convicted of other types of offences.[13]

Present research findings

The majority of desistance studies examine the process of successful desistance, and narrative change.[14] There is little qualitative research conducted specifically and solely on those who have not successfully desisted, and the reasons for this failure. The present research aimed to address this gap. The research explored both men's experience of the intervention they attended in prison, and how men experienced their release from prison and their perceptions of their reoffending. In-depth interviews were conducted with six individuals who had been convicted of a sexual offence, had completed an intervention (the Core Sex Offender Treatment Programme, SOTP)[15] on their prison sentence (between 2001 and 2010), and had then gone on to reoffend with a further sexual offence. The age of the participants ranged from 33 to 66, and original convictions ranged from rape, to downloading indecent images. The interviews were analysed using interpretative phenomenological analysis (IPA)[16], the goal of which is to explore in detail the subjective conscious experiences of the individual. The analysis produced nine higher order inter-related themes (see Table 1).

Table 1: Higher Order Themes, Descriptions and Example Sub-Themes

Higher Order Theme	Description	Example sub-themes
Treatment as a difficult but useful process	Participation in SOTP was useful in terms of skill acquisition and understanding offending, but was also a difficult process to go through.	Group setting Dealing with what I've done Skills acquisition Difficult experience Reliving experiences
Treatment: going through the motions	Participants felt they had little option but to participate in an intervention as it was a requirement of their sentence. However many felt they lacked motivation and engagement.	Importance of motivation Requirement of sentence Lack of engagement
Treatment scratched the surface	Treatment is only the start of a lifelong process to change. More aftercare needed, and focus should be on appropriate resettlement issues.	Need personal commitment Treatment is only the start Focus more on employment Focus more on release plans

10. Laws, R., & Ward, T. (2011). *Desistance from sex offending: alternatives to throwing away the keys.* New York: The Guildford Press.
11. Farmer, M., Beech, A. R., & Ward, T. (2012). Assessing desistance in child molesters: a qualitative analysis. *Journal of Interpersonal Violence*, 27, 1-21.
12. Milner, R. (2017). *Desistance in men who have previously committed sexual offences: An exploration of the early processes.* University of York.
13. McAlinden, A., Farmer, M., & Maruna, S. (2017). Desistance from sexual offending: Do the mainstream theories apply? *Criminology and Criminal Justice*, 17, 266-283.
14. King, S. (2013). Early desistance narratives: A qualitative analysis of probationers' transitions towards desistance. *Punishment & Society*, 15, 147-165.
15. Mann, R. E., & Thornton, D. (1998). The Evolution of a multisite sexual offender program. In W. L. Marshall,Y. M. Fernandez, S. M. Hudson,&T.Ward (Eds.)., *Sourcebook of treatment programs for men convicted of a sexual offence* (pp. 47-57). New York: Plenum.
16. Smith, J. A. (2008). *Qualitative Psychology: A practical Guide to Research Methods. Second Edition.* SAGE Publications.

Living as a 'sexual offender'	Difficulty trying to get on with life following release from prison with a conviction for a sexual offence. Feelings of being labelled create difficulties with relationships, employment, housing and social capital.	Feeling labelled Disclosure issues Employment difficulties Being judged Living with guilt, shame and regret
Feelings of hopelessness and negative self	Intense hopelessness about oneself and the future, and having a negative view of oneself.	Low self-esteem Lack of confidence Giving up No hope for future
Isolated, alone and no support	Isolation, loneliness, and lacking of support. Feelings of loss related to losing family and friends, being abandoned, deserted or rejected by others as a result of their conviction.	Despair/unhappiness Rejected/hurt by others Loss of family and friends Isolation/loneliness Lack of support network Lack of engagement with society
Poor problem solving	Feeling unable to deal with life's problems, and using ineffective coping strategies. Feelings of despair in relation to lack of relationships, not being able to find employment and external locus of control.	Ineffective coping strategies Overwhelming life problems Relationship problems External blame Lack of maturity
Resettlement issues	Practical difficulties associated with being released from prison including issues with hostel placements, finding suitable accommodation, movement restrictions, lack of purposeful activity and financial difficulties.	Accommodation difficulties Lack of purposeful activity Negative peer influences Probation restrictions
Internet offending as less harmful	Belief that viewing indecent images of children was less harmful than committing contact offences.	Minimising harm Lack of a victim

The first three themes were related to the programme the participants had attended on their previous prison sentence. For the most part, treatment was a multifaceted experience; that is the participants described it as a difficult, intense and demanding process, particularly having to talk about their offence, but they also felt they had developed a number of skills including perspective taking, problem-solving and improved coping abilities. But whilst useful, participants also talked about the fact that participation in the programme was not optional, as it was often a requirement of their sentence. And because of this, some felt that they were not ready to participate or motivated to change, and instead just went 'through the motions':

> *'It was just to tick the boxes at the time. I was ticking boxes and just attending and I wasn't really open'.*

The men also spoke about the fact that treatment can only be considered the start of a lifelong effort to desist from crime, and that further support following a programme and on release from prison is needed.

Being labelled as a 'sexual offender' was a prominent theme. Participants consistently described the difficulty of trying to get on with life following release from prison with a conviction for a sexual offence. Repeatedly, the interviewees reported that they felt they had been labelled, which caused major problems in other areas of their lives, including gaining employment, finding suitable accommodation, developing and forming relationships with others, and being an active member of society. In most cases, it appeared that this difficulty may, in part, have contributed towards their path to a sexual reoffence and prevented them from forging 'non-offending' identities. One participant described the time he was told he needed to be on the Sex Offender Register:

'Well if I've got no hope of getting off this register and always going to be viewed with suspicion and all the rest of it, there's no point in trying, so, a lot of times I didn't care, I really didn't care.'

A feeling of hopelessness about oneself and the future, and having a negative view of oneself also emerged. Feelings of guilt and shame in relation to their offending were common, as were feelings of despair and unhappiness. Lack of social capital was also prominent; the feeling of being alone and having no support was frequent. There was also an intense feeling of loss amongst participants, which related to the loss of family and friends, feelings of being abandoned, deserted, rejected or hurt by others, and feeling let down by others.

Some of the participants felt that they lacked the skills to deal with daily life, and the lack of problem-solving skills in some was apparent. The problems described by the participants varied and included, for example, not being able to communicate with people, having relationship breakdowns, and not being able to cope with things not going their way. The use of ineffective coping strategies in dealing with problems, a lack of consequential thinking and examples of poor problem-solving emerged regularly, as did the individuals proportioning external blame to events in their lives. Another related theme was that of participants describing the practical issues associated with being released from prison. Difficulties included issues with hostel placements and finding suitable accommodation, having restrictions placed upon them and their movements, having a lack of purposeful activity due to their conviction, financial difficulties, and problems with peer influences.

Feelings of guilt and shame in relation to their offending were common, as were feelings of despair and unhappiness.

The final theme related to those who had been convicted of a non-contact offence for their subsequent prison sentence (where previously they had committed contact offences) who voiced opinion that they felt that viewing indecent images of children was less harmful than committing contact offences. This offending pattern might represent a de-escalation in offending, and it is possible that these individuals were using these minimisations as a way of starting to shift their identities, and progressing nearer to their future 'non-offending' self as part of their desistance journey.

Assimilating the findings

This research provided a rich description of the experiences of a small sample of MCSOs who had taken part in treatment during incarceration and subsequently reoffended. Assimilating the findings with the wider literature there are six key areas which are particularly important to highlight.

Identity Change

Cognitive transformation is clearly important for desistance amongst MCSOs. There are different routes that individuals take to successfully form a new identity. Some may use denial and minimisation as a way to manage the incongruence between their preferred identity and past actions. Others tend to describe the offending as being situational, related to the particular circumstances at the time. Whether or not this is reality, it may enable people to view their offending as an aberration, driven by the situation rather than their personality, thus enabling them to sustain a positive self-identity that is separate from their offending self.[17]

But it is also clear that criminal stigma and being labelled has a damaging impact on those trying to reintegrate back into the community following release from prison[18], and to form new identities, and this seems to be particularly problematic for MCSOs. The ability to shift one's identity from that of 'offender' to that of 'non-offender' seems to be very difficult for a group who is so stigmatized within prison and beyond the prison gates, and for whom the label of 'sexual offender' is difficult to leave behind.

We know that the impact of labelling people can be incredibly harmful, and that we tend to internalize the stigma that others put on us.[19] There are a wealth of studies which support this labelling hypothesis, including evidence within the criminal justice system. In a large study of around 96,000 men and women over a two-year period in Florida, researchers found that those who were formally labelled an 'offender' had

17. Farmer, M., Beech, A. R., & Ward, T. (2012). Assessing desistance in child molesters: a qualitative analysis. *Journal of Interpersonal Violence,* 27, 1-21.
18. LeBel, T. P. (2017). Housing as the tip of the iceberg in successfully navigating prisoner reentry. *Criminology & Public Policy*, 16, 891–908.
19. Maruna, S. (2012). Elements of successful desistance signalling. *Criminology & Public Policy,* 11, 73-86.

substantially higher recidivism rates within two years, compared to those who had not been labelled.[20] Whilst some may be able to overcome the impact of labelling, others may not, and wider society has a duty to provide support. Research indicates that the general public often believe that recidivism rates for MCSOs are higher than they actually are, that this group are particularly unlikely or unable to change, and that particularly strict controls need to be in place to manage their risk to others.[21] Stigma-reducing strategies including education could help. But the use of labelling crime-first language, which negatively influences public perceptions of people convicted of crime, also needs addressing. Stigmatizing labels, such as 'criminal', or 'sexual offender', can create barriers to services and can hinder support for groups of people.

Hope and Future Orientation

Individuals who desist from crime are usually motivated to change their lives and feel confident that they can turn things around.[22] The impact of these motivational factors has even been found in long-term studies up to ten years after release from prison.[23] Hope plays a particularly key part in the early stages of change, giving people confidence that they can exercise choice and control over their lives, and overcome the challenges they face as they try to give up crime.[24] People are more likely to have hope, and be motivated to work toward a different, better life, if they are regarded as a person with potential and opportunity. Having a sense of hope and a positive future orientation is commonly described by successful desisters who have previously committed sexual crime, whereas those who persist in offending often describe a feeling of hopelessness about themselves and the future. Together, these findings suggest that individuals should be encouraged to take responsibility for their future actions, placing less emphasis on past actions. And that generating hope is vital.

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Social Capital

Social capital includes having productive things to do with one's time, such as employment or education, having appropriate support and relationships in place, and making a meaningful contribution to society. Many people who desist from crime talk about the importance of feeling like part of a group, and the powerful effect of having someone believe in them.[25] They are often strongly influenced to desist by interactions with others that communicate a belief that they can and will change, that they are good people, and that they have something to offer people or society more generally.[26] Overall, the desistance research with MCSOs, suggests that desisters describe the importance of many of the factors of social capital, including the relevance of generativity or making a positive contribution to society. Conversely, in the current research the feeling of being isolated, alone and having no support was relevant to all participants to some extent, as was a lack of social capital.

The presence of healthy relationships, community participation, a positive sense of identity, motivation and are all fundamental and important for functioning.[27] For MCSOs these social inclusion factors are particularly pertinent, especially when evidence indicates that serving a custodial sentence for a sexual offence is associated with elevated concerns about housing, weaker social bonds, social isolation, greater relational difficulties and greater fear of

20. Chiricos, T., Barrick, K., Bales, W., & Bontrager, S. (2007). The labelling of convicted felons and its consequences for recidivism. *Criminology*, 45, 547-581.
21. de Vel-Palumbo, M., Howarth, L., & Brewer, M. B. (2019). 'Once a sex offender always a sex offender'? Essentialism and attitudes towards criminal justice policy. *Psychology, Crime & Law*, 25, 421-439. Harris, A. J., & Socia, K. M. (2016). What's in a name? Evaluating the effects of the 'sex offender' label on public opinions and beliefs. Sexual Abuse, 28, 660-678.
22. Burnett, R. & Maruna, S. (2004). So 'Prison Works', Does It? The Criminal Careers of 130 Men Released From Prison under Home Secretary Michael Howard. *Howard Journal of Criminal Justice*, 43, 390-404.
23. 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, 131–59.
24. Weaver, B. (2014). Control or change? Developing dialogues between desistance research and public protection practices. *Probation Journal*, 61, 8-26.
25. Rex, S. (1999). Desistance from Offending: Experiences of Probation. *Howard Journal of Criminal Justice*, 36, 366–83.
26. McNeill, F., Batchelor, S., Burnett, S., & Knox, J. (2005). *21st Century Social Work. Reducing Reoffending: Key Practice Skills.* Edinburgh: The Scottish Executive.
27. Ward, T., & Maruna, S. (2007). *Rehabilitation*. London, England: Routledge.

victimization[28], and that being in prison for a sexual offence appears to act as a barrier to primary goods, which then makes re-entry even more difficult.

Problem-solving

Problem-solving emerges as a particular issue for MCSOs.[29] The problems described by the participants in the present research varied, but a feeling of despair in being confronted with engulfing problems in life came through strongly from the participants' experiences. The key issue was that individuals appeared to lack skills in problem-solving, which we know is a key dynamic risk factor for MCSOs[30], and one that rightfully continues to be addressed in interventions targeting reoffending.

Resettlement Issues

MCSOs also face significant resettlement issues on release from prison. On re-entry some of the participants in this research described how they were determined to stay out of prison and had a positive view of their future. This positivity was diminished over time due to other aspects of their life on release, such as difficulties with employment, housing and healthcare. The barriers faced by individuals on release from prison cannot be underestimated. In 2018, only 11 per cent of adult male prison leavers were confirmed to be in employment 6 weeks after they left prison[31], and 24 per cent of adult males leaving prison in 2018/19 were recorded as rough sleeping, either homeless, or in unsettled accommodation, on the first night of release. Previous research indicates that social services to obtain basic needs, access to education, employment and housing social support from family and friends and the ability to adapt to the unstructured life on the outside are all key to successful transition.[32]

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Interventions to support desistance

The learning from this research sharpens the focus on the need to re-examine interventions designed for MCSOs. All of the participants had attended Core SOTP[33], which has now been replaced with a set of interventions which are more individualized, more future focused, and which have a greater emphasis on hope and identity. The new programmes, including the Horizon programme, targeted at men assessed as medium, high or very high risk of reconviction[34], are based on the most up to date theory of behaviour change, a bio-psycho-social model of offending[35], the Good Lives Model (GLM)[36], as well as the desistance literature.

Once a programme is finished further work is also needed to consolidate the learning and skills developed, throughout the sentence and on release from prison. Some participants were not able to recall in full the content or their experience of participating in the programme, either because perhaps their participation was too far in the past, or they hadn't practiced the skills that they had learnt during the programme. This suggests the importance of appropriate timing of interventions, as

28. Baker, T., Zgoba, K., & Gordon, J. A. (2019). Incarcerated for a sex offence: In-Prison Experiences and Concerns about Reentry. *Journal of Sexual Abuse*, 1-22.
29. Milner, R. (2017). *Desistance in men who have previously committed sexual offences: An exploration of the early processes.* University of York.
30. Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk of sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse,* 22, 191-217.
31. Ministry of Justice (2019a). *Community Performance Quarterly, to March 2019, Employment Table.*
32. Denney, A. S., Tewksbury, R., & Jones, R. S. (2014). Beyond basic needs: Social support and structure for successful offender reentry. J*ournal of Qualitative Criminal Justice and Criminology*, 2, 39–67. 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, 131–59. Visher, C., Palmer, T., & Roman, C. G. (2007). *Cleveland stakeholders' perceptions of prisoner reentry*. Urban Institute.
33. Mann, R. E., & Thornton, D. (1998). The Evolution of a multisite sexual offender program. In W. L. Marshall,Y. M. Fernandez, S. M. Hudson,&T.Ward (Eds.)., *Sourcebook of treatment programs for men convicted of a sexual offence* (pp. 47-57). New York: Plenum.
34. Wilkinson, K. & Powis, B. (2019). A Process Study of the Horizon Programme. *Ministry of Justice Analytical Summary*.
35. Mann, R. E., & Carter, A. J. (2012). Organising principles for the treatment of sexual offending. In B. Wischka, W. Pecher, & H. Boogaart (Eds.), *Behandlung von Straft tern: Sozialtherapie, Ma regelvollzug, Sicherungsverwahrung [Offender Treatment: Social therapy, special forensic hospitals, and indeterminate imprisonment].* Freiburg, Germany: Centaurus. 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 service users in Her Majesty's Prison and Probation Service. *Advancing Corrections: Journal of the International Corrections and Prison Association,* 3, 21-47.
36. Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior,* 12, 87-107.

well as the need for reinforcement of programme content and skills learnt. Her Majesty's Prison and Probation Service offer support in this way via the New Me MOT[37], a toolkit that can be used by custodial or probation staff to provide ongoing support to programme completers.

Lack of support people receive during the transitional period from prison to community can make the desistance process particularly difficult and uncertain. Circles of Support and Accountability (CoSA) offers one way of supporting this reintegration, and the overall evidence for the effectiveness of CoSA is promising; for example there is some evidence that there are benefits for core members in terms of reductions in social isolation and loneliness and improvement in psychological wellbeing.[38] Further research has examined the importance of mentoring and peer support roles for MCSOs[39], which can help people take on new, positive identities, and help people to distance themselves from harmful labels and be viewed as 'human beings'.

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Implications for Practice

So what does this mean for practice? One of the key implications from this research is the need to focus on better transition from prison to probation for men convicted of sexual offences, and ensure that services are available to support people with housing, employment, healthcare, social engagement and accessing essential services. To do this we need better communication and information sharing between settings, and greater follow up of care provided in the community (including use of peers, use of support structures such as CoSA, and other services which build social capital and positive identity). There are also implications around interventions for this group specifically, which have already in large been addressed by the development and roll out of new programmes within HMPPS in England and Wales. Programmes are likely to be most beneficial when participants are motivated to change, when they focus on identity change, when they use language and techniques that promote non-offending identities, when they are future-oriented and do not use exercises that encourage people to take responsibility for past actions which are unlikely to promote desistance[40], when they are supplemented with other resources aimed at improving social capital and opportunity to develop and practice skills learnt, and when they are focused on the individual. But we must also remember that programmes can only be one part of the picture; on their own they are unlikely to always result in changes, but if accompanied by other support (programme follow up support as well as targeted support on release from prison), they can be the start of a positive process of change. Those of us working across prison and probation can also use every opportunity to build hope and encourage future orientation amongst the people in our care, by believing that people can change, and helping them find their strengths and talents and supporting them to believe that a better future is possible and helping them to understand how they might get there. But the biggest implication or change all of us working with men convicted of sexual offences can do is to monitor the language we use. Using language which is humane and respectful, which doesn't label or stigmatise people, is essential if we are to support people in shedding their old identities and building future non-offending positive identities.

37. 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 service users in Her Majesty's Prison and Probation Service. *Advancing Corrections: Journal of the International Corrections and Prison Association,* 3, 21-47.
38. Kitson-Boyce, R., Blagden, N., Winder, B., & Dillon, G. (2019). "This time it's different" preparing for release through a prison-model of CoSA: A phenomenological and repertory grid analysis. *Sexual Abuse,* 31, 886-907.
39. Perrin, C., Blagden, N., Winder, B., & Dillon, G. (2018). "It's sort of reaffirmed to me that I'm not a monster, I'm not a terrible person": sex offenders' movements towards desistance via peer-support roles in prison. *Journal of Sexual Abuse*, 30, 759-80.
40. Although there is some evidence that people can learn new ways of behaving by looking at past patterns of behaviour, when this is done in a positive sense, participants need to understand they are doing this work to create a better future, and the past behaviour is used to identify what strengths people need to develop, rather than to shame or encourage responsibility for past acts. This is not to suggest that *participants on programmes should not be required to take responsibility for their actions.* However the evidence suggests that people should be required to take strong responsibility for their future actions, and less emphasis needs to be placed on their past ones. In many cases, where participants exhibit denial or minimisation, it is not necessary for this to be challenged, where such neutralisations are a post-hoc, protective factor. Indeed where such denial helps a person construct a more positive self-identity it may serve as a protective function.

Conclusions

The findings presented in this article are consistent with many of the results we see from traditional desistance studies. We must focus on the transition from prison to community, often a period of stress, loneliness, fear and alienation for MCSOs. And whilst we cannot change society's perceptions of MCSOs overnight, we are able to make an impact with the language we use. We are far more likely to successfully help people to desist from committing crime and causing harm to themselves and others if we give them the opportunity to develop new pro-social identities, and adopt messages of hope and motivation. And we are less likely to reinforce the stigma associated with prison and crime, and in doing so risk worsening people's future chances, if we communicate with non-labelling language. It is also important to recognise the equal importance of the risk need and responsivity and rehabilitation approach to offending, and the desistance approach. Historically they have been presented as polarised ways of describing offending patterns. However, in recent times there has been greater recognition that both 'schools' are important, and can be used together to further our understanding of how to help people lead offence free lives.[41]

Although uncomfortable for many members of the public, research suggests that accepting MCSOs into the community and helping them overcome the barriers to successful reintegration encourages prosocial behaviour and prevention of further offending.[42] Whilst we can do our best to target and deliver effective interventions to this group in prison, we also need to ensure we give them the best chance of re-entry by supporting them to develop new identities, by helping them to develop and practice skills to lead offence-free lives, by supporting them with reintegration, by supporting them to become part of society, and by giving them hope for their future.

41. Maruna, S., & Mann, R. (2019). Reconciling 'Desistance' and 'What Works'. *HM Inspectorate of Probation Academic Insights.* February 2019/1.
42. Tewksbury, R., & Connor, D. P. (2012). Incarcerated sex offenders' perceptions of family relationships: Previous experiences and future expectations. *Criminology, Criminal Justice, Law & Society,* 13, 25.

Criminal Justice in Wales

Carwyn Jones, *a former First Minister of Wales and currently a Professor of Law at Aberystwyth University is interviewed by* ***Karen Harrison****, a Professor of Law and Penal Policy at the University of Lincoln.*

Professor Rt. Hon. Carwyn Jones is a former First Minister of Wales, a role he held between 2009 and 2018. He left the Welsh Parliament in 2021 after representing the Bridgend constituency for twenty-two years which included eighteen consecutive years in government. Before politics he practised at the Bar for ten years and was a Professional Tutor on the Bar Vocational Course at Cardiff University, where he taught Karen! He is now a Professor at Aberystwyth University with a strong interest in constitutional law. He is also Bencher at Gray's Inn. Since leaving politics he has been involved in broadcasting and business consultancy and is also involved with a number of charities. His autobiography was published in 2020. In his spare time, he enjoys sport, reading and travel and is now trying to catch up with a list of tasks around the house that his family tell him he has neglected for the past twenty years.

The interview took place on 20th September 2021.

KH: How would you say Wales differs from England in terms of criminal justice?

CJ: Well, the most obvious difference is that unlike England, Wales doesn't control its criminal justice system. Scotland does, Northern Ireland does, but Wales is an adjunct really to the system in England. What has that meant in practical terms? So, first of all the rurality of Wales makes it increasingly difficult for people to access legal advice, particularly legal aid and they have to travel long distances to get it because rural solicitors are not able to obtain the necessary contracts to be able to provide that advice. Secondly, courts, we have a very small number of courts in Wales now. Rural areas have lost their courts. It's nothing now for people to have to travel 30 or 40 miles just to get to a magistrates' court. Now, the principle always was that justice travelled to the people but that's no longer the case, particularly in Wales. There is also an issue with the education of prisoners and health provision for prisoners, because they are provided by organizations of Wales that are not responsible to the UK Government. So, you've got this jagged edge which is jarring between different organizations in terms of how they work with each other. So, if you're looking at the proper approach to the rehabilitation of offenders, you need everybody on board and unlike in Scotland or Northern Ireland, the bodies that have to come together to provide that are all answerable to different people, and that creates problems in terms of being able to create a completely coherent strategy. Finally, is that we have a different language and as somebody who's a native Welsh speaker, I don't have the right to a jury trial in my own language, in my own country. I'm able to speak Welsh. I'm able to use Welsh, but I'm not entitled to a Welsh speaking jury. Everything has to be translated, and that again, is a major difference. I mean, the Welsh language was excluded from the courts until 1942, by law, and we're not in that situation now, but it does show that the bilingual nature is not fully appreciated by having one criminal justice system for the two countries.

KH: How supportive/proactive do you think Westminster is in terms of ensuring that those differences are recognised and acted upon?

CJ: Not at all is the simple answer. The difficulty we have, and it's the same with the Home Office and the MoJ [Ministry of Justice] is that they forget about the Wales bit after the word England in England and Wales. Wales is treated as an adjunct to England. Whatever is applied in England is applied to Wales, even though the circumstances might be different. For example, when decisions were taken to close down courts. That decision was taken effectively in London by somebody looking at a map. No real consideration was given to public transport links, to distances, it was taken on the basis that 10 miles in London is equivalent to 10 miles in rural Northwest Wales, it isn't, but that's the approach that was taken. So, I don't think there's any attempt at all to recognise Wales' distinctiveness. They are absolutely set against any devolution of the criminal justice system, even though they accept it in Scotland and Northern Ireland. Largely because we have this bizarre situation in Wales where we have the only Parliament in the common law world, without its own jurisdiction. We rely on Westminster to enforce our laws, which is not a sensible long-term policy. On the ground, on a practical level the non-devolved and devolved bodies do work together, they're professionals, they're practitioners and the politics doesn't interfere. But what it does mean is that any one

of those bodies could pull out at any time. We had a situation a few years ago where there was an attempt to pull the police out of meetings where the Welsh Government was involved and then they realized how daft that was because you need people to work together. So, we have this ad hoc arrangement in Wales which has worked, but it's not really stressed proofed, and it's subject to the goodwill of both governments to work together and that's unlike anywhere else in the UK and that to me is an obvious weakness.

KH: Do you think that's because Wales is viewed as a principality rather than as a country?

CJ: No, it's because of the Acts of Union of 1536. One of the consequences of that legislation was that the Welsh legal system was abolished. The Welsh courts were abolished, and Wales was integrated into England, it effectively became part of England until 1967. Scotland was never in that position. Scotland entered into the Union with its own jurisdiction, its own laws. Ireland was the same and Northern Ireland picked up from that in 1921 and became its own jurisdiction. When the Welsh Assembly was established it didn't have primary law-making powers, and so the question of having separate legal jurisdiction didn't arise. But now it does and not having legal jurisdiction is problematic. So, being part of a criminal justice system that's answerable to Parliament at Westminster in London, which doesn't apply to Scotland or Northern Ireland means Wales is in effect, when it comes to the criminal justice system, on a par with Cornwall, even though Wales is a country that has its own government and parliament.

KH: What are the challenges faced by the police, the courts, prisons and probation in Wales?

CJ: In terms of the police, it's funding. We have four constabularies; one is very rural and the other three are mixtures of both. South Wales is probably the most urban and for years South Wales Police has struggled with funding. Most funding comes from Westminster and South Wales Police has unique challenges, for example, it hosts large sporting events in Cardiff, which for example Bristol wouldn't have. So that's been a problem for us in terms of ensuring that all of those issues are appreciated in Wales. In terms of the courts, there simply aren't enough. We've seen so many rural courts closed, and we've seen courts closed down in urban areas. I live in a town of 40,000 people and we've lost our county court and our magistrates' court. You have to travel 20 miles to Cardiff to access those now. There was no reason for it other than to sell off the land, the magistrates' court was demolished, and the land was sold, so it was a money-making exercise. It was nothing to do with the delivery of justice and that's caused enormous problems. The probation service was in turmoil. It's now one national probation service in Wales again, but answerable bizarrely to Whitehall and not to the Welsh Government. And with the prisons again, on a practical level, it's a question of how they work with the health boards and with the education authorities to deliver what they need to deliver. That has to be done cross government as it were, but also prison provision in Wales is very poor. So, we don't have a category A prison, perhaps we don't need one and we don't have a women's prison. No woman can serve a custodial sentence in Wales and we know that part of the process of rehabilitation is for people to be able to serve their sentences close to their communities and close to their families. If you're a woman in Wales, you are discriminated against in that way, because you cannot serve your sentence in your own country. In terms of the prison population, we are effectively part of a joint prison service with England. To create a separate prison service would be an expensive undertaking, although that's not something we should shy away from if we have control of that system. But prison provision is very, very patchy across Wales and offenders in Wales have to travel great distances to serve their sentences.

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KH: What was the decision-making process in terms of putting HMP Berwyn in Wales?

CJ: It wasn't seen as a Welsh prison. It's a big prison, there just happened to be land available. There was strong public opinion in Wrexham against the prison, so they gave it the name of a mountain range about 25 miles southwest of Wrexham to try and sweeten the pill. The prisons in South Wales are all quite close to each other, none of them more than 20 miles apart. There's nothing in the West, nothing in the Northwest, nothing in the middle and then there's Berwyn which was not designed to be a Welsh prison because there aren't 2000 offenders in North Wales to put in that prison. So, it was simply a decision taken in Whitehall for the benefit of the prison system.

KH: What steps have been taken to create a particular Welsh criminal justice culture or ensuring that criminal justice practices are appropriate for Wales?

CJ: Not much I'm afraid is the answer. We tried when we were in government to do that and I suppose at a practical level the best example is the ability of bodies to cooperate with each other regardless of where the line of responsibility is. But there's no sense of a Welsh criminal justice system. There is a Welsh Probation Service now, but that's fairly new. There is a Welsh courts service, but that's not run from Wales and there's no Welsh prison service.

KH: You are a region aren't you in terms of the prison service, which, as you say, is similar to Devon and Cornwall.

CJ: Yes, well, that sums it up really — a region. So, we are alone in the UK in having no control and no say in the way our own justice system operates. And that's the fundamental objection that many of us have. Different powers rest in different places, the major difference between Scotland and Wales now is justice. If you are part of a justice system with a country that's 20 times your size, you will not get much of a look in. That's certainly the impression that I've had. Wales has simply been tailored to what is deemed to be appropriate. I just don't think that any thought has been given to the importance of providing justice in rural areas, including parts of rural England, because the decision makers and decision takers all live in large urban areas.

You can't control the prisons unless you have control of sentencing policy again, because you don't control the method by which people end up in prison.

KH: On the basis that criminal justice in Wales is run by Westminster, what are the limitations of this?

CJ: Our justice system is entirely within the control of another parliament and another government in a way that isn't the case in Scotland and Northern Ireland. Wales has 40 MPs, but that's out of 650 and after the next election it will be 32 MPs out of 650. So, Wales doesn't exactly dominate debate in Westminster. So, whenever there's talk of justice, frankly I don't think Wales counts. There have been some changes, we now have a Lord Chief Justice of England and Wales, when I studied to become a Barrister, it was just for England. But these are just words, we're not seeing anything in practice. We don't see anything that would actually benefit Wales. It's all things that they have to do, so the bilingual nature of justice system forms, they are compelled to provide them, but beyond that the MoJ would see no reason as to why Wales is any different from England. There are many of us who would see those differences and would like to take Wales down a different path, for example, when it comes to criminal justice.

KH: What might a future criminal justice strategy for Wales look like?

CJ: There are some who might say well, we could have bits devolved. We could devolve probation; we could devolve the police. My view is you can devolve the police, but once people are through the doors of the criminal justice system everything is linked. You can't have control of the probation service unless you have control of sentencing policy because you have to control the flow of people, who are put under the aegis of the probation service. You can't control the prisons unless you have control of sentencing policy again, because you don't control the method by which people end up in prison. I think there's certainly room for debate in Wales. There are some of my former colleagues in the Welsh Parliament who believe that women shouldn't be incarcerated at all. I don't get that. I think if you murder somebody, your gender shouldn't make a difference as to what the sentence is, but they would actually be quite opposed to establishing a women's prison at all. Other colleagues would want to see smaller prisons which are able to focus more intensely on rehabilitation. They don't like the idea of big prisons, such as Berwyn with its 2000 places. Can Berwyn really focus on rehabilitation when there are so many prisoners all under one roof? And what would we do with our most extreme offenders. We would probably have to buy places from the English prison system and then that raises more questions if you're relying on somebody else to provide services for you. These are all questions that arise, and all these factors become part of the debate, but it's not a debate we can have because we are inextricably linked to the system that exists at the moment, which is going in a different direction to what many of us would like to see. Unlike England, unlike Scotland, unlike Northern Ireland, people in Wales have no say over the direction of that policy.

KH: What is happening with the proposal for a new prison in Wales?

CJ: That's disappeared. There was a problem with the land as they hadn't checked who owned the land and that was part of the problem. They do have an awful habit of announcing that they want to take forward new facilities without telling anyone and without consulting on it. The MoJ are not good at preparing the ground for announcements. You could make the argument that there needs to be a prison in the northern valleys, for example, because everybody there has to come down to the southern prisons to serve their sentence. You could make a case for a prison in the middle of Wales as well, but none of these things are debated because those in London just don't get it. They want to impose their own template on England and then Wales as a result. They are reluctant to devolve criminal justice to us because they wonder why do they want this power? They must be wanting to do something that we won't like so we won't give them the power in the first place.

KH: What is your view on custodial provision in Wales? Is current provision fit for purpose?

CJ: No. Firstly geography. There's no geographical spread. Secondly, prisons in Wales are not designed with Welsh prisoners in mind. So that clearly is an issue, but we can't have a debate in Wales about alternative criminal justice provision because we don't have the power to deal with it. I think we could do something quite different and better if we had those powers. One of the examples that I have given is smaller prisons. That would cost more per head, inevitably because of the capital costs of building them, but we may end up with a better outcome, but at the moment we can't even do that. We can't even have that debate because we don't have those powers. However, building prisons is not a vote winner. Crumbling Victorian prisons are not an election issue. People are either indifferent or they take the view that's all they deserve. Whereas if you sit down and say, look, if we had a prison system that stopped people from reoffending, the emotional cost to the victims and the cost to society is much less. If you start talking about the longer term, then they start to get it. It's not simply about sticking them in prison and when they come out, hoping for the best. But it's not a debate that we can have. Let's not pretend that everybody can be rehabilitated because they can't, but at least we could give it a good try with some of those who are slipping through the net at the moment.

KH: If you were still in office what would your priorities be for criminal justice in Wales?

CJ: Devolve it, but that would take time. You can't devolve it overnight, you can't suddenly say from the end of this year you're in charge of everything, that doesn't work. It has to be gradual and there is a cost involved. You could probably devolve the police pretty quickly, but when it comes to the prison system and the courts, that would take some time and you would need a few years to do that, to get that right; to make sure the money is in place and to put in place the capacity in the civil service. You don't want to take over something when you don't have the capacity amongst your own civil servants to actually run the system and create policy. So yes, for me that will be the biggest objective because we can tinker around the edges with the justice system, but we can't really do anything fundamental without being able to control it ourselves and to me without that there's not an awful lot that we can do.

Recognising good practice in prisons and probation

Simon Shepherd *is Director of The Butler Trust. He is interviewed by* ***Dr. Jamie Bennett****, Deputy Director in HM Prison and Probation Service.*

Simon Shepherd has been Director of The Butler Trust, a charity celebrating and promoting what's best in UK prisons, probation and youth justice, since 2008.

Simon originally trained as a forensic psychologist and worked for the Prison Service for nine years, including at Glen Parva, Swinfen Hall, Featherstone, Holloway, Wandsworth and Prison Service HQ. He spent the next ten years in the drugs and alcohol field, first as Chief Executive of the European Association for Treatment of Addiction and then as head of the Federation of Drug and Alcohol Professionals. He has also served as an independent expert on the Scottish Accreditation Panel for Offender Programmes, and the Correctional Services Accreditation Panel for Offending Behaviour Programmes in England and Wales. And he has been a visiting lecturer at Kings College, London; City, University of London; and Birkbeck, University of London.

The Butler Trust was set up in 1985 to recognise and celebrate outstanding practice by those working with offenders, through an annual award scheme. The Trust is named after Richard Austen Butler (RAB), later Lord Butler of Saffron Walden, who was Home Secretary from 1957 to 1962, and introduced a series of reforms to improve the management, care and rehabilitation of offenders. During his parliamentary career, as well as being Home Secretary, Butler served as President of the Board of Education, Chancellor of the Exchequer, Foreign Secretary and Deputy Prime Minister.

Her Royal Highness The Princess Royal is the Trust's Patron. Each year she presides over the Award Ceremony, presenting Award Winners and Commendees with their certificates.

Since its launch the Trust has widened its scope to bring first probation and then youth justice within its purview, and increasingly focuses not only on recognising excellence on the part of staff and volunteers working in correctional settings, but also on helping to further develop the work of Award Winners and Commendees, and to share good practice more widely.

The interview took place in December 2021

JB: The Ruth Mann and Kathy Biggar Trophies were inaugurated by the Butler Trust in 2021. What was the thinking behind them?

SS: We know that there are lots of good things going on across the prison and probation estates, but they often remain as local initiatives and are not shared more widely. There are probably many reasons, not least that Governors, and their Probation equivalents, are so busy doing their jobs that they don't feel they have the time to share what they do with their colleagues. I suspect too that there's a natural modesty on many people's parts, and a reluctance to 'blow their own trumpets'. So we came up with the idea of a competition — people love a competition — and it worked! We had almost 50 initial submissions for the Ruth Mann Trophy for custodial settings, and another 30 for the Kathy Biggar Trophy, from probation and youth justice settings.

JB: Could you describe Ruth Mann and Kathy Biggar, what work distinguished them and why the Trust launched a prize named in their honour?

SS: As I am sure many people are aware, Ruth and Kathy were both outstanding champions of good practice throughout their careers. Ruth, who was a Prison Psychologist, was passionate about uncovering and sharing practice that contributed to a rehabilitative culture in prisons, while Kathy, a Probation Officer, was (among many other things) behind the Listeners programme and its roll-out across the custodial estate. They were also both very special human beings. So it just felt appropriate to name the Trophies in their honour, and we were delighted their families agreed to let us do so.

JB: What are the criteria for the trophies and what is the process for submissions and judging?

SS: While our Annual Awards are for people, the Trophies are for are examples of local practice which have a positive impact on prisoners and/or staff, and which could potentially be rolled out more widely. That might be something unique to a particular workplace, or a notable example of a wider initiative. We write to Governors, and Probation Directors, asking them if they have any initiatives which they think might be of interest to their colleagues elsewhere. We follow that up with a brief telephone interview to find out a bit more, and then write-up a submission for them, from that. We have two panels of sector experts — one for each Trophy — who review all the submissions, and then interview those shortlisted, before deciding on the finalists. A larger panel then review both sets of finalists together, to decide on the winner in each case.

JB: The first Ruth Mann Trophy was awarded to HMP Maghaberry in Northern Ireland, for introducing autism friendly visits. Could you describe this work?

SS: Neurodiversity, including autism, is common not only among both prisoners but also their children. Maghaberry have introduced special visits just for families with children with autism, together with 'pre-visit guides' for the children on what to expect, additional equipment in the crèche, and a 'relaxation room' — with bubble lamps, toys and gadgets — to help provide a calming environment. And all the staff on duty during 'autism friendly' visits have received autism awareness training. It's a brilliant way to help children with autism cope in a situation which is difficult enough at the best of times, and which often leads to them not being able otherwise to visit at all.

JB: The two other finalists were HMP Full Sutton for a project to refurbish and de-fog Perspex windows, and HMP Wealstun's initiative to introduce problem solving mentors. Could you describe these initiatives?

SS: Full Sutton's 'see the light' initiative is a simple idea, to repolish fogged Perspex windows, so prisoners and staff can see out of them again. It's cost-effective, brightens the living and working environment, and brings the outside in. While Wealstun's 'Problem Support Mentors' makes use of the skills and resources of prisoners to help their peers — training them as wing-based peer mentors to act as social problem solving coaches, using the 6 step problem solving principles of the Thinking Skills Programme (TSP) to help other prisoners find solutions to their problems.

JB: The first Kathy Biggar Trophy was awarded to the London National Probation Service, for their young adult transitions programme. Could you describe this work?

SS: London Probation's young adults transition programme is a 10 session, trauma-informed, modular 1-2-1 programme for young adults moving on from youth justice services to adult probation. It's a particularly vulnerable time for young people, and data suggests that the programme reduces their anxiety about the transition, reduces breaches and 'failures' on transition, and improves their engagement with adult services.

JB: The two other finalists were East of England National Probation Service for their student counselling service, and Hillingdon Youth Offending Team for their parent champions, who support families of those at risk of exploitation. Could you describe these initiatives?

SS: Many people on probation could benefit from counselling for a wide range of issues, but it is hard for service users to access and not something that the services themselves are funded to provide. East of England NPS have neatly resolved the problem by offering placement opportunities to local counsellors in training, so they can provide counselling to their service users free of charge. And Hillingdon YOT's parent champions programme, run by the charity Brilliant Parents, provides peer support to the families of children at risk of exploitation, by other parents who have experienced similar situations themselves.

JB: How were the winners recognised for their achievements?

SS: We presented the winners with their Trophies at local events in their places of work, with Michael Wheatley, Ruth's husband, making the presentation at HMP Maghaberry, and Pam Wilson, a close friend and colleague of Kathy's, presenting the trophy to London NPS.

JB: How have you disseminated the good practices that you have identified through the Trophies?

SS: To help disseminate the notable practice we've identified through the Trophies, we have uploaded write-ups of all the submissions we received (not just the winners and finalists) to our knowledge exchange platform — www.theKnowledgeExchange.uk. We also sent write-up on each of the finalists to Governors and Probation Directors across the country.

JB: There must be many prisons and community-based services that have innovative and successful practices. What would you say to practitioners about the value of the Ruth Mann and Kathy Biggar Trophies?

SS: After the success of this year's pilot, we're going to make the Trophies an annual thing, and we'd encourage as many Governors and Probation Directors as possible to take part each year. There is so much good stuff going on that really needs to be shared as widely as possible. And it's not difficult to do — all we need is a couple of sentences outlining each initiative and we'll take it from there.

Maternal imprisonment and family life: From the caregiver's perspective

By Natalie Booth
Publisher: Policy Press Shorts Research
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Price: £47.99

Families of people in prison is a rich and growing field of research. Much of this research focuses on men in prison, but there has also been increasing interest in the experiences of women and maternal imprisonment specifically. This monograph is a valuable addition to the existing research. Although women represent only a small part of the total prison population in the UK, it cannot be denied that the impact of maternal imprisonment on children is significant and negative.

In this monograph, Natalie Booth makes a number of significant contributions to what we already know about maternal imprisonment. She draws on the experiences of 15 imprisoned mothers in England and Wales, and 24 relatives caring for children of imprisoned mothers. Although this is a relatively small sample, she was able to elicit valuable, in-depth, and often touching testimonies. This monograph does not simply quote from the interviews, but often provides in-depth, contextual stories of the participants, which adds richness to the narrative and helps to bring the findings alive, as well as giving voice to families who are very often rendered voiceless and invisible within policy and society.

In chapter 3, Booth makes a convincing case that families in this context should not be narrowly limited to significant others and immediate nuclear blood kin. In her research, she found that 'the repercussions of losing the mothers to prison were felt by many relatives and friends within their kinship networks' (p. 41). Caring for the children left behind was often a collective venture, but one often undertaken by maternal kin as opposed to paternal kin. This was reinforced by the fact that some interviewees opted to be interviewed collectively as opposed to individually and spoke in collective 'we' terms. Most of the existing research sees impact of imprisonment on families individually — e.g., on a wife, a child — so this perspective is valuable indeed. Notably, friends were a significant source of support for the family left behind — this particular group has not received much academic or policy attention at all. Fathers were present in a minority of the cases in Booth's sample, albeit not always regularly.

A second original point of analysis pertains to children other than those of the imprisoned mothers. This is a group of children which no research has previously discussed. Booth names them 'doubly invisible children' (p. 50) and they include a wide range of children who are impacted, practically and emotionally, when someone has to look after an imprisoned mother's child. For example, there is a story of one woman who took on the care of her imprisoned relative's baby. She herself had young children, and the baby meant they received less attention and had to cope with the usual disruptions of having a baby in the house (such as noise).

In Chapter 4, Booth discusses how family life was renegotiated after a mother's imprisonment. It is well-known that often, a prison sentence is not expected[1] (Masson, 2019), and therefore there are few opportunities to make appropriate preparations. It is perhaps not surprising, therefore, that many relatives felt shock and a sense of bereavement when a prison sentence was handed down. When children had to move households (for example, to live with their grandparents), significant adjustments to the whole family's life had to be made. Family members also had to negotiate the imprisoned mother's affairs, such as furniture, finances, and so forth. More interesting is the manner in which Booth describes caregivers adjusting their own identities; for example, one father noted that he had to 'act like a mother' (p. 87) for his son. Older grandparents had to revert to parenting practices

Chapter 5 recounts the well-known issues faced by families of people in prison; the emotional and practical problems associated with the criminal justice system. Chapter 6 focuses on stigma and social support. This touches on a previously under-researched issue — the challenges of being a non-legal guardian. This was especially pertinent for grandparents of children with a mother in prison and included practical challenges such as changing the child's address with the child's GP. There were also financial costs associated with obtaining Residency Orders, running at times into thousands of pounds. Other well-known financial challenges, including inadequate social welfare support, were also identified. The many axes of stigma (in society, online, in prison) were also identified.

Overall, this is an immensely well-written monograph covering some well-known themes but also shedding light on some issues that have not yet received academic or policy attention. Of special note is the issue of children of non-imprisoned parents who are also affected by imprisonment — the needs of these children have not yet been discussed to date. Secondly, the communal nature of caring for children of women in prison is especially interesting and highlights the diffuse, complex nature of the impact of imprisonment on families; it is not simply spouses and children of people in prison affected, but cousins, parents, friends, and other kin. This is especially pertinent to understand as family structures in modern society become more heterogenous.

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1. Masson, I. (2019). Incarcerating Motherhood. The Enduring Harms of First Short Periods of Imprisonment on Mothers. London: Routledge.

PRISON SERVICE JOURNAL

Purpose and editorial arrangements

The *Prison Service Journal* is a peer reviewed journal published by HM Prison Service of England and Wales. Its purpose is to promote discussion on issues related to the work of the Prison Service, the wider criminal justice system and associated fields. It aims to present reliable information and a range of views about these issues.

The editor is responsible for the style and content of each edition, and for managing production and the Journal's budget. The editor is supported by an editorial board — a body of volunteers all of whom have worked for the Prison Service in various capacities. The editorial board considers all articles submitted and decides the outline and composition of each edition, although the editor retains an over-riding discretion in deciding which articles are published and their precise length and language.

From May 2011 each edition is available electronically from the website of the Centre for Crime and Justice Studies. This is available at http://www.crimeandjustice.org.uk/psj.html

Circulation of editions and submission of articles

Six editions of the Journal, printed at HMP Leyhill, are published each year with a circulation of approximately 6,500 per edition. The editor welcomes articles which should be up to c.4,000 words and submitted by email to **prisonservicejournal@justice.gov.uk** or as hard copy and on disk to *Prison Service Journal*, c/o Print Shop Manager, HMP Leyhill, Wotton-under-Edge, Gloucestershire, GL12 8BT. All other correspondence may also be sent to the Editor at this address or to **prisonservicejournal@justice.gov.uk**.

Footnotes are preferred to endnotes, which must be kept to a minimum. All articles are subject to peer review and may be altered in accordance with house style. No payments are made for articles.

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