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Learning Together

Crossing Over- A Reflective Piece

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My experience of working within the Criminal Justice System (CJS) is somewhat two sides of the same coin; working in the same establishments with the same prisoner population yet in very contrasting roles. This article will endeavour to explore my experience and reflections of working as a Prisoner Custody Officer (PCO) and the transition to a Higher Assistant Psychologist (HAP). The article will consider the themes of compassion and trauma with reflection of how my view of these themes compare and contrast between roles. I chose Gibbs[1] reflective model as its cyclic nature offers a structured framework to evaluate experiences. Gibbs' reflective cycle includes six stages of reflection; description, feelings, evaluation, analysis, conclusion and action plan. This model allows reflection on learning and planning for future events based on successes and drawbacks of the present experience. I will incorporate these into my own reflections of practice throughout the article.

The (CJS) is a collection of agencies and institutions which is directly involved in the apprehending, prosecuting and punishing of those suspected or convicted of committing a crime. Within these organisations and establishments, many more processes come into play such as victim support, prevention of crime and rehabilitation. The CJS can typically be divided into three main groups- police, courts and prisons. Within each of these divisions are different jobs which have specific agendas- each with distinct assets and skills required by the worker to competently carry out the role. Consequently, individuals working across different departments in the CJS may have differing values or have opposing reactions to the same experience within the system. Two themes which have emerged within the literature lately concern the importance of compassion[2] and the need to be sensitive to trauma.[3] I have experienced striking variations in the levels of compassion present and have been vicariously exposed to a range of trauma in my roles as a PCO and HAP. I have witnessed the positive power of compassion in a prisoner's journey and conversely the disabling impact of trauma within custodial environments. Alongside this I have become increasingly aware of the importance of self-compassion in working within this environment. Both felt highly pertinent themes that spanned the two roles.

Compassion

Compassion can be defined as 'the sensitivity shown in order to understand another person's suffering, combined with a willingness to help and to promote the wellbeing of that person, in order to find a solution to their situation'.[4] The term compassion is heavily incorporated in the field of Healthcare and Mental Health- compassion features as one of the core Values for Tees, Esk and Wear Valleys NHS Foundation Trust.

As for Her Majesty's Prison and Probation Service (HMPPS), values include purpose, humanity, openness and together[5]; unlike the NHS, compassion does not feature as a value. A report for the House of Commons Justice Committee on Prison Officers states that rehabilitation requires a mix of both discipline and compassion.[6] Arnold[7] defines the 'ideal officer' as having capabilities of showing care and compassion5. Nevertheless, day to day as an Officer, this may take the back seat as risky or dangerous situations occur impromptu with the need to put discipline and physical intervention first.

I have always considered myself a kind and caring person who likes to help others so prior to me working within the forensic field, I would have easily labelled myself as compassionate. I believe this has been evident in my previous jobs working with children with Special Educational Needs (SEN) and Social, Emotional and Behavioural Difficulties (SEBD); compassion is something I found quite natural. When I first began my

1. Gibbs G (1988). Learning by Doing: A guide to teaching and learning methods. Further Education Unit. Oxford Polytechnic: Oxford.
2. Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment,* 15(3), 199-208.
3. Jervis, V. (2019). The Role of Trauma-Informed Care in Building Resilience and Recover. *Prison Service Journal,* (242), 18-25.
4. Perez-Bret, E., Altisent, R., & Rocafort, J. (2016). Definition of compassion in healthcare: a systematic literature review. *International journal of palliative nursing,* 22(12), 599-606.
5. HM prison and probation service. (2018). Her Majesty's Prison and Probation Service Annual Report and Accounts 2017-18. England: OGL.
6. House of Commons Justice Committee. (2009). Role of the Prison Officer. London: The Stationery Office Limited.
7. Arnold, H. (2016). The prison officer. In: Jewkes Y, Crewe B, Bennett J (eds) Handbook on prisons, 2nd edn. Routledge, Abingdon, pp 265–283

role as a PCO, I still believed this to be true however, when I look back on my journey as a PCO, I can see how I changed as a person over the course of the job.

It soon became apparent that compassion took a back seat in my job as a PCO. Reflecting back, it was easy to follow suit of other colleagues and adapt my behaviour to fit with fellow peers. In the beginning, I would like to think I displayed a true reflection of my personality. I remember a time a prisoner disclosed concerns around self-harm- the standard operating procedure for this event would be to open a self-harm document. My response, I opened a form but also sat with this prisoner for a considerable length of time, seeing this as a priority and something that was fairly concerning. I got the prisoner crossword puzzles from a newspaper and regularly checked in on his progress. As time went on in the role, self-harm became less of a 'concern' and more of an 'inconvenience'. I think this shift in attitude was down to a number of factors. A 'prison culture' was clear with officers- self-harm could potentially be viewed as a behaviour from prisoners with intention to manipulate staff. From my experience, this 'manipulative behaviour' was viewed as an inconvenience- especially when prisoners were seen to be wasting time and resources for their own gains for example superficially cutting and receiving paramedic or ambulance care due to reasons such as not wanting to wait at court. These incidents could also have potential to make shifts for staff longer than necessary. When shifts were already long, and the demands of the job were physically and mentally draining, it became somewhat easier to just do the bare minimum- open a form. At the time, I didn't consider there to be a problem, however, looking back, I am disappointed that the traits I prized myself on disappeared so quickly. Most likely because the job became draining (five shifts a week of 12-14 hours long) but also the behaviour and reaction of other colleagues was easy to imitate. Processes within the job became 'normalised' where 'extraordinary situations are rendered seemingly ordinary'.[8] Research has also noted the emotional demands of a job are likely to contribute to burnout.[9] Reflecting back, it is apparent that emotional contagion was evident in my own presentation, whereby other colleague's emotions and behaviours triggered similar responses in myself.

On the other hand, beginning work as a HAP, compassion is a primary focus. This is depicted in the values of the NHS — my employer — but also demonstrated vividly by the team I work in. As a member of the Mental Health Team, I am expected to show compassion to patients- to be there to listen, understand and provide treatment and support. This is something which I think is easier to do in a healthcare professional role. I believe this is due to the team sharing the same views and values therefore being influenced by fellow colleagues but also I find there is an expectation from prisoners that you (as a health care professional) will sit and listen to their mental health concerns. There is trust from the patient- you are seen as an agency which can and will provide help. However, acting as an officer, I feel prisoners don't have that same trust and do not wish to divulge their concerns to an officer. As a HAP, in civilian clothes, there is a different relationship compared to an officer in a 'white shirt'. I have noticed prisoner/patients response and reaction to me has differed, depending on the uniform I am wearing.

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At times, as a PCO, it was difficult to show compassion. As an officer, you were seen as a 'white shirt' which caused potential barriers and conflict. When a (CandR) incident would occur, it would be difficult to be compassionate as an initial response would have to be authority. Crewe, Liebling, and Hulley[10] argues frontline staff are required to exercise judgment in deciding whether to use authority, and what kind of authority to use however in extremely high-stakes environments, with service users who are particularly dependent and complex, authority is

8. Ashforth, B. E., & Kreiner, G. E. (2002). Normalizing emotion in organizations: Making the extraordinary seem ordinary. *Human Resource Management Review,* 12(2), 215-235.
9. Schaible, L. M., & Six, M. (2016). Emotional strategies of police and their varying consequences for burnout. *Police Quarterly*, 19(1), 3-31.
10. Crewe, B., Liebling, A., & Hulley, S. (2015). Staff prisoner relationships, staff professionalism, and the use of authority in public and private sector prisons. *Law & Social Inquiry,* 40(2), 309-344.

necessary over compassion.[11] Similarly, it was not uncommon to experience either physical or verbal abuse from prisoners- as a result of this, it was hard to be compassionate, especially if you or a colleague became injured as a result. I feel these attitudes were mirrored among others. In this authoritative position as a PCO, I was required to be the 'officer in charge' and be able to give orders to prisoners. This was reflected in my communication style which at times was assertive when needed. Reflecting on this, it is possible to see why prisoners would react in defensive or aggressive ways and why they wouldn't wish to share personal information. Even at times when I would try to be empathetic or compassionate, it was sometimes irrelevant as I had that 'white shirt' on and so automatically seen as the opposition. This perhaps contributed to why I became less compassionate over time as regardless of my individuality, I was still just an 'officer'.

However, as a HAP communication style, approaches and relationships are very different to that of a PCO. In my role now as a HAP, work with patients is collaborative and client led. I have a genuine concern for patients I work with and a real desire to support these men. Communication style is adapted to the patient and patient's needs. Work focusses on natural validation and problem solving in a safe environment. I believe there is more opportunity as a practitioner to build rapport with clients, to offer understanding and empowerment. Having consistent and frequent contact with a patient allows this to unfold. With patients I see as a HAP, regular contact allows me to gain a better understanding of the patient, to know what's going on for that person and to explore this with them. This gives me an opportunity to be flexible when the patient may be struggling as I have this background understanding. My role also has flexibility as to how many contacts myself and a patient will have depending on the patient need.

This was quite different in the role as a PCO. It was easy to forget about being compassionate as the job was completed under time constraints. There were deadlines for collecting prisoners, taking prisoners to court, taking prisoners to prison and in this process it was easy to just get the job done. The tasks within the job were completed to a 'factory line' fashion and looking back, it was easy to forget what the impact was for the prisoner we were working with. To us, we were there to complete the job to time restrictions- the quicker this was done, the quicker we can clock off. Reflecting on this, as long as I got that prisoner out of court and to prison by X o'clock, it didn't matter. It didn't matter what that prisoner was going through, whether this was his first time in custody, whether he was scared… I just had to get him there. It surprises me how little compassion I had. If I could go back, I would certainly like to think I would handle things with a bit more consideration.

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Trauma

Trauma is the psychological impact or damage that occurs after a distressing event. Trauma can be subjective and whilst two people may have the same experiences, only one may become traumatised. The DMS-5 definition of a traumatic event involves 'exposure to actual or threatened death, serious injury or sexual violation' furthermore, a person can 'directly experience or witness the traumatic event or learn the traumatic event has occurred to a close family member or friend'. The experiences may be first hand, lone events or repeated.[11]

Histories of trauma are more common among the prisoner population- this is reflected in high levels of Post-Traumatic Stress Disorder (PTSD) among imprisoned people.[12] Between 68 per cent and 95 per cent of male prisoners have experienced at least one traumatic event in their lifetime.[13] However, on the flip side, individuals working with prisoners may be subject to traumatic events themselves- the Prison Officer who is attacked with serious violence or the first response nurse who witnesses a death in custody.

Not surprisingly, prisoners may have their own agenda or judgments when interacting with different agencies within the CJS, for instance, attitudes may

11. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.
12. Baranyi, G., Cassidy, M., Fazel, S., Priebe, S. & Mundt, A.P. (2018). Prevalence of Posttraumatic Stress Disorder in Prisoners. *Epidemiologic Reviews,* 40, (1): 134–145
13. Pettus-Davis, C., Renn, T., Lacasse, J. R., & Motley, R. (2018). Proposing a Population-Specific Intervention Approach to Treat Trauma Among Men During and After Incarceration. *Psychology of Men and Masculinity.*

differ towards the arresting police officer compared to the defence lawyer. Similarly, the interactions from different staff and agencies towards prisoners may contrast due to the role and demands of the job.

My educational background is in Psychology and Forensic Psychology and from this, I believe I had a basic, if not good understanding of mental health, trauma and impacts it can have upon an individual. My knowledge of trauma and the impacts it has seemed to go out of the window when I was an officer despite working with people who are susceptible to triggers in custodial environments.

Work conducted as an officer was not trauma-informed. From what I remember of my basic training, mental health was covered in brief however there was no training on trauma. Training involved knowledge of self-harm and suicide and what signs to look out for and the subsequent processes to follow from this. The initial training was not delivered in a trauma informed way. At the time of receiving this training, I didn't give this much thought, and so assumed the training provided would be sufficient for the role I would be doing. It wasn't until I started in my HAP role that I realised how little consideration I had given to prisoners with mental health concerns, specifically around trauma.

Within my first few months as a HAP, I had already been given the opportunity to attend Trauma Informed Care (TIC) Training which, although was not compulsory, I was encouraged to attend. Within the mental health service, there is a huge push on offering Trauma Informed Care (TIC). The training I received on TIC demonstrated how to apply this to the patients I work with- especially when psychology interventions take on a trauma focus. From a mental health perspective, I feel it is assumed that other agencies/professionals would have an understanding of the impact of past trauma and triggering situations or environments however coming from an Officer role, this wasn't the case for myself.

There were times when I think back to my role as an officer which would be highly traumatic or re-traumatising for prisoners. The process of being searched would involve an officer physically touching/patting down a prisoner to obtain whether any prohibited items had been concealed, this would then be followed by the officer handcuffing the prisoner (wrist to wrist). In my role of an officer, this procedure was crucial for minimising risk to the person, myself and others however, if a prisoner had experienced a traumatic event involving touch or restraint, this procedure could be extremely re-traumatising. This is similar for any CandR incident that occurred. Again, concerning risk, CandR would be used to restrain prisoners who were a risk to themselves or others- this could include acts of self-harm against themselves or acts of harm/violence against others. As these processes were part of my job, little thought went into potential impacts for the prisoner. I would receive little information regarding the prisoner prior to receiving them in our care- I would certainly not be privy to information regarding historic trauma. Because of this, I was never mindful of the potential distress that could be caused to the prisoner.

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Reflecting back, I should have had more of an awareness of how that prisoner could be impacted especially due to my educational background in psychology. In my role as a HAP, trauma work with a patient involves an understanding of triggers, emotions, behaviours and coping strategies. I am now aware, due to this role, that self-harm can be a coping strategy however views of self-harm as an officer were often seen as manipulative behaviours and officers would potentially have to restrain someone to prevent self-harm. Looking back at this, it is evident why a prisoner would react negatively to restraint as we are now preventing them from self-soothing. Also, in my HAP role, I now have the understanding that a high percentage of the prison population have experienced some form of trauma in their lifetime. When a CandR incident occurred, a prisoner would be restrained by three officers- hugely traumatic especially if the original trauma had similar elements- being restrained/restricted movement/three against one etc.

Despite on reflection thinking I should have been more aware of potential impacts on the prisoner, CandR intervention was a last resort and primarily came down to risk therefore even if I had been consciously

aware of potential impacts, the physical intervention would still have been a necessity in that situation.

Working in a prison environment, it is assumed that staff may themselves experience vicarious trauma- experiencing trauma through the feelings or actions of others. In the roles I have worked in within custodial settings, I have been exposed to situations where I could potentially have been affected. As part of my PCO role, I would sit in the dock with prisoners for the trial duration- hearing details about the crime, seeing evidence, listening to testimonies. At times, this could have a significant impact upon my mental wellbeing, especially if the case involved gruesome or horrific elements. I believe part of the 'officer mentality' is that it's your job and you just get on with it, you can't let it affect you. There was little to no management support or services available for mental health wellbeing after being exposed to high levels of traumatic material. Despite this, I worked with a great team of officers who were always present. Upsetting content of trials, post CandR incidents and general stressful events in the work day were handled with fellow colleagues and more often than not used dark humour to get through the shift. However, as aspects of the job needed completing to time frames and staffing levels were low to start with, it wasn't unusual to experience a potentially traumatic incident yet have no time to reflect on this before having to continue with the task at hand.

Similarly, in a therapist role, vicarious trauma is not uncommon. I work with patients who have experience traumatic events and in some cases, this comes up in session. I believe this can potentially effect a practitioner however, I feel that I have built up a personal resilience and I am able to deal with this myself to a certain extent. There are times, however, where a 'de-brief' is necessary. Being in a clinical profession, I am lucky to receive weekly clinical supervisions as well as group and peer supervisions. Having these resources is extremely beneficial in my work as I am able to off-load.

Conclusion

I feel my experiences as an officer have made a positive contribution to the HAP I am today. I have an appreciation for officers and can relate to the struggles they experience as I have once been there myself. My experiences, both educational and operational, have allowed me to develop my skills and be reflective on my practice. Throughout both of my roles and the transition between the two, I feel I have been on a journey with compassion and trauma. In regards of trauma, I believe my knowledge and experience was typical for the experiences I had at University and in previous jobs however over the course of my role as a PCO to my role as a HAP, I feel this increased over time. Compassion, on the other hand, took a slightly different path. I believed myself to be a compassionate person when starting as a PCO however, this clearly declined in some respects over the course of the officer job. I feel starting in the HAP role, my compassionate side increased once again, to how I felt before, if not more. Having a different perspective in dissimilar jobs within the criminal justice system has certainly made me reflect on my work and consider how to better my professional skills. I hope to take these reflections on through my career and have a consideration and awareness of my own practice.