An Exploration of the Implementation of Trauma-Informed Care in Forensic Settings for Males

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Thesis Abstract

The overall structure of this thesis takes the form of six chapters. The first chapter is an introduction to current literature on the need for, and understanding of, trauma-informed care in forensic services. Chapter two presents a systematic review on active implementation of trauma-informed care in forensic services with male service users. This identified crucial aspects of organisational culture, resistance, and re-humanisation. The third chapter outlines a case study of a male with a forensic history and personality difficulties detained in a high secure category B prison. This explores the impact of residing on a psychologically informed planned environment (PIPE) and engaging with compassion focused therapy. Through this it is illustrated that ongoing challenges to engagement with therapeutic environments and interventions were present. In chapter four a psychometric critique of the Attitudes Related to Trauma-Informed Care scales (ARTIC; Baker et al., 2016) and exploration of its applicability in forensic settings is presented. Recommendations to make the ARTIC scales more applicable to forensic settings are identified. A research study comparing the trauma-informed care attitudes between staff at a PIPE approved premises, and a non-PIPE approved premises, with exploration of staff and residents' experiences is presented in chapter four. Statistically significant differences in attitudes related to trauma-informed care were not identified across the PIPE and non-PIPE staff groups. Through comparison of the themes that emerged, it appeared that the PIPE model provided confidence and support to the staff team to feel capable to support their residents. However, the PIPE model seemed to create an uncomfortableness for the staff team in appearing to move away from risk management. Overall, it was discussed by participants across both approved premises that there was support for the residents in the transition to the community, with therapeutic relationships being valued. Further findings, interpretations, and links to existing literature is discussed. The final chapter draws upon the entire thesis, providing a summary of the key findings and includes a discussion of the limitations and implications of the findings. This includes a recommendation for further exploration regarding the integration of risk management with trauma-informed approaches.

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Chapter One: Thesis Introduction

1. Thesis Structure

This thesis aims to add to the literature exploring trauma-informed care in forensic settings, in particular for male service users. It is comprised of six chapters: an introduction, a systematic review, a case study, a psychometric critique, and an empirical research study, and the discussion. Although the chapters in this thesis are presented in sequence, they also stand as independent studies/chapters.

Chapter one introduces the current knowledge and literature on trauma-informed care, specifically considering its application within forensic services. The definitions of trauma-informed care and approaches are discussed. Additionally, the prevalence and impact of trauma histories within forensic populations is outlined. This is followed by chapter two, which includes a systematic review of eight papers, exploring trauma-informed care in forensic settings that includes male service users. In chapter three, a case study of a male with personality difficulties and a forensic history is presented. The treatment pathway for this individual included compassion focused therapy (CFT) and residence on a psychologically informed planned environment (PIPE). Chapter four, details and critiques the attitudes related to trauma-informed care scale (ARTIC; Baker et al., 2016). Chapter five includes an empirical research study comparing the trauma-informed attitudes, and experiences, of staff at a PIPE and a non-PIPE approved premises, as well as exploration of residents' experiences. A discussion and conclusion of this thesis is provided in chapter six.

1.1. Trauma-informed care

Since the initiation of the adverse childhood experiences (ACE) research in 1995, it has been recognised that early trauma can result in physical and mental health difficulties throughout the lifespan (Felitti et al., 1998). Trauma is defined by the American Psychiatric Association (APA, 2013) as experiences that are perceived as threatening injury or death, causes feelings of terror, fear and helplessness, and can include abuse, violence, neglect, and disasters. However, alternative conceptualisations of trauma that

promote a biopsychosocial understanding have been adopted. Emphasis is placed on the impact of social trauma such as marginalisation, poverty, racism and inequality (Blanch et al., 2012). This is reflected in SAMSHA's (2014) definition of trauma which highlights that a traumatic event does not need to be life threatening but includes incidences in which an individual's psychological and social integrity is threatened, as well as placing importance on the way the event is experienced, and the impact. This definition of trauma is adopted throughout the thesis. The impact of traumatic experiences has been well documented. It is evidenced that exposure to trauma influences the development of the brain, including altering brain circuits and hormonal systems that regulate stress (Nemeroff, 2004; Perry, 2009). Trauma can also alter the individual's perception of themselves and the world (Dye, 2018). Such altered perceptions will have long lasting impacts. This is reflected in that those who have experienced trauma often present with depression, anxiety, sensitivity to rejection, unstable relationships, and difficulty with trusting others (Briere & Jordan, 2009).

In response to the recognition of the prevalence and impact of trauma, trauma-informed care was developed by Harris and Fallot (2001). They discussed that trauma-informed approaches would improve system design and assist services to deliver care that were welcoming and appropriate to the needs of individuals with trauma histories. SAMSHA (2014) identified the key principles of a trauma-informed approach as: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues. These principles apply across both clients and staff. Further key elements include: seeing through a trauma lens; recognising the various forms of trauma, referring people to trauma-specific services, and avoiding re-traumatisation (Elliott et al., 2005). Embedded within the trauma-informed approach is a need to recognise a history of traumatic experiences is a possibility for all clients and the impact this may have on their ability to feel safe and build trusting relationships (Department for Levelling Up, Housing & Communities, 2023; Kezelman & Stravropoulos, 2012). An organisational approach is required, which includes a system-wide endeavour to adopt trauma-informed care across policies and practice (Thirkle et al., 2018).

The trauma-informed perspective has been described as a paradigm shift as it represents a change in the framework for understanding clients and the context of their presenting difficulties (Butler et al., 2011). This paradigm shift occurs through trauma-informed care being grounded on the understanding of, and responsiveness to the physical, psychological and emotional impact of care (Hopper et al., 2010). A previous dominant approach within healthcare settings is person-centred care. This is defined by its attributes of being holistic, individualised, respectful and empowering (Morgan & Yoder, 2012). Additional to the approach of person-centred care, trauma-informed care promotes that all staff understand the consequences of trauma and can then understand the behaviours of service users as adaptive (Elliott et al., 2005). This includes reframing complex behaviour in relation to its function of survival, which then allows services to address the needs of the service users (Sweeney et al., 2016). This reflects that services are provided through the lens of trauma which can lead to patient healing and greater professional satisfaction (Bassuk et al., 2017; Fallot & Harris, 2001).

Fallot and Harris (2001) identify that trauma-informed services incorporate an understanding of the impact of trauma and seek to avoid re-traumatisation, whereas trauma-specific services have a focused task to directly address trauma and facilitate trauma recovery. Trauma-specific services provide clinical interventions and specific therapies that treat the impact of trauma (DeCandia & Guarino, 2015; Sweeney et al., 2016). Whereas the focus for the trauma-informed approach is policies that can be implemented by entire organisations, involving changes to culture and practice (Guarino et al., 2009; SAMHSA, 2014). This involves the modification to practices in order to avoid iatrogenic harm (Raja et al., 2015). The trauma-informed principles overlap with a number of other good practice approaches (Sweeney et al., 2018) however the trauma-informed perspective represents a whole-systems approach (Sweeney & Taggart, 2018), as well as the explicit recognition of prevalence of trauma and the understanding of the impact of this on the lives of service users (Jennings, 2004).

Trauma-informed care has been identified as offering a compassionate and rewarding manner of working (Purkey, et al., 2018). This could indicate that trauma-informed care allows staff to achieve greater satisfaction in their work. This is of importance due to the

understanding that working with individuals with trauma histories can place significant stress and potential for vicarious trauma on staff. It has been found that organisational trauma-informed care has the potential to improve physical and emotional safety, and reduce burnout among staff members (Sheppard et al., 2022).

1.2. Trauma, and trauma-informed care, in forensic settings

It is acknowledged that experiencing trauma in childhood is linked to an increased risk of violence, criminal activity and mental health difficulties in later life (Larkin et al., 2013). This is likely due to trauma creating a chronic sense of threat and a lack of safety, which may result in survival behaviours that can include offending (Willmot & Jones, 2022). It is important to emphasise that most people who experience trauma will not commit violence, and that the link between trauma and offending is multi-faceted (Neller & Fabian, 2006). However, among those that engage in offending behaviour, there is often a history of traumatic experiences (Maschi et al., 2011; Stinson et al., 2021). This is reflected in the higher rates of childhood trauma in forensic services than within the general population (Widom, 2017).

There has been an increased recognition that social injustice, trauma, stigma and institutionalization may have a potential role in creating the contexts for offending (Jones, 2019). Individuals within forensic settings will likely experience amplified trauma as a result of contributing factors such as mental illness, incarceration, legal complications and social issues (Cromar-Hates & Chandley, 2015). Within NHS England's (2019) long term plan they highlight that individuals within criminal justice services are some of the most vulnerable members of our society as they will have likely experienced greater problems than the rest of the population. This is further emphasised by the identification that many institutions, certainly criminal justice settings, are too frequently places where violent trauma is perpetuated rather than eliminated (Fallot & Harris, 2009). Along with this is the understanding that individuals that have histories of experiencing trauma may often have their needs overlooked as their behaviour may be perceived as self-destructive (Magruder et al., 2017). Additionally, it is noted that forensic services are characterised by a focus on punishment (Bloom & Bradshaw, 2022). This likely limits the ability to recognise and respond to the psychological needs of individuals that have

committed offences. Arguments have been made to reject the punitive and often marginalising and dehumanising values within forensic services (Bennett & Shuker, 2017).

To better meet the needs of individuals within forensic services, trauma-informed approaches are increasingly becoming a priority (Fritzon et al., 2020; Department for Levelling up, Housing & Communities, 2023). Adopting trauma-informed care to forensic services does not excuse crime, instead it informs effective intervention strategies that assist with rehabilitation and reintegration (Levenson & Willis, 2019). It has been outlined that a trauma-informed approach may provide individuals understanding of their offending behaviour and enable them to make changes to their behaviour (McCartan, 2020). There are also potential benefits of trauma-informed care in forensic settings for the staff team. It is considered that staff in forensic settings may have experienced direct trauma, and trauma-informed care can assist in creating staff safety (Miller & Najavitis, 2012).

1.3. Personality difficulties and the offender personality disorder pathway

Although trauma alone is not a necessary or sufficient explanation of personality disorder, those with personality disorders frequently report a range of adverse childhood experiences (NOMS & NHS England, 2015). This is reflected by Willmot and Evershed's (2018) finding that among those given a diagnosis of personality disorder in forensic services, insecure attachments and complex developmental trauma are widespread. They outline that with this population, it is important to formulate challenging behaviour as responses to perceived threat or survival strategies. This viewpoint is emphasized within the power threat meaning framework, which outlines how individual's presentations and distress can be explained in relation to experiences of power in the individual's life, the threat this may have posed, the meaning of this to the person and the threat response (Johnstone & Boyle, 2018). This framework highlights that among individuals that would meet the criteria for a diagnosis of personality disorder, there is a tendency to have used survival strategies to manage threat, and therefore they may have cut off from their emotions and may present in a hostile interpersonal style. It should be considered that these individuals will have likely grown-up experiencing threat,

discrimination, social exclusion and deprivation (Farrington, 2007). This understanding of personality disorder emphasises the importance of recognising the experiences an individual has had and how they have learnt to cope throughout their lifetime, especially when faced with adversities. There has been criticism of risk assessments focusing too heavily on risk factors such as personality disorder, rather than adopting a formulation-based approach to risk, which takes into account the meaning and function of an individual's offending behaviour (Logan & Johnstone, 2010).

It is estimated that 30-50% of the probation caseload and 60-70% of the prison population meet the criteria for personality disorder (HMPPS & NHS England, 2020). Therefore, management of individuals with personality disorder is a priority for the criminal justice system (West, 2014), particularly as there is evidence to suggest that having personality disorder is associated with a greater likelihood of recidivism (Listwan et al., 2010). The recognition that many individuals with personality disorder traits within the criminal justice system had unmet needs, led to the creation of the Offender Personality Disorder (OPD) pathway (DOH & MOJ, 2011). The service users within the OPD services are men that have been identified as presenting as high risk to others during their sentence and are likely to have personality disorder traits that are linked with their risk (Skett et al., 2017). The criteria for OPD services is different for women. Key aims of the OPD service include to enhance the psychological wellbeing of service users and to develop "psychologically informed" environments (Ryan et al., 2019). Developing an understanding of service users on the pathway, and the links between their personality difficulties and offending histories is a central principle (Knauer et al., 2017). Therefore, the pathway has adopted a person-centred, holistic, formulation-based approach, which describes risk and need (Skett et al., 2017). Within the OPD services, the formulations have careful consideration of past aversive and traumatic experiences to map the emergence of their thinking and relationship style (Bruce et al., 2020). This case formulation allows for a better understanding of the person and their behaviour to be developed and will result in a pathway plan that reflects their need (NOMS and NHS England, 2015). Importantly, a shift from using the term personality disorder to personality difficulties has occurred, which is to emphasise a movement away from a medicalised approach and instead have a focus on the psychological principles of

personality of being on a continuum (HMPPS & NHS England, 2020). Therefore, the term personality difficulties will be adopted throughout this thesis.

The OPD pathway has a focus on relationships and the social context in which people live (NOMS and NHS England, 2015). Within OPD services a holistic approach is taken, and a key element is a trauma-informed approach (Skett & Lewis, 2019). It incorporates a biopsychosocial theoretical framework that recognises the role of biological factors, as well as the psychological and social components (Skett et al., 2017). The OPD pathway recognises that traumatic experiences are at the core of disturbances and interfere with an individual's ability to manage their emotions and behaviours (Skett et al., 2017). An important element of this has been the development of psychologically informed planned environments (PIPEs). PIPEs are designed to support transition and personal development at significant stages of a service user's pathway, which has included it being applied to Approved Premises (NOMS and NHS England, 2015). The PIPE model has planned structures that provide opportunities for psychologically informed practice to take place, including structured groups, creative sessions, regular personal officer/key worker sessions and group supervision for staff (Turley et al., 2013).

1.4. Justification for the thesis

Research on the implementation of trauma-informed care is relatively new, and further research is needed (Mahon, 2022). The majority of research and publications has focused on identifying good practice (Department for Levelling up, Housing & Communities, 2023). These appear to provide a theoretical perspective of the need and potential application of trauma-informed care, rather than exploring the active implementation of trauma-informed care. Research exploring the application of trauma-informed care in forensic settings for males is incredibly limited. Therefore, this thesis aims to progress insight into this area.

Chapter Two: Trauma-Informed care in forensic services for males: A systematic review

Abstract

A recognition of the high prevalence of trauma in forensic populations has increased the momentum of trauma-informed care in forensic services in recent years. Through this, a greater understanding of criminal behaviour is promoted, as well as a recognition of the impact of trauma on service users, staff and organisations (Willmot & Jones, 2022). This review explored the effectiveness, as well as the perceived barriers and facilitators, regarding the active implementation of trauma-informed care within forensic services that included male service users. Systematic searches of APAPsycINFO, Embase, MEDLINE, PTSDpubs, Scopus, and Web of Science were conducted, as well as searches for grey literature, to identify relevant articles. From these searches, eight articles were deemed to meet the inclusion criteria. Articles were screened and evaluated with the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). Findings from the included studies were narratively synthesised because of high study heterogeneity. Three key themes were identified. The organisational culture emerged as a crucial factor in the application of trauma-informed care. This included the importance of staff having an understanding of the impact of trauma, recognising that trauma also has an impact on staff, and the benefit of reflective practice. A further theme highlighted that resistance is often experienced when adopting trauma-informed care in forensic services. Factors contributing to this included a need for buy-in among staff teams, and the challenges of trauma-informed care being perceived to be in contrast to the dominant approach of punishment. The final theme encompassed that trauma-informed care required re-humanisation of the clients that they work with. To achieve this, it was essential that empowerment and choice was promoted, and social connections were created. This systematic review highlighted the paucity of research on trauma-informed care in forensic services that included male service users. It is indicated that for effective implementation of trauma-informed care in forensic services, the organisational culture needs to be prioritised. Further consideration is required on the coherence of trauma-

informed care and risk management to assist with overcoming resistance to its implementation.

2.1. Introduction

There is an increased interest on trauma and its profound impact on people's lives, including psychologically and behaviourally. There is a need to be aware and responsive to the impact of trauma for people that access and work within forensic services. This is due to the prevalence of trauma being significantly higher in populations of individuals that have committed offences than the general population (Matheson, 2012). This likely reflects that individuals that have been exposed to trauma may respond to later situations that reproduce experiences of loss of power, safety, choice and control in ways that appear excessive if their trauma history is not considered (Sweeney et al., 2016). Therefore, trauma should be conceptualized as a risk factor, a treatment need, and a factor that limits ability to engage with treatment (Holloway et al., 2018). Yet, the presentation and challenges of working with a highly traumatised population in threatening and controlling environments of forensic services is overlooked in models of offender rehabilitation (Looman & Abracen, 2013; Miller & Najavitis, 2012).

Trauma-informed care provides a framework for responding to the needs of a traumatised population. The adoption of trauma-informed approaches to forensic practice provides a greater understanding of the complexities of offending behaviour, as well as recognising the impact of trauma on service users, staff and organisations (Willmot & Jones, 2022). The implementation of trauma-informed care in forensic inpatient mental health settings has the potential to create positive changes in the social climate, reducing the risk of re-traumatisation and improve outcomes for staff and patients (Rodwell & Frith, 2024). An exploration of trauma-informed ways of working with individuals who have committed offences was conducted by McCartan (2020). It was emphasised that understanding what contributes to an individual's offending behaviour allows for effective responses and risk management. To achieve this, it is argued that there needs to be a recognition of the impact of trauma as this would allow the individual to better understand the reasoning for their offending behaviour and change their behaviour. Similarly, Taylor & Hocken (2021a) argued that through a slow response to knowledge of the impact of

trauma on offending, this has limited the ability to address the origins of criminogenic need. They discuss that criminogenic capabilities should be understood functionally, with consideration of how trauma and adversity shapes people's lives and how their defensive strategies may inadvertently create harmfulness. Viewing criminal behaviour through a trauma lens does not excuse such behaviour, but instead improves understanding of criminal behaviour and allows for improvement in desired outcomes (Levenson & Willis, 2019).

To embed trauma-informed care in an organisation, a shift in beliefs and culture across the organisation is required (Dinnen et al., 2014). This includes a readiness to change (Hummer et al., 2010). It could be perceived that due to the arguments and evidence for a trauma-informed approach within forensic settings that this readiness to change is emerging. There is a need for actual changes across various aspects of the criminal justice system to achieve trauma-informed care (Mulcahy, 2018). However, achieving such change and organisational shifts within the criminal justice settings, which has a focus of public protection and risk management is challenging. In addition, staff working with individuals that have committed offences will likely encounter aggression and hostility from clients that can create a sense of threat, and this limits the buy-in for trauma-informed care among staff members (Levenson & Willis, 2019). It is noted that there is a perceived conflict between care and control in forensic settings, which trauma-informed practices would heighten (Vaswani & Paul, 2019). Despite this, it is argued that successful implementation of trauma-informed care can improve outcomes for service users and support positive working environments for staff (Unick et al., 2019). For such outcomes to be achieved, implementation of trauma-informed care in forensic settings needs to recognise the unique challenges, strengths and cultures of forensic organisations (Miller & Najavitis, 2012). It is evident that further exploration of the implementation and impact of trauma-informed care in forensic services is required.

2.1.1. Existing systematic reviews

Systematic reviews have been conducted exploring various aspects relevant to trauma-informed care in forensic services. However, the exploration of the implementation and adoption of trauma-informed care in these settings is limited. A review of the literature

was conducted by Fritzon et al (2020) to generate understanding of the relationships between trauma and criminogenic need. They argued that there is a need to consider the role of trauma in offending among males and females, particularly as trauma may be connected to risk factors for criminal behaviour. Simjouw et al (2020) conducted a scoping review to identify trauma-informed training or education for forensic mental healthcare staff. Nine studies were included and all of these focused on justice-involved youth. They did not identify any publications that targeted adult forensic populations. From this review, it was determined that trauma-informed forensic mental healthcare can help to contextualize behaviour and experiences in a manner that supports effective treatment and recovery. The challenges with generalising these findings to adult forensic populations were noted. A rapid review assessment on trauma-informed care for incarcerated individuals who engage in self-injurious behaviours was conducted by Martin et al (2017). However, they were not able to identify any relevant studies. Through synthesising the literature exploring trauma-informed care for the reduction of mental health symptoms, they identified modest benefits of trauma-informed care. The included studies were conducted primarily with female offenders. One systematic narrative review has been conducted on trauma-informed practice in the criminal justice system by McAnallen & McGinnis (2021). From their searches, seventeen studies were included. All included studies focused on women and young people involved in the criminal justice system. The key aspects of trauma-informed care identified through the themes were the importance of recognising trauma, having safety for clients and staff, the importance of relationships and these supporting recovery, the need for gender-responsive and trauma-informed services, and the impact of organisational ethos. This review highlighted that there is a gap in the evidence of the application of trauma-informed practice in forensic settings, as well as that future research should consider the specific needs of men in forensic services. To the best of the authors knowledge, no further systematic reviews examining trauma-informed care in forensic services have been conducted.

2.1.2. Aims and objectives

This systematic review aimed to identify and synthesise findings from studies on the application of trauma-informed care in forensic services that included male service users. There is currently a gap in the literature on practice that responds to the trauma

needs, through trauma-informed care, that are specific for males in forensic services. The findings of this systematic review will inform further research and the application of trauma-informed care in forensic services.

2.2. Method

2.2.1. Rationale for Mixed Studies Systematic review

Systematic reviews combining qualitative, quantitative, and/or mixed methods studies provide potential for addressing complex interventions and phenomena, specifically for assessing and improving clinical practice (Heyvaert et al., 2013). It is argued that research in criminal justice is multifaceted, and therefore mixed methods research allows both quantitative trends and qualitative insight that conceptualizes experience to be captured (Wilkes et al., 2021). Mixed methods systematic reviews can bring together the findings of effectiveness (quantitative evidence) and patient, staff or other's experience (qualitative evidence) and enhances their usefulness in decision making (Bressan et al., 2016). Therefore, a mixed method systematic review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for mixed method systematic reviews (Lizarondo et al., 2019).

2.2.2. Search Strategy

Due to the limited research conducted on the implementation of trauma-informed forensic services for males, a wide inclusion criteria was adopted. The inclusion criteria consisted of empirical articles that explicitly referenced the application of trauma-informed care in forensic services including males. To assist with the creation of the search matrix, and study selection, the population exposure outcome (PEO) framework was utilised (see figure 1).

The exclusion criteria was: a) articles not within forensic services, b) courts and police were not included due to the lack of ongoing contact with service users, c) research specifically focused on forensic services for women or young people, d) articles primarily exploring trauma-focused intervention, e) working with victims of offending.

Figure 1: PEO framework

Population	Staff working with adult male clients in both secure and community forensic services.
Exposure	The explicit adoption of trauma-informed care principles in the service.
Outcome	Organisational Challenges, Staff and client experiences.

To assist with developing the search strategy, an initial scoping search was performed on key databases relevant to the topic. This scoping review identified a vast amount of research that had reference to trauma-informed care. However, it was deemed that there was low relevancy of the search results. Additional advice was sought from the research librarian at the University of Nottingham. It was deemed appropriate to refine the results through limiting the searches to the title, abstract and keywords. Subject headings were not used as it was identified that these lacked the specificity required for the searches required.

In August 2024, a search was conducted using the title, abstract, and keywords search terms on the following six databases: APAPsycINFO, Embase, MEDLINE, PTSDpubs, Scopus, and Web of Science. Grey literature was also consulted in August 2024, including reviewing the first 200 outputs from Google Scholar, and reviewing relevant organisations such as Ministry of Justice, and thesis libraries. The reference and citation list of all included articles, and key papers, were reviewed.

The search strategy consisted of the following search terms: (trauma sensitive *or* trauma responsive *or* trauma informed *or* trauma aware *or* trauma integrated) AND (offend* *or* jail *or* correctional facilit* *or* correctional institution* *or* forensic *or* probation *or* secure service* *or* secure hospital* *or* forensic inpatient *or* criminal justice *or* justice system *or* secure care *or* prison *or* parole *or* incarcerat*).

2.2.3 Selection of studies

Results from database searches were transferred onto the EndNote software. This totalled 2,127 documents. Following removal of duplicates, 855 papers remained for screening. The remaining articles were screened through review of their titles and abstracts to ensure they met the inclusion criteria. After this initial screening had been completed, six studies remained. Full-text screening took place, and this resulted in one further study being excluded. Further searches of the grey literature, and reference and citation lists identified six articles. Once screened, three were deemed to meet the inclusion criteria. This resulted in eight studies being included in the systematic review. See Figure 2 for PRISMA Flow Chart Diagram.

2.2.4 Quality appraisal

As this systematic review adopted a mixed-methods design, therefore including diverse methods, the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was utilised to appraise the quality of included articles. The MMAT is a tool that allows for the critical appraisal of quantitative, qualitative, and mixed method studies. The quality appraisal highlighted that a number of included studies were presented in reports rather than published peer-reviewed journals. This impacted on the reporting on crucial factors related to the methodology, data analysis and interpretation of results from the data. However, it was deemed appropriate to include all studies, regardless of their quality, in order to gain insight into the current evidence base for the implementation of trauma-informed care in forensic services.

2.2.5 Data collection and management

From the included studies, data was extracted using a pre-defined template. The extracted data included publication characteristics (publication format, year of publication, and place of publication), the trauma-informed approach explored, setting of the research, relevant aims, relevant key findings, conclusion, and reported limitations. The data extracted is displayed in table 1.

2.2.6. Characteristics of included studies

All studies were published between 2019 and 2024. The studies originated from the United States of America (USA; Dagenhardt et al., 2024; Dion et al., 2019) and the United Kingdom (UK; Seel et al., 2023; Seitanidou et al., 2024; Taylor & Akerman, 2022; Mueller et al., 2021; Hiett-Davies, 2022). Five studies utilised a qualitative approach, whilst the remaining three adopted a mixed methods approach. The trauma-informed approach adopted within the services varied.

Reporting of the characteristic and demographic information of the participants in the studies were limited. The included articles were services for adults, aged 18 or over. The settings consisted of the community, forensic mental health inpatient services, prison in-reach mental health, and prison. Although all services included male service users, some studies also included the evaluation of services for females. Reference to female service users within studies was not incorporated into the systematic review. Four studies researched services solely for males (Dagenhardt et al., 2024; Dion et al., 2019; Seel et al., 2023; Taylor & Akerman, 2022), whilst the rest were services for males and females (Seitanidou et al., 2024; Mueller et al., 2021; Hiett-Davies, 2022; Petrillo & Bradley, 2022).

The majority of the studies participants were staff members working within a forensic service that is implementing a trauma-informed approach. Four studies included healthcare professionals working within forensic mental health services, such as low or medium secure services and a community forensic service (Taylor & Akerman, 2022; Seitanidou et al., 2024; Hiett-Davies, 2022). The participants of one study consisted of seventeen healthcare professionals, including a consultant psychologist, an occupational therapist, trainee psychologists, an assistant psychologist, an art therapist, social workers, consultant psychiatrists, deputy ward managers, and head of nursing (Seitanidou et al., 2024). Within Hiett-Davies' (2022) study there were fifty-one staff members from nine forensic inpatient teams including secure settings and forensic in-reach. A further study included prison staff within a category B prison working on one residential unit (Seel et al., 2023). Seven staff members participated in this study, with a mean age of 32.6 years, with length of service ranging from two months to six years. Additionally, one custodial unit manager participated in this research. Petrillo & Bradley's (2022) research consisted of thirty-eight practitioners using trauma-informed

approaches across six probation areas. One study included seven staff members working in a human service agency specialising in re-entry programs, which included two female family support specialists and five male peer guides (Dagenhardt et al., 2024). The peer guides had spent time in prison previously. A further study included staff working in a responsible fatherhood program, as well as five key expects on a trauma-informed system of care, training and resources (Dion et al., 2019). Twelve experts currently or previously in roles of implementing trauma-informed care in correctional facilities were utilised within Mueller et al (2023).

Of the included studies, four also included service users as participants (Dagenhardt et., 2024; Taylor & Akerman, 2022; Seel et al., 2023; Hiett-Davies, 2022). Forty-three prisoners, with a mean age of 31.81 years and mean of 33.50 weeks in the prison, participated in Seel et al's (2023) research. A further study included seven African American program participants (Dagenhardt et al., 2024). Two studies included patients within secure forensic services (Hiett-Davies, 2022; Taylor & Akerman, 2022).

2.2.7 Data Synthesis

After full screenings of the articles had been conducted, eight articles were included in the final analysis. Due to the limited studies including statistical measures, and the various measures included, it was not possible or appropriate to combine data in a statistical analysis. Therefore, it was deemed appropriate for a narrative synthesis of the findings to take place. The quantitative findings, from the mixed-method studies, are outlined. In addition, the quantitative and qualitative findings have been narratively synthesised. The studies were grouped together based on the key areas present across the included studies.

Figure 2: *PRISMA 2020 Flow Diagram Displaying the Searches*

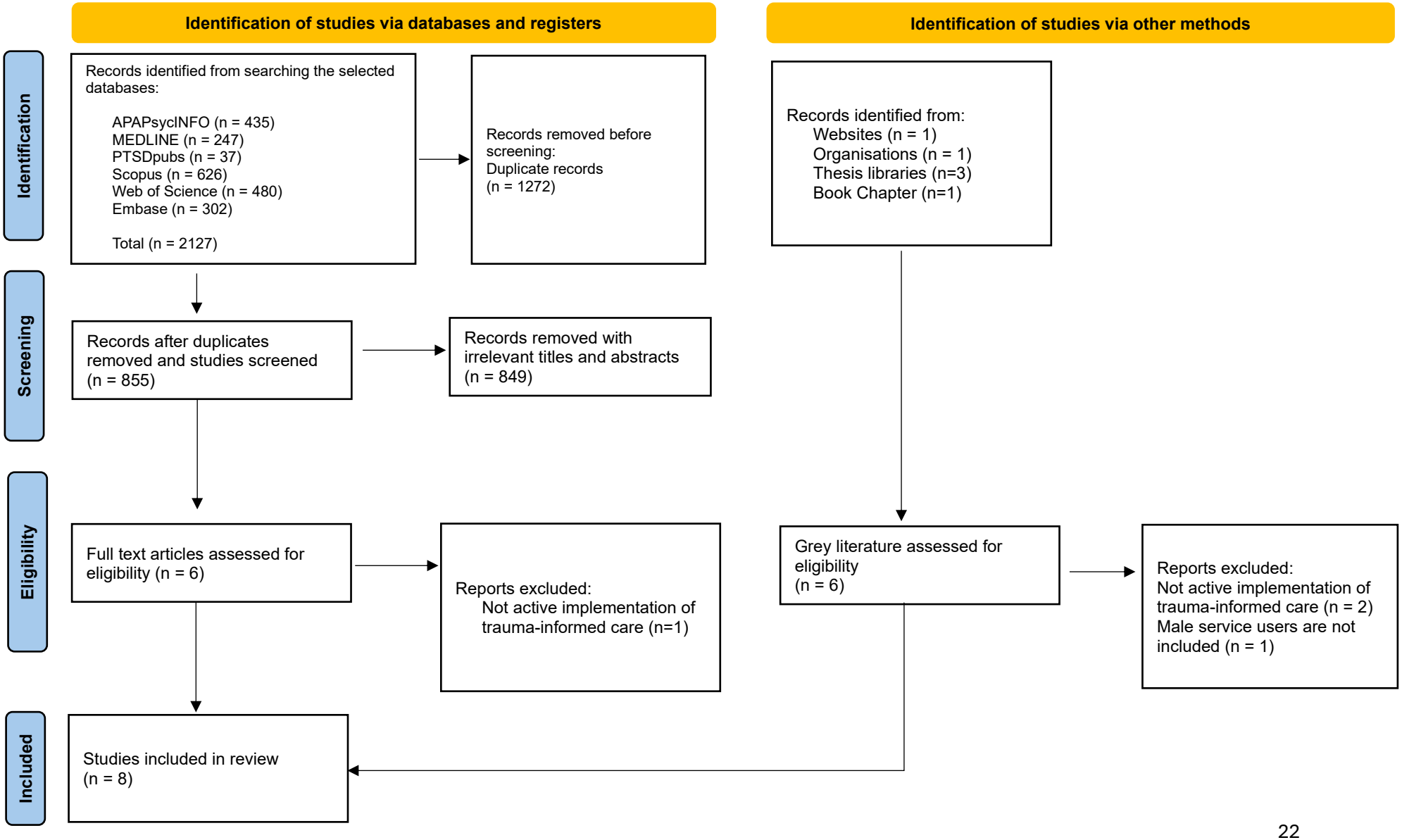


Table 1: Summary of included studies

Study no.	Author(s), year of publication, and country,	Trauma informed approach, setting, and client information.	Relevant aims	Design and analysis	Sample demographics	Relevant key findings	Conclusion	Reported Limitations
1	Dagenhardt, R, D., Sharif, S., Bacalso, E., & Topitzes, J. (2024). USA	A Smart Re-entry Program that emphasises the importance of trauma-informed and healing-centred care. An Urban Midwestern City in the United States. Pre-release (Incarceration) and post release (Community). Incarcerated and recently released men	To evaluate the process of a re-entry program, and examine the challenges and strengths associated with implementing the programme.	Qualitative Semi-structured interviews and narrative analysis.	7 program participants (African American men). 7 staff members. This consisted of 2 female African American/Black family support specialists, and 5 male peer support workers (3 African American/Black and 2 Hispanic/Latinx).	Themes: Culture and goals of the program Strengths and Challenges of Implementation Team and Administrator relations Peer Guide and Client Relations	The re-entry program balances professional service provision with trauma-informed practices for both staff and clients.	Focused on one program in one Midwest Urban Centre, which has its own sociocultural issues. Clients who engaged with the research may have done so due to having positive experiences and favourable impressions. This could skew insights into participants' perspectives.
2	Dion, R., Azur, M., Morzuch, M., & Laflair, L. (2019).	The program implements a trauma-informed system of care.	The purpose of the brief was to describe how fatherhood programs serving men in	Qualitative Interviews. Analysis not stated.	Directors of six programs serving men in re-entry.	Organisational commitment to trauma-informed approach being necessary.	These programs are able to support fathers in coping with their trauma histories by incorporating principles of trauma-	None stated.

	USA	Community The client group is low-income fathers who have been incarcerated sometime in their lives and may have experienced trauma.	re-entry can implement a trauma-informed system of care.		Multiple levels of staff at five fatherhood programs. Five experts on a trauma-informed system of care, training and resources.	Staff training in awareness of and appropriate response to trauma. Practices to foster healing and avoid re-traumatisation	informed care into their programs. This requires an organisational commitment, ongoing staff training, and a culture that supports healing.	
3	Seel, C. J., May, R. J., & Austin, J. L. (2023). UK	A trauma-informed, peer-led enrichment intervention. A large privately operated Category B prison in the UK, on a unit with a capacity of 99 prisoners, which were males aged between the ages of 20 and 63.	To assess the feasibility of a trauma-informed, peer-led strategy for increasing meaningful engagement during association times.	Mixed Methods Surveys Qualitative feedback via surveys and written feedback from operational manager of the unit. Review of institutional data on major infractions (e.g., assaults, incidents at height, drug	47 prisoners that had resided on the unit for a minimum of 48 hours during the course of the intervention. Seven-unit staff members, and an operational manager of the unit.	Prisoners felt that the intervention had important effects on their wellbeing and behaviour, as well as improving social relationships with peers. Staff responses indicated overall agreement with the importance of increasing meaningful engagement via association activities but were less enthusiastic about the peer-led nature of the activities on staff-prisoner relationships or prisoner behaviour.	This study provides preliminary evidence that trauma-informed care commitments can be incorporated into the design of behavioural interventions in prisons.	A lack of direct observation data for prisoner misconduct. The study was conducted during the COVID-19 pandemic which created unanticipated changes to the research protocol, and limited the exposure of the activities.

				possession) and self-harm and minor problem behaviour were extracted from prison record.				
4	Seitanidou, D., Melegkovits, E. A., Kenneally, L., Elliott, S., & Alves-Costa, F. (2024). UK	A forensic service, covering low or medium secure settings embedding trauma-informed care principles. Client information not stated.	To explore the perceptions and experiences of healthcare professionals (HCPs) adopting a TIC framework in SFS, examining associated barriers and facilitators.	Qualitative. Semi-structured interviews Thematic analysis	15 healthcare professionals, including Psychologists, Assistant Psychologists, Trainee Psychologists, Psychiatrists, Mental Health Nurses, Social Workers, Occupational therapists, Art therapists, Ward managers.	Themes: Understanding trauma Organisational and personal barriers Barriers to implementation Facilitators/Reflections Practical recommendations	The study identified a core role of organisational culture in working with trauma and adopting a trauma-informed perspective. The role of creating rapport and offering an individualised and culturally sensitive approach.	Nursing professionals were under-represented. The study took place close to the time to the COVID-19 pandemic, which likely impacted participants' perspectives, and training availability,
5	Taylor, J., & Akerman, G. (2022). UK	Integrated a Compassion Focused Therapeutic Community (CFTC). This represents a fusion of trauma-sensitive and	To explore how the residential treatment milieu can be organised in order to enhance the prospect of rehabilitation	Mixed Methods Quantitative data: EssenCES (Essen Climate Evaluation Schema;	Staff and Patients (men) of the medium secure therapeutic community.	Reduction in the number of seclusion episodes. Across the course of the evaluation period there was a steady reduction in the use of PRN medications.	The evidence suggests that there was a reduction in risk that became evident over time. There was a steady increase in the subjective experience of the social climate.	Due to the rolling nature of the intervention and the changing group composition, no formal statistical analysis was conducted.

		compassion-focussed practice within the guiding principles of a DTC. A medium secure ward in England, UK. Men	and reintegration. To evaluate the compassionate and trauma sensitive approach.	Schalast *et al*, 2008) Seclusion data Adverse Childhood Experiences Scale (Felitti et al., 1998) PRN medication use Qualitative feedback		EssenCES: There was a steady increase in patient perception across all three subscales (therapeutic hold, patients' cohesion and mutual support, experienced safety). Staff perceived an increase in cohesion and therapeutic hold. Staff perception of the safety of the ward remained relatively static 70% of patients that moved on had moved to less secure setting or been reintegrated into the community.	It is indicated that the use of the compassion focused therapy community model in secure settings can have a positive impact on the lives of those living and working there	The changes reported may have been due to a range of extraneous variables.
6	Mueller, S., Hart, M., & Carr, C. (2021). USA	Various rehabilitation programs in correctional facilities that incorporated trauma informed practices.	Aimed to explore current rehabilitation programs that adopt a trauma-informed approach in correctional facilities.	Qualitative – interviews The authors used the constant comparison method under grounded theory to analyse the interviews.	12 experts currently or formerly in roles of implementation of trauma-informed programs in correctional facilities.	Themes: recipient mind-set ancillary relations, program foundations, intentions resistance	The greatest common components to rehabilitation among the programs were utilising a strengths-based approach, and empowering individuals to have a voice.	This study did not differentiate between programs implemented to differing populations. Few of the programs had clear evaluation measures in place and effectiveness

								was often based on anecdotal evidence.
7	Hiett-Davies, V. (2022). UK	Nine NHS (England) forensic inpatient teams, including high, medium, low secure settings and prison in-reach. Services/service users included: women's services, male mental health admission/acute services, personality disorder services, and intellectual disability services. Developed and implemented a trauma strategy and a trauma-informed framework.	To evaluate the implementation of the trauma strategy and trauma-informed framework.	Mixed Methods Quantitative data: EssenCES (Essen Climate Evaluation Schema; Schalast *et al*, 2008). Attitudes Related toTrauma-Informed Care (ARTIC: Baker et al., 2016). Professional Quality of Life Scale (ProQOL: Stamm, 2009) Bespoke benchmarking tool (Covington, 2016). Trauma awareness training questionnaire	51 staff 47 service users	Post-intervention (18 months later) identified: Improvements on all questions on the benchmarking tool for staff, particularly the choice and collaboration questions. There was significant positive change on the ARTIC scale. For the ProQOL, average staff ratings of compassion satisfaction increased, while reported levels of burnout and secondary traumatic stress had reduced. Service user responses saw a slight deterioration in average scores, in particular on the trust, choice, and empowerment benchmarking survey scales. Focus groups highlighted increased	To implement trauma-informed care, commitment from organisational leads is required. The approach adopted allowed the forensic services to achieve genuine trauma-informed care. Positive changes in culture were noted.	The post-intervention measures were administered during a COVID-19 lockdown which may have impacted experiences of trauma-informed care, specifically choice and empowerment.

				Qualitative: Focus groups with employees from each team following the intervention.		compassion, team cohesion, psychological safety and better service user outcomes.		
8	Petrillo, M., & Bradley, A. (2022). UK	Various Trauma informed approaches. Community, National Probation Service, UK. Adults on probation, including males and females.	To explore the views and experiences of staff working with adult trauma in probation, reporting on types of trauma-informed approaches and explores the benefit and challenges with implementing trauma-informed practice.	Qualitative Interviews and Focus groups Constructivist Grounded theory	38 probation staff	Themes: Approaches to trauma-informed practice in probation The benefits of trauma-informed practice Supporting staff who work with trauma Barriers to trauma-informed practice in probation	Probation as an organisation, and the staff within it, are at different places and moving at different rates in the journey to become trauma-informed. To support the implementation of trauma-informed practice: Compulsory trauma-informed training for all staff Making clinical supervision available and accessible to all frontline staff Trauma-informed specialists in all probation delivery units, and at different levels	None stated.

2.3. Findings

Primary findings indicate that there are various facilitators and barriers to implementing trauma-informed care in forensic settings. The findings across settings, professional groups, and clients were combined within this review. The quantitative findings are outlined below. The findings in this section are separated into organisational culture, resistance, and perceived punishment vs rehabilitation. Table 2 outlines the contribution of the studies to the narrative synthesis.

Table 2 - Articles contributing to each area of narrative synthesis

	Organisational Culture			Resistance		Re-humanisation	
Study	Organisational Culture: Understanding	Organisational culture: Vicarious Trauma	Reflective spaces	Buy-in	Perceived punishment vs rehabilitation	Empowerment & choice	Social Connection
Dagenhardt, R, D., Sharif, S., Bacalso, E., & Topitzes, J. (2024).	✓			✓	✓		✓
Dion, R., Azur, M., Morzuch, M., & Laflair, L. (2019).	✓	✓		✓		✓	✓
Seel, C. J., May, R. J., & Austin, J. L. (2023).				✓		✓	✓
Seitanidou, D., Melegkovits, E. A., Kenneally, L., Elliott, S., & Alves-Costa, F. (2024).	✓	✓	✓	✓			✓
Taylor, J., & Akerman, G. (2022).	✓		✓			✓	✓
Mueller, S., Hart, M., & Carr, C. (2021).	✓		✓		✓	✓	✓
Hiett-Davies, V. (2022)	✓	✓	✓		✓	✓	
Petrillo, M., & Bradley, A. (2022)		✓	✓	✓	✓	✓	✓
Total studies:	6	4	5	5	4	5	7

2.3.1. Outline of Quantitative Findings

Three studies evaluated the implementation of trauma-informed approaches using mixed method approaches. The quantitative findings from these studies are outlined below, as well as incorporated into the narrative synthesis.

Seel et al (2023) implemented a trauma-informed approach using peer-led activities on a prison wing unit and conducted questionnaires with prisoners and staff on a unit. The facilitation and attendance of the peer-led activities were recorded. It was found that the most activity with the most filled spaces was the cooking group with 81.0% of spaces filled. This was followed by bingo with 68.1% of spaces filled. The music, chess, and guitar tutoring sessions filled around half of their available spaces. The questionnaires found that 81.40% of prisoners stated that they were interested in participating in structured activities during association time, as well as 39.5% stating that they would be willing to lead activity groups for their peers. The prisoner responses indicated strong support for more structured activities on the unit. Both prisoner and staff that completed the questionnaires identified that offering activities during association times were important (90.6% and 85.7%, respectively) and should be continued (89.4% and 71.4%, respectively). Differences in perceptions of the peer-led activities between prisoners and staff respondents were found. This included 76.5% of prisoners liking that activities were peer-led, whilst 26.8% of staff liked this approach. The staff indicated that the activities would be better if they were run by staff (85.7% agreed or strongly agreed), whereas 9.4% of prisoners agreed. Improved relationships with officers through the activities were perceived by 60% of prisoners, whilst 42.9% of staff agreeing and 28.6% disagreeing. Additionally, a within-participant design was implemented to compare the frequency of infractions, self-harm and positive behaviour when the activities were available with when they were not. This analysis suggested a lack of treatment effect, however given the low frequencies of each variable across conditions this was to be expected.

Within Taylor & Akerman's (2022) study quantitative data was collected, and analysed, prior and following the implementation of the trauma-informed approach. They found that there was a steady decline in the number of episodes and the duration of seclusion over the course of the evaluation period. Similarly, there was a steady reduction in the

use of PRN medication across the evaluation period. They collected EssenCES (Essen Climate Evaluation Schema; Schalast et al., 2008) with staff and patients of the medium secure unit. This has subscales of 'therapeutic hold'. 'patients' cohesion and mutual support', and 'experienced safety'. For patients, there was a steady increase across the three subscales. Among the staff team, an increase in patient cohesion and mutual support, and therapeutic hold was found. The staff perception of safety of the ward remained relatively static across the evaluation period. In addition, 70% of patients that had moved from the unit had moved to a less secure setting or the community.

Quantitative findings were also outlined by Hiett-Davies (2022). A bespoke benchmarking tool that asked questions relevant to the five pillars of trauma-informed care was implemented among staff and service users pre- and post-intervention. For the staff team, there was an improvement in across all of the pillars of trauma-informed care, particularly for choice and collaboration. However, for the service users there was a slight deterioration in average scores, particularly for trust, choice, and empowerment. It is recognised that the post-intervention scores were collected during a covid-19 lockdown which likely significantly impacted upon the service users' perception of these areas. Among the staff team, there were significantly significant improvements on the ARTIC scale (Attitudes Related to Trauma-Informed Care; Baker et al., 2016). Improvements were also found on staff ratings of compassion satisfaction, and reductions in reported levels of burnout and secondary traumatic stress as measured by the ProQOL (Professional Quality of Life Scale; Stamm, 2009).

2.3.2. Organisational Culture

Across all the included articles, the culture of the organisation adopting the trauma-informed approach was highlighted. There were strengths, and challenges within this.

It was identified across included studies, that the implementation of trauma-informed care had a positive impact on the culture of the service, as well as then creating further benefits for individuals involved with the service. A perceived increase in the social climate and a decrease in seclusion episodes were identified, which was considered to indicate a more positive and less threat-focused culture (Taylor & Akerman, 2022). A

positive culture was experienced with it being explained that it is felt that all members of the organisation are "in it together", that they operate like a family, and that the leadership is egalitarian which creates a sense of collaboration (Dagenhardt et al., 2024). This was also reflected in a further study, with it being discussed that leadership support to being trauma-informed was viewed as essential (Dion et al., 2019). Additionally, it is considered by participants with a higher level of seniority that change to becoming trauma-informed should be led from a senior level and this would allow for a culture of opportunities for trauma-informed care (Seitanidou et al., 2024).

It was recognised that when the organisational culture was not conducive to trauma-informed approaches this caused significant challenges. It appeared that the adoption of trauma-informed approaches felt limited by the culture of the secure forensic service, including the impact of the dominant medical model (Seitanidou et al., 2024). There were also practical challenges. High workloads and caseloads were recognised to be obstacles to trauma-informed care within probation as it limits the learning culture (Petrillo & Bradley, 2022). Also, participants ability to access the trauma-informed service was limited by regime changes and the perception that they needed to prioritise work, vocational training, and tasks needing to be completed within association time (Seel et al., 2023).

2.3.2.1. Understanding

Understanding the impact of trauma among service users and staff is vital to effective trauma-informed approaches and was raised across studies. This was present within six of the included studies. Following implementation of trauma-informed practices, healthcare staff showed increases in their attitudes towards trauma informed care, and the staff reflected upon this knowledge allowing for positive changes to clinical practice (Hiett-Davies, 2022). It was experienced by patients that staff were more understanding of them at the evaluation period, as well as staff experiencing a greater level of understanding of the patients' lives (Taylor & Akerman, 2022). Such understanding highlighted the importance of formulations as a foundation for trauma-sensitive practice (Taylor & Akerman, 2022). Staff working in probation identified that they used the principles of trauma-informed care to improve their understanding of trauma in their

clients' lives, as well as this resulting in less frustration about what is usually perceived as 'challenging' interpersonal behaviours (Petrillo & Bradley, 2022). Adopting a culturally responsive understanding of trauma and presentations was deemed necessary (Seitanidou et al., 2024; Mueller et al., 2023).

Issues in understanding trauma was raised due to the cultural variability and subjectivity of the definition of trauma, as well as understanding of trauma varying across different professions due to their unique trainings (Seitanidou et al., 2024). The development of an agency-wide policy that defines trauma, gender differences, and trauma-informed practices was developed to support staff members in being able to recognise and respond to trauma (Dion et al., 2019).

An essential first stage in promoting understanding of trauma for the staff members was trauma-informed care training. Trauma-informed experts outlined that staff should be taught about trauma to promote understanding on the impact of trauma, and how to understand how practices in corrections can trigger and escalate behaviour (Mueller et al., 2023). It is suggested that for long-term organisational change, staff require ongoing training to process and apply the information (Dion et al., 2019). It was deemed that training on trauma was positive in preparation for working with clients, with staff particularly appreciating using the training to prepare for their role (Dagenhardt et al., 2024). Further training was considered to be required to encourage greater recognition and management of trauma (Seitanidou et al., 2024). Additionally, a need for keeping trauma at the forefront within the culture of the organisation was recognised. It is considered that for an organisation to be trauma-informed, the continual focus of the impact of trauma and being responsive to this was deemed crucial (Seitanidou et al., 2024; Dion et al., 2019). There was a desire within secure forensic services for trauma-informed approaches to be integrated with the medical and legal practices (Seitanidou et al., 2024). A fatherhood program implemented a trauma champion to keep the focus on trauma-informed approaches (Dion et al., 2019).

2.3.2.2. Vicarious trauma

The recognition of the impact of trauma on staff was promoted and highlighted as a crucial element of an organisational culture that supports trauma-informed care in four studies. The potential for vicarious trauma among staff members was noted, with the relationship of this with their own experiences, clients' presentations and the ward environment being acknowledged (Seitanidou et al., 2024). Programs recognised that an organisational commitment to ensuring that staff are protected from trauma in their work were required, with policies being in place to support staff wellbeing (Dion et al., 2019). However, it was also experienced that working in a trauma-informed way could require additional emotional labour, but the organisation was a long way from achieving tailored support plans for the staff team in managing vicarious trauma and compassion fatigue (Petrillo & Bradley, 2022).

The implementation of trauma-informed care did appear to have some positive results for staff wellbeing and experiences. This is evidenced by the reported increases in staff ratings of compassion satisfaction, and reduced levels of burnout and secondary traumatic stress (Hiett-Davies, 2022). Staff teams felt that self-improvement, self-care, and healing trauma was emphasised for them (Dagenhardt et al., 2024). Training that provided staff with personal learning and growth related to their own work was deemed beneficial (Dion et al., 2019). This reflects that through implementation of trauma-informed care, the organisations and staff teams were able to recognise the impact of the work on themselves, and they desired opportunities that can be viewed as reducing the likelihood of vicarious trauma.

2.3.2.3. Reflective spaces

The relationship between trauma-informed care, understanding of service users, and organisational culture with reflective practice and spaces was discussed in five of the included articles. It was deemed that self-reflection is necessary in order to be able to support clients in a trauma-informed manner, as it allows for exploring biases and improvement of practice through supervision (Seitanidou et al., 2024) Supervision was also recognised as being required for promoting trauma-informed care and supporting staff wellbeing (Petrillo & Bradley, 2022).

Following incidents, reflective meetings with staff and residents took place and it appeared that this allowed for a space to process threat, likely creating greater understanding among staff and residents (Taylor & Akerman, 2020). An increase in curiosity and desire to understand drivers behind behaviour was identified, allowing for discussions of different approaches to care without a fear of criticism (Hiett-Davies, 2022). However, it was also recognised that reflective practice can be experienced as emotionally challenging (Seitanidou et al., 2024).

There appeared to be difficulties with self-reflection and showing emotions within various teams, and among service users. This was underpinned by a culture of machismo, and the perspective that there is no time for feelings when working in secure forensic services (Seitanidou et al., 2024). Whereas among probation staff it was discussed that the organisation did not have a culture in which supervision and reflection was encouraged (Petrillo & Bradley, 2022). This was outlined to be due to high workloads, being over-stretched, and engaging with support services attracting criticism. Similarly, it is recognised that there is a culture of not discussing emotions among clients. Program staff noticed among the men, that had previously been in prison, there was a perception that sharing information would make them vulnerable and appear weak (Mueller et al., 2023). To overcome this, staff attempted to normalise emotions, as well as adopting culturally sensitive approaches (Mueller et al., 2023). Additional attempts made to normalise emotions occurred through open discussions about emotions, with it being considered that the ability to have more skilful and creative responses to emotions may have been linked with reduced use of PRN and seclusion (Taylor & Akerman, 2022). It was recognised among staff that prioritising clinical supervision would allow for a culture to be developed in which staff wellbeing is not optional (Petrillo & Bradley, 2022).

2.3.3. Resistance

Trauma-informed care is a relatively new approach being adopted into forensic services, which may challenge usual ways of working. This can create resistance among various professionals and organisations, which will likely impact on its application and longevity.

2.3.3.1. Buy-in

Hesitancy among the staff teams to implement trauma-informed practice were evident within five of the included studies. It is considered that there was a lack of 'buy-in' for a variety of reasons. There was a perception that the introduction of trauma-informed initiatives increased staffs' workload, despite them not having to run the activities, which may have reflected their dissatisfaction with them (Seel & et al., 2023). Additionally, the staff members in this team responded that they would support the activities if another staff member was provided, and 87% of staff respondents discussed they felt the activities would be better if staff run the activities rather than them being peer-led (Seel et al., 2023). This indicated that the introduction of peer-led activities was perceived as extra work for staff to manage, however they appeared resistant to peer-led activities and wanted to have control of these. Again, the demands of staff members' day to day tasks, as well as understaffing, were seen as a barrier to the implementation of trauma-informed care among frontline staff members in secure hospital settings (Seitanidou et al., 2024). Having the buy-in of senior management for trauma-informed practice was identified as crucial for making shifts in organisational culture (Petrillo & Bradley, 2022). It was perceived that currently trauma-informed practice is not enough of a priority currently to drive its development (Petrillo & Bradley, 2022).

To support buy-in among staff members, two programs implemented a designated staff member to oversee trauma-informed initiatives, as well as a further program inviting experts to discuss trauma-related topics and held spaces for team discussions on applying trauma-informed concepts (Dion et al., 2019). This promoted continual learning and skill building. In recognition of this, it should be considered that a lack of buy-in from staff members may also be related to a feeling of being unskilled and not confident in the application of trauma-informed practice. To overcome this, it was suggested that it may be beneficial for frontline staff to be supported by psychological professionals to integrate trauma informed skills (Seitanidou et al., 2024). It was noted that to increase staff buy-in for trauma-informed programs that frontline staff should be involved in the design of the intervention (Seel et al., 2023; Seitanidou et al., 2024).

Partner agencies being supportive of trauma-informed approaches was recognised as crucial, and with challenges. The efforts of probation to be trauma-informed was undermined if partner agencies do not also adopt this approach (Petrillo & Bradley, 2022). This was reflected in the challenges raised by staff members in the Department of Corrections (DOC) resistance to the program, with staff feeling that the DOC were restricting access to clients (Dagenhardt et al., 2024). It was particularly felt among peer guides that the DOC was unwilling to support them due to their criminal history (Dagenhardt et al., 2024). A further program attempted to increase their working relationship and collaboration with their state DOC through training prison staff in trauma-informed principles (Dion et al., 2019). Wider resistance is recognised by Mueller et al., (2023) in community opposition to incarcerated individuals' reintegration into society, as well as politics acting as a systemic barrier to implementation and funding. They argue that addressing resistance on an institutional level is required for an effective program approach (Mueller et al., 2023).

2.3.3.2. Perceived punishment vs rehabilitation

With a shift towards trauma-informed practices, this seemed to challenge the perceived dominant punitive approach with a movement towards a trauma-informed rehabilitative approach. This was referenced within four of the included studies. This was particularly prevalent for probation staff. They discussed that some tasks associated with risk assessment felt at odds with the principles of trauma-informed practice, raising that they are required to do enforcement, risk management and rehabilitation at the same time (Petrillo & Bradley, 2022). At times it was felt that these aspects could pull in opposite directions but there were also times when they could work well together, such as trauma-informed practice allowing for a more nuanced understanding of risk (Petrillo & Bradley, 2022). The benefit of incorporating a trauma lens into risk assessment, rather than focusing on risk alone, was considered to have a positive impact on restrictive practices (Hiett-Davies, 2022).

Participants held the perspective the DOC was resistant to the trauma-informed care program because the DOC experienced the program as threating to reduce the need for traditional corrections (Dagendhardt et al., 2024). Similarly, it was perceived by staff of

trauma-informed programmes that the wider organisation had a stance of incarceration being for punishment and that the clients are 'bad people that need to be punished', and this was experienced as creating a contradiction with the aims of the program (Mueller et al., 2023). This accentuated the perspective that having staff and administration on board for rehabilitative efforts is essential (Mueller et al., 2023). As noted in 'organisational culture', having the support of the organisation in the program is vital, particularly when facing contradictions in the manner of working within forensic services. Having a clear goal and focus on changing corrections and re-entry from 'punishment and restriction' toward transforming lives (Dagendhardt et al., 2024) may have provided the team members with a motivation to strive for their goals, whilst anticipating challenges of a percieved focus on punishment and restriction.

2.3.4. Re-humanisation

This area focused on the importance that staff placed on embedding practices that allow for 're-humanisation' of the clients that they work with. This incorporated two key aspects of empowerment and choice, and social connection.

2.3.4.1. Empowerment and Choice

The importance of empowerment and choice was reflected upon within five articles. Re-humanisation was identified as restoring autonomy, with choice and dignity being encouraged for the service users (Mueller et al., 2023). This autonomy, along with empowerment and choice, was fostered through the delivery of peer-led activities (Seel et al., 2023). In this study, the individuals in prison were asked what activities they wanted to facilitate, along with the opportunity to facilitate the activities, with 76.5% liking that the activities were peer-led. Feedback from the operational manager noted that the activities had created a sense of 'normality' to the prisoners. Through being able to facilitate the activities, it is likely that the service users experienced the power being shared. Further practices to support power-sharing included collaboration with clients for service planning, a non-judgemental approach, and a reminder that involvement in the program is voluntary (Dion et al., 2019). It was recognised that incorporating trauma-informed approaches enhanced traditional human-centred values of probation work, which was welcomed (Petrillo & Bradley, 2022). Across services amended pathways of

care were adopted to include interventions and approaches that promoted a focus on safety, engagement and feeling contained (Hiett-Davies, 2022). The amended pathway included flexible timetables that allowed patients to have choice in activities, with activities being tailored to the patients' needs, capacity, and ability to engage with others. It appears that increased empowerment and choice was present for patients and staff within Taylor & Akerman's (2022) research. The reduction in sedative medication and seclusion may reflect increased confidence among the staff and patients to manage emotional distress.

Implementation of trauma-informed approaches appeared to have a positive impact on staff in which they felt empowered through these approaches and theories to have more autonomy, empowerment and choice in the way that they approached their work. Among probation practitioners, there was a recognition that due to trauma-informed practice, an alternative framework was provided for responding to complexity and they felt safe moving towards 'helping' people (Petrillo & Bradley, 2022). Additionally, healthcare staff reported feeling empowerment, having a purpose, being motivated to change and a willingness to share and receive good practice ideas following trauma-informed training (Hiett-Davies, 2022).

2.3.4.2. Social Connection

The relationships between service users, staff, and the wider community were discussed in seven of the included studies. It was deemed that psychological safety, which would be achieved through social connections, is fundamental for personal growth (Dion et al., 2019). To achieve this, creating rapport and offering an individualised and culturally sensitive approach to explore the experience of trauma were adopted (Seitanidou et al., 2024). Focus was placed on creating relationships that promoted safety, trust and collaboration (Petrillo & Bradley, 2022).

Emotionally safe environments have been achieved through group settings in which there are opportunities for support from peers (Dion et al., 2019). Peer-guides provided a greater level of connection due to them being able to relate to the challenges that clients have faced (Dagenhardt et al., 2024). Peer-led interactions through activities allowed for

“a better community within the prison” with many individuals residing on the prison unit identifying that they had made the unit feel more positive, as well as positively impacting their mental health (Seel et al., 2023). The activities that were social in nature were better attended than those more skill-building (Seel et al., 2023). Through the implementation of a trauma-informed approach, it was observed by staff that the patient group were more cohesive and supportive of each other (Taylor & Akerman, 2022). Therefore, it is emphasised that the service users valued being able to build social connections with other service users, as well as accessing support through these interactions. Programs that foster connections, including having a support network of organisations, to support the individual are of benefit (Mueller et al., 2023). It was acknowledged that practitioners are not working in isolation, and expertise and partner agencies to enhance support for clients are of great importance (Petrillo & Bradley, 2022),

2.4. Discussion

2.4.1. Interpretation of findings

This is a systematic review and narrative synthesis of the literature of active implementation of trauma-informed care within forensic services that included male service users. A previous review found that there are high amounts of psychiatric comorbidity among prisoners with PTSD, with links to aggressive behaviour and this supports the need for trauma-informed approaches in prison (Facer-Irwin et al., 2019). Similar findings were found among a high secure male forensic inpatient population, with all patients having been exposed to a traumatic event in their lifespan, with recommendations of adopting a trauma-informed approach in forensic settings (McKenna et al., 2019). Additionally, it is highlighted that it is important to recognise trauma among forensic staff teams and implement strategies to reduce and buffer the impact of stress on their wellbeing (Ireland et al., 2022).

Following searches, eight studies were identified that met the inclusion criteria. The trauma-informed approach varied across the articles. They also included a variety of forensic services including secure hospital, prison, and the community. Psychometric measures were limited within the articles, with the majority of the studies being qualitative. There was significant overlap across the studies. The narrative synthesis of

the literature identified three key areas of organisational culture, resistance, and re-humanisation. Within these, barriers and facilitators to the implementation of trauma-informed care in the forensic settings were highlighted.

This review identified that organisational culture is of significant importance to the successful implementation of trauma-informed approaches. Having leadership support to being trauma-informed care was viewed as central to its success (Dagenhardt et al., 2024; Dion et al., 2019; Seitanidou et al., 2024). This is consistent with previous findings that successful implementation of trauma-informed care requires senior-leaders who are committed to the goal, and driving the agenda, as well as prioritising trauma-informed care activities (Muskett et al., 2013). The elements of the organisational culture that were of importance to the participants of the studies within the review were being able to develop understanding of clients' behaviour through a trauma-perspective (Seitanidou et al., 2024; Mueller et al., 2023; Taylor & Akerman, 2022; Dion et al., 2019; Dagenhardt et al., 2019). It is suggested that trauma-informed care in forensic services allows for viewing and responding to criminal behaviour through a trauma lens (Levenson & Willis, 2018). Additionally, the participants within the reviews appreciated that there was a recognition that the work they conduct has an emotional impact on themselves and their colleagues, and the service being responsive to this. Dagenhardt et al., (2024) discussed an appreciation that self-care and healing trauma was promoted for the staff team. Similarly, a focus on being able to develop curiosity through reflective spaces was crucial (Hiett-Davies, 2022). Challenges with this were noted in that reflective practice can be emotionally challenging and there is a culture of hesitancy to share emotions in forensic services (Seitanidou et al., 2024). As well as a culture in which engaging with support services is not promoted and is limited due to under-staffing (Petrillo & Bradley, 2022). It is recognised that for many professions, engaging in reflective practice can be a new and daunting task, which might result in emotional reactions, but can allow for ongoing staff support to be provided (Davies & Jones, 2024).

Previous research into a new rehabilitative approach within a prison, found that organisational culture is deeply embedded within the prison narrative, and this can be difficult to change (Prescott, 2021). Further barriers with implementing trauma-informed

care have been identified as organisational cultures that can actively conflict with trauma-informed approaches, such as using 'power-over' approaches (Sweeney & Taggart, 2018). This is reflected in the current review, in which many staff and programs identified their difficulties in working with wider forensic systems and organisations. This included staff within both a prison and secure hospital settings being concerned about the additional work demands that accompanied trauma-informed care (Seel et al., 2023; Seitanidouet al., 2024). As well as it being felt that the department of correction was resistant to the trauma-informed program (Dagendhardt et al., 2024). Staff perceived that the programs' trauma-informed approach did not align with other organisations focus on punishment (Mueller et al., 2023). It is considered that prisons have a philosophy and culture that is retraumatising and increases hostility and violence (Bloom & Bradshaw, 2022). Prison officers are exposed to challenging and often dangerous situations (Binley, 2023). Therefore, it is unsurprising that individuals working in forensic services who are exposed to violence and traumatic experience, may be hesitant to new initiatives that they do not view as fitting with their current way of keeping themselves safe. These staff members have important security concerns that take priority over a focus on trauma, which results in organisational culture change being slow (Miller & Najavitis, 2012). Also, for staff working in forensic inpatient wards, there is a dual emphasis on care and control of risk of violence posed by patients (Marshall & Adams, 2018). However, trauma-informed care and staff training in forensic services are beneficial to creating an environment conductive to staff and institutional safety, as well as rehabilitation (Miller & Najavitis, 2012). A crucial challenge in implementing psychological approaches to rehabilitation involves identifying instances in which the approaches are complementary and when they are contradictory, identifying how to reconcile these differences (Morse et al., 2023). An attempt to reconcile this difference through a more collaborative approach was made through training prison officers in trauma-informed principles (Dion et al., 2019). It appeared that training in trauma-informed care could have positive impacts as probation staff that used trauma-informed approaches spoke of it assisting with their understanding of risk (Petrillo & Bradley, 2022). It was highlighted that working to overcome the challenges and resistances at institutional level is required for effective program implementation (Mueller et al., 2023).

Across the included studies, value was placed on being able to implement a sense of re-humanisation with their service users. Essential aspects of this were identified as promoting autonomy, peer-support, and collaboration (Mueller et al., 2023; Seel et al., 2023; Petrillo & Bradley, 2022). These aspects also enhanced social connection, which was identified as crucial within the trauma-informed programs and services. Taylor & Akerman (2022) described how through the trauma-informed approach, there was a greater sense of cohesion among the patients. The relationships among the patients, staff groups, and wider community were central within this. Among individuals with forensic histories, there is significant importance of therapeutic relationships due to the likely absence of relationships in the community for the client group (Nijdam-Jones et al., 2015). The significance of interpersonal relationships is indicated in the trauma-orientated framework for offenders (Gueta et al., 2022).

2.4.2 Strengths and Limitations of the review

The systematic review identified eight articles that met the inclusion criteria. This indicates that there are few studies that have explored and evaluated trauma-informed forensic settings that include male service users. The included articles for this review were published between 2019-2024. This represents that the implementation of trauma-informed care in forensic services including males is a new approach that is gathering momentum. Articles were identified that explored the views on the potential introduction of trauma-informed care among forensic staff members (Crole-Rees et al., 2023; Owen et al., 2021). This further highlights that adopting trauma-informed care for these services is in its infancy. The implementation of trauma-informed care and research into it, has been limited due to COVID-19 restrictions. The COVID-19 pandemic had a substantial impact on forensic mental health service provision and implementation, as well as impacting the implementation of therapeutic and social activities, and service outcomes (Puzzo et al., 2022). This is referenced in Seitendiou et al's (2024) research, which discusses that their study occurred close to the time of the COVID-19 pandemic, and this may have impacted on the perceptions around organisational responses, training availability, and wellbeing. Additionally, Seel et al's (2023) research was impacted by unanticipated changes to the prison regime as a result in changes of COVID-19 restrictions. Furthermore, it is important to acknowledge that the stressors in prisons

were amplified during the pandemic (Memon et al., 2019). Therefore, the research conducted during or shortly after the COVID-19 pandemic should be interpretated with caution.

Among the included articles, half of them examined trauma-informed care specifically for male service users. The rest did include males but also included perspectives of people working with females. Trauma-informed care argues for a gender-responsive approach. Therefore, the specific needs of men should be considered in the application of trauma-informed care. This is of significant importance in forensic settings as males account for a substantial amount of the service users. Within the UK prison estate, 95% of the prisons are for males (Ministry of Justice and Official Statistics, 2024). Among the research available on the application of trauma-informed care in forensic services, the majority has considered this for female or young people. This is demonstrated in McAnallen & McGinnis' (2021) systematic review of trauma-informed practice and the criminal justice as all included articles were focused on services for women and young people. This is of interest given that research has demonstrated that trauma is prevalent among men within prison settings (Facer-Irwin et al., 2019). It could be interpreted that there is a greater societal acceptance of considering the role of trauma, and responding to this, among females and young people. It is evident that further research that solely focuses on trauma-informed care for male forensic service users is required. The needs of men in forensic services, and their trauma histories, should not be overlooked. It is positive that research is beginning to develop in this area, as reflected in this systematic review.

There were limited empirical studies utilising quantitative approaches to identify the effectiveness of trauma-informed care. It is likely that this is due to the adoption of trauma-informed care in such settings is in its early stages, as mentioned above. The development of empirical quantitative evidence of the effects of trauma-informed care is required.

All articles included in this review were conducted in the USA or the UK. Sweeney et al., (2016) has outlined that trauma-informed approaches originated in the USA and that

these approaches have begun to reach the UK. This may be reflective of the cultural understanding and acceptance of trauma within Western societies. There is recognition that understanding of culture is crucial, with the meaning being given to trauma varying across cultures, as well as healing taking place within an individual's cultural context (Ardino, 2014). Therefore, the understanding of trauma-informed care developed from this review is limited to the USA and UK and cannot necessarily be generalised beyond these countries.

The included articles provided a valuable insight into how the current adoption of trauma-informed care is being received and experienced by staff, and some service users in forensic services. Such understanding of the barriers and facilitators to its application is beneficial is being able to inform further application of similar trauma-informed approaches in the setting of forensic settings for males.

2.5. Conclusion and implications for clinical practice

In conclusion, this systematic narrative review highlighted the limited exploratory evidence for trauma-informed care in forensic services that includes male service users. Prioritisation of organisational culture is crucial for the effective implementation of trauma-informed care. Having opportunities and training to develop understanding of the impact and presentations of trauma was highly valued. A focus on the impact of trauma exposure for the staff teams, as well as opportunities for reflection and staff support is vital.

It is recognised that working in forensic services includes working with agencies, institutions, and within a political landscape. The experience of resistance was prevalent and caused difficulties for the adoption and potential effectiveness of trauma-informed care approaches. Such resistance is considered to be related to the organisational cultures of forensic services, high amounts of understaffing and lack of resources, and a perceived conflict between the dominant punishment model and rehabilitation. Through the narratives, it was evident that achieving 'buy-in' from a range of professionals, and overcoming institutional resistance is required to integrate trauma-informed practice within forensic services. It is considered that sharing knowledge and understanding of

the benefits of trauma-informed care for staff and service users, and the recognition of the coherence of trauma-informed approaches with risk management would be of benefit. It is also essential to acknowledge the reasons for resistance to the implementation of trauma-informed care in forensic services, including systemic aspects such as understaffing, and explore ways to overcome this. Finally, there was indication that providing services that promoted social connection for forensic service users was of benefit. This should be promoted in further implementation of trauma-informed care in forensic services for male clients.

Chapter Three: A Case Study of a Male Residing on a Prison PIPE and Engaging with Compassion-Focused Therapy

Ethical Considerations

This case study is a factual account of a treatment assessment and intervention for a client detained within a high secure HMPS establishment. Although this treatment has been written up in the form of a case study for the purposes of the requirements of the Doctorate in Forensic Psychology, it was implemented as part of the client's recommended treatment pathway. The work was supervised by a Forensic Psychologist and informed consent was obtained from the client to write it up as a case study. Both verbal and written consent was obtained from the client for their engagement to be written as a case study (Appendix A).

Note to the Reader

All aspects of the case study were completed by the author including assessment, formulation, and intervention. Therefore, this case study is based upon primary information which has been gathered from sessions with the client, clinical notes written by the author, reports written by the author and discussions between the author and their supervisor.

The work conducted with this client started during the author's third placement. For the purposes of confidentiality, the client has been given a pseudonym and will be referred to as Matthew throughout the case study.

Abstract

Trauma and personality difficulties are prevalent in forensic populations. In recognition of this, the Offender Personality Disorder (OPD) pathway was developed to provide a service that is responsive to the needs of this client group. The OPD pathway is a set of psychologically informed services, including Psychologically Informed Planned Environments (PIPEs) and treatment services. The OPD service aims to reduce reoffending and improve the wellbeing of service users (Skett & Lewis, 2019). To assist with these aims, a respectful therapeutic environment is embedded, as well as psychologically informed practice and individualised formulations (Skett et al., 2017).

A case study is presented of Matthew's treatment within OPD services. Matthew was detained within a high secure category B prison for the charge of grievous bodily harm with intent. It was identified that he presented with difficulties with shame, self-criticism, and emotion regulation. He also presented with behaviour of violence towards himself and others.

Compassion Focused Therapy (CFT) has been found to be effective in treating shame and self-criticism (Boersma et al., 2014). As well as a crucial aim being increasing emotion regulation capability (Irons, 2022). This treatment method has been applied to forensic client groups, with a focus on developing understanding of functioning as not their fault, with the notion that it is their responsibility to not act in a harmful manner towards themselves or others (da Silva & Rijo, 2022).

The intervention incorporated twenty-three individual CFT informed sessions, as well as residing on the PIPE wing. Towards the end of the intervention, Matthew was suspended from the PIPE wing due to violence towards others.

3.1. Introduction

3.1.1. Client

Matthew was a 29-year-old white British male on an extended determinate sentence for Grievous Bodily Harm (GBH) with intent who was detained within a category B high secure prison. The offence occurred in public alongside a peer as a co-defendant with the victim being a stranger to him. At the time of the offence, Matthew had been consuming alcohol and taking illicit substances of synthetic cannabinoids (spice).

Matthew reported a chaotic childhood. In his early years he witnessed domestic abuse from his father towards his mother. At aged six, Matthew and his siblings were placed under the care of social services by his father. During this time, Matthew's sister experienced abuse from their carer. After a short period, Matthew and his siblings returned to the care of their mother. In secondary school, Matthew struggled to concentrate and reported that rather than ask for help he began smoking cannabis instead of attending school. Following this when Matthew was entering his adolescence, his mother's alcohol intake increased significantly, and she also began using a range of illicit substances. At the age of fifteen Matthew experienced bullying at school and was taken out of school by his mother. Therefore, he left school with no qualifications. When Matthew was sixteen, he was detained in a secure children's unit due to violence against his mother's partner. Upon release, Matthew remained living with his mother and began drinking frequently.

Matthew has many previous convictions, including offences relating to violence, as well as robberies. Whilst in custody, Matthew presented with challenging behaviours. There were common occurrences of self-harm. This included cutting himself to the arm and neck, as well as tying ligatures. Additionally, substance use continued within the prison.

3.1.2. Referral Process

Matthew self-referred to the Offender Personality Disorder (OPD) service of the Psychologically Informed Planned Environment (PIPE) wing. In his referral he stated that he would like to be considered for the PIPE wing as he felt it would help with his progression.

The referral was reviewed by the team who conducted an OPD screening. The OPD screening tool consists of 10 items, with individuals scoring on seven or more items indicating the presence of problematic personality traits that are associated with serious offending behaviour (HMPPS & NHS England, 2020). Matthew was deemed to meet the initial criteria for the PIPE service, so he was placed on a waiting list for an assessment.

3.1.3. Critical Analysis of the literature

3.1.3.1. *Trauma and Personality Difficulties*

Trauma has been defined as incidences in which an individual's psychological and social integrity is threatened (SAMSHA, 2014). It is recognised that trauma has adverse effects on the person's functioning, as well as mental, social and emotional wellbeing (Iyengar et al., 2019). There is evidence that repeated exposure to adverse experiences can cause damage to the developing brain, and significantly increase the risk of mental health difficulties and risky behaviours (O'Neill et al., 2021). Early adverse experiences also contributes to social, emotional, and cognitive impairment (Felitti et al., 1998). The impact of trauma requires attention given the long-standing and pervasive difficulties that it can cause individuals and societies. This is of particular significance in forensic services, given the high prevalence of trauma histories among forensic populations (Maschi et al., 2011; Stinson et al., 2021).

It is outlined that childhood trauma is evident in the development of personality disorder, along with the interaction of temperamental, environmental and genetic factors (Bozzatello et al., 2021; Jiang & Zhang, 2023). Emotional dysfunction has been identified as a crucial element associated with personality disorder, and essential to treatment (Frederiksen et al., 2021). Emotional dysregulation, as well as interpersonal difficulties, affective instability, and identity disturbances are particularly prevalent in individuals that demonstrate difficulties associated with borderline personality disorder (BPD) (Reichl & Kaess, 2021). BPD is characterised by a vulnerability to easily activated, intense, and persistent emotional distress (Chapman et al., 2017). Due to this, individuals with BPD may adopt avoidant approaches to emotion regulation (Rosenthal

et al., 2005). This difficulty with regulating emotions may limit an individual's ability to behave effectively and pursue goals (Chapman, 2019).

There is recognition that personality disorders have had a pejorative connotation as they were viewed as being 'behavioural' (Crowe, 2008). This limited the treatment and care that individuals with personality difficulties received. Previously borderline personality difficulties were regarded as untreatable however progress in understanding and management has resulted in better outcomes (Bohus, 2021). The policy document 'Personality Disorder: no longer a diagnosis of exclusion' begun this paradigm shift through outlining the need for individuals with personality difficulties to be able to access appropriate care and management (NIMHE, 2003).

In an approach to legitimise the experiences of individuals with personality difficulties, it is essential to gain an understanding of the person's presenting needs and contributing factors. This has incorporated through adopting a biopsychosocial model for understanding personality difficulties, considering biological vulnerabilities, early experiences, and the role of social factors (HMPPS & NHS England, 2020). This reflects the acknowledgement that among individuals with personality difficulties, there is an extensive history of trauma and attachment difficulties. To incorporate this into practice, it has been raised that it is important and beneficial to formulate the individual's challenging behaviours as a response to perceived threat and survival strategies (Willmot & Evershed, 2018). The Power Threat Meaning Framework (PTMF) provides a non-diagnostic approach to contextualising an individual's difficulties in relation to the power that has operated in their life, the meaning they have made of these experiences, the threat responses they have used, and access to power resources (Johnstone & Boyle, 2018).

3.1.3.2. Personality Difficulties and Offending

The high prevalence of individuals with personality difficulties in the criminal justice system prompted the development of responsive services for these individuals with complex needs and high levels of risk of offending. The Offender Personality Disorder (OPD) pathway was developed for those in the criminal justice system who presented

with personality difficulties, high or very high risk of harm to others, and a justifiable link between the emotional and behavioural problems and risk. The key aims of the OPD pathway are to reduce repeat offending, develop a competent workforce, and to improve the wellbeing of service users (Skett & Lewis, 2019). To assist with these aims, a respectful therapeutic environment is embedded, as well as psychologically informed practice and individualised formulations (Skett et al., 2017). This reflects the trauma-informed approach that is adopted. There is a focus on the role of attachment and trauma and how the current therapeutic relationships can be enabling and helpful (Bali et al., 2023).

Psychologically Informed Planned Environments (PIPEs) are a prominent service in the OPD pathway. These are residential services that are a whole environment, both within prisons and approved premises (Rawlings & Haigh, 2017). The core components of PIPEs are workforce development, supervision, socially creative sessions, structured sessions, psychosocial environment (Castledine, 2015). This allows for the intra and interpersonal relational process, and group processes to be understood within the model (Brown, 2014). The importance of relationships and interactions are central to PIPEs, with a focus being on the environment, creating a community, and allowing residents to build confidence in building and maintaining relationships (Preston, 2015). This is the goal of PIPEs rather than to deliver specific psychological interventions. An evaluation of PIPEs showed evidence of improvement in social and relational functioning among the residents (Kuester et al., 2022). OPD treatment services that are more intensive in nature and allow for complex mental health and risk needs to be explored, are also offered alongside certain PIPEs (Skett & Lewis, 2019).

3.1.3.3. Psychological Treatment – Compassion Focused Therapy

A therapeutic model that has been applied to individuals with personality difficulties is Compassion Focused Therapy (CFT). CFT adopts an evolutionary focus, incorporating recognition of the role of our basic motivational systems and emotional systems, as well as their interplay with contextual factors that occur throughout people's lives (Gilbert, 2014). It attempts to de-pathologize adaptations to difficult environments through acknowledgment of our tricky brains and their developments (Gilbert, 2010). It is

proposed that individuals have evolved emotion regulation systems of the drive, resource-seeking system, and the threat and protection system (Gilbert, 2009). People who have had early experiences of neglect or trauma, or whose early attachment relationships were highly threat-focused, are thought to have greater difficulty generating positive affiliative emotions and are therefore more vulnerable to psychopathology (Lawrence & Lee, 2013). It is of great importance to support individuals that have experienced complex trauma, and may have an over-active threat system, to be able to develop their soothing system and reduce feelings of distress. When the threat system is poorly regulated, emotion dysregulation is more likely to occur. A crucial focus of CFT is to work with the emotion regulation difficulties through development of the compassionate self (Irons, 2022). Additionally, it is noted that individuals that have experienced trauma, may have difficult relationships with themselves. This is often characterised by high levels of shame and self-criticism (Kim et al., 2011). Therefore, a further key objective of CFT is to increase an individual's felt sense of compassion, which is achieved through development of skills and experiential exercises (Cuppage et al., 2018).

Anger, and associated behaviours, are a common response to feelings of shame, rejection, and feelings of inferiority (Gilbert & Miles, 2000). Therefore, utilising CFT to reduce shame may also reduce feelings of anger and risk of offending (Laithwaite et al., 2009). An integrated way of working with individuals with criminal histories is offered by CFT. It allows challenging behaviours to be understood as evolved threat responses, considering the function of the behaviour, whilst also providing the individual with the capacities for emotional regulation (Taylor, 2017). This encourages individuals to develop a compassionate understanding of their harmfulness and develop competencies and motives to develop a harm-free life (Taylor & Hocken, 2021a). This reflects a sensitivity to trauma, whilst also addressing risk. Forensic clients are supported to understand their functioning as not their fault, as it is developed through evolutionary, genetic, epigenetic, and environmental influences, with the notion that it is their responsibility to live in a way that is not harmful to themselves or others (da Silva & Rijo, 2022).

3.1.3.4. Aim of the Case Study

In accordance with the thesis aim of exploring trauma-informed care in forensic settings for male service users, the case study is of a male residing on a trauma-informed environment of a PIPE wing within a prison. The case study intended to gain greater insight into the impact of residing on a trauma-informed PIPE wing. In addition to this the case study explored if engagement in psychological treatment whilst residing on a PIPE wing can improve emotion regulation abilities and reduce the presence of challenging behaviours. The challenging behaviours focused on were violence towards others and harm towards self. It is considered whether the application of compassion-focused therapy can assist with improving emotion regulation. The case study intended to describe therapeutic engagements with Matthew, who displayed difficulties with emotion regulation, and harm towards self.

3.2. *Assessment, Analysis and Formulation*

3.2.1. Assessment

The author and an operational member of the PIPE team conducted an interview assessment with Matthew. During this, Matthew initially presented as anxious and uncomfortable in answering questions about himself and his experiences. However, as the assessment progressed it appeared that Matthew was able to share some important and key experiences of his history, as well as his reflections of these.

The assessment considered Matthew's current and previous experiences. When exploring his childhood and adolescence, Matthew identified that he was raised by his mother who he described as an alcoholic, and due to this he often looked after himself. With regards to education, Matthew discussed that he often got into trouble at school, he would fight with others, and often did not attend school. He was removed from school by his mother due to being the victim of bullying. Matthew presented as insightful regarding his history of self-harm and the factors contributing to this. It was identified by Matthew that he can get low in mood, and this results in him having 'outbursts', particularly as he feels that he keeps his emotions in and does not speak to others about these emotions that he is having. Speaking to others was highlighted by Matthew as being helpful to him.

In the community, Matthew had harmed himself on a couple of occasions. He did not receive mental health support in the community. Matthew referenced suffering from anxiety and that he found being in large groups difficult.

Matthew raised that he began drinking at a young age. In the community and whilst in prison, Matthew had used illicit substances. Matthew provided a brief overview of his offence, stating that he had assaulted the victim by stamping on the victim's head several times. He noted this offence had occurred with a co-defendant. Relationships with others were discussed in the interview. It was recognised by Matthew that he does not like to talk to peers. It appeared that he had a limited support network. Matthew described that he did not have contact with his mother due to her drug use, however he does have contact with his sister.

Additionally, file reviews were conducted to support the assessment. This provided further insight into Matthew's offending history, presentations, and behaviours. From these reports, the impact of illicit substances was apparent. Matthew had been under the influence of alcohol and illicit substances at the time of his offence. He had also been using illicit substances whilst in custody. A review of his prison records demonstrated a pattern of being on an Assessment, Care in Custody and Teamwork (ACCT) document due to his risk of self-harm and suicide being considered that it required monitoring, for short periods.

Following the initial assessment, Matthew was discussed in the referrals meeting where it was deemed that he would be suitable for the PIPE following a period of stability. Therefore, he was accepted onto the OPD treatment service which would be conducted via outreach prior to moving to the PIPE unit.

A further assessment of Matthew's needs was conducted in the initial two sessions. Whilst in this assessment phase, Matthew had harmed himself and this was explored with him. To ease anxiety, a relaxed approach was taken which utilised a template of a person. Matthew was encouraged to use the template to reflect on important components of himself. Initially, this appeared challenging for him. Through gentle

exploration and building upon feedback from operational team members, it was noted that he can be likeable and has good humour. Matthew then raised that he feels he is 'not good enough', 'lonely' and 'has a bad temper'. The reasoning for these feelings were considered, and Matthew identified that he had often been made to feel not good enough in his family and that his siblings were often treated more preferably than him. Additionally, Matthew raised that he struggles to talk to other people and that he would like to have more interactions with others. Between the assessment sessions, Matthew had added more comments to his person template. This included 'I am a disappointment', 'I'm disrespectful', 'heartless', 'I'm miserable' and 'I'm stupid'.

3.2.2. Psychometric Testing

Difficulties in Emotion Regulation (DERS; Gratz & Roemer, 2004)

The DERS is a 36-item self-report measure to assess the individual's typical levels of emotion dysregulation across six dimensions. These six dimensions are non-acceptance of emotional responses, difficulties in engaging in goal-directed, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity.

Self-Compassion Scale (SeCS; Neff, 2003)

The SCS is a 26-item self-report scale that measures the individual's self-compassion. Self-compassion is identified as being kind and understanding towards oneself, viewing experiences as part of human experience, and having mindful awareness of painful thoughts and feelings (Neff, 2003). The scale includes six subscales of self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification. Responses are given on a 5-point Likert scale ranging from 1 = "almost never" and 5 = "almost always".

Fears of Compassion Scales (FCS; Gilbert et al., 2011)

The fears of compassion scales is a self-report questionnaire. It measures trait levels of fears of compassion in three key areas of from others, towards others, and towards oneself. It consists of 28 items that are scored on a 5-point Likert scale (0= don't agree at

all, 4= completely agree). FCS is an internationally used instrument of proven validity and reliability in both clinical and nonclinical samples (Biermann et al., 2020).

The forms of self-criticising/attacking and self-reassuring scale (FSCRS; Gilbert et al., 2004).

The FSCRS is a self-report instrument that measures self-criticism and self-reassurance. The scale contains 24 items to examine how critical and attacking or how supportive and reassuring the individual is when things go wrong for them (Gilbert et al., 2014). It has shown good reliability and has been used in several different studies and in a range of different populations (Baião et al., 2014).

Trauma Symptom Inventory-2 (Briere, 2011)

The Trauma Symptom Inventory-2 (TSI-2) tests trauma-related symptoms and behaviour. It is a 136 self-report item. There are 12 clinical scales of: anxious arousal, depression, anger, intrusive experiences, defensive avoidance, dissociation, somatic preoccupations, sexual disturbance, suicidality, insecure attachment, impaired self-reference, and tension reduction behaviour. The TSI-2 scale also assessed different non-specific psychological outcomes of traumatic events, which reflects an individual's difficulties in attachments, perceptions of self and others, and dysfunctional behaviours (Ales & Erdodi, 2022).

The TSI-2 was conducted to offer an objective understanding of Matthew's trauma symptoms presented. Matthew's scores demonstrated a clinically elevated score on depression, anger, defensive avoidance, and rejection sensitivity. Problematic elevation was identified on the scales of self-disturbance, trauma, externalisation, anxious arousal, impaired self-reference, reduced self-awareness, and tension reduction behaviour.

Clinically elevated scores:

- Depression: Frequent feelings of sadness and unhappiness and a general sense of being depressed. Individuals may perceive themselves as worthless and inadequate, and view the future as hopeless. Such individuals may describe

periods of isolating themselves from others. Suicidality and/or self-injurious behaviour are possibilities.

- Anger: Individuals often describe anger as an intrusive and unwanted experience and may see their angry thoughts or behaviours as not being entirely in their control. They may also describe pervasive feelings of annoyance, bad temper or a sense of mistreatment such that minor difficulties or frustrations provoke contextually inappropriate angry reactions or behaviours.
- Defensive Avoidance: Individuals often attempt to suppress or eliminate painful thoughts or memories from awareness, and frequently attempt to avoid events or stimuli in their environment that might restimulate such thoughts or memories. It may be associated with a decreased willingness to discuss or process negative or trauma-related experiences in therapy.
- Rejection Sensitivity: This focuses primarily on preoccupation with, and fears, about the possibility of rejection and abandonment. Typical items describe excessive concern about being rejected in interpersonal situations and being abandoned by desired or loved ones, needing attention in interpersonal contexts and worries about not being liked or cared for.

3.2.3. Clinically Meaningful Change Analysis

A two-step method for establishing clinically significant change at the individual level was recommended by Jacobson & Traux (1991). The first step involves establishing whether the change from pre- to post-treatment is reliable. To determine this, the reliable change index (RCI) is calculated using the following formula:

$$\text{RCI} = \frac{(\text{Xpost} - \text{Xpre})}{\text{SEdiff}}$$

In which,

$$\text{S}Ediff = \sqrt{2(\text{SEM})^2}, \text{ and } SEM = SD\sqrt{1} - \text{r}$$

The standard deviation (SD) of the clinical norm group is utilised for the RCI. An RCI equal to or greater than 1.96 is expected for a 95% confidence interval that the change did not occur due to random fluctuation. Therefore, this indicates a statistically reliable change.

The second step involves establishing whether a post-treatment score is clinically significant. Three methods for determining whether the post-treatment score is clinically significant based on the clinical and non-clinical normative data available. When clinical and non-clinical normative data is available, Criterion C should be used for calculating a clinically significant cut-off score. This allows to it to be established whether an individual's functioning is closer to the normative mean of the non-clinical population than the normative mean of the clinical population. The formula to calculate the clinically significant cut off using criterion C is:

$$C = \frac{(\text{SDclinical} * \text{Mnonclinical}) + (\text{SDnonclinical} * \text{Mclinical})}{(\text{SDclinical} + \text{SDnonclinical})}$$

The minimum clinically important difference (MCID) represents the smallest improvement considered meaningful by a client (Copay et al., 2007). It has been identified that the MCID is half a standard deviation (Norman et al., 2003). The healthy/non-clinical norm group standard deviation (SD) is utilised. The MCID is a threshold for value for change, and a change greater than the MCID is considered to be meaningful or important.

For each of the psychometric subscales, the RCI, clinical cut-off, and MCID is calculated and presented within the relevant table within the results section.

3.2.4. Formulation

A preliminary formulation was developed through Matthew's assessment. This adheres to the 'Five P's' framework.

Presenting Behaviour: Violence towards others is a presenting risk behaviour for Matthew. He has a history of violent offending behaviour, including the index offence of GBH with intent. Additionally, Matthew describes experiencing low mood and harms himself. He presents as critical of himself and demonstrates difficulty with emotional regulation.

Predisposing Factors: Matthew experienced a problematic and chaotic childhood. During his early years, he witnessed his father be violent towards his mother. Being subjected to this may have decreased Matthew's sense of safety, as well as demonstrating to him that violence is an acceptable way to manage emotions and deal with difficulties. Matthew's feelings of security and safety was likely decreased further by him and his siblings being placed into social care by his father. This also likely created a belief of that he is unlovable and unworthy of care from others. Additionally, Matthew's sister experienced abuse from the carers whilst in care. Matthew may have felt vulnerable and helpless during this time.

When returning to the care of his mother, it appears that Matthew lacked stability and consistent care due to Matthew's mother's use of alcohol and illicit substances. It appears that Matthew began to rely upon himself for care. Given his chaotic upbringing, Matthew likely did not have the knowledge of healthy and appropriate ways to cope with such challenging situations. Matthew's mother also had partners that would be physically abusive towards both Matthew and his mother. Matthew experienced bullying at school and was subsequently removed from schooling. It is considered that this would have significantly impacted Matthew's self-esteem.

Precipitating Factors: Matthew would often take on the care of his mother who was using substances, feeling a need to protect her. This resulted in Matthew being violent towards his mother's partners. Such behaviours likely assisted Matthew in overcoming feelings of being vulnerable and helpless, and instilled that violence is a way to manage difficult feelings.

Matthew lacked social connections with others and found interacting with peers difficult, seemingly due to his low self-esteem. Therefore, he experienced loneliness. To gain connection with others and peer approval, Matthew would engage in anti-social behaviours. This included consuming high volumes of alcohol and illicit substances, as well as committing offences of violence and robberies.

The use of alcohol and illicit substances provided a way for Matthew to manage his emotions. When under the influence of drugs and alcohol, his risk of behaving in a violent manner increases. Matthew had consumed alcohol and illicit substances prior to the index offence. He has also committed offences to fund the use of substances.

Perpetuating Factors: Matthew appears to have a very critical sense of self. He tends to view himself as a failure and unlikeable, this is enhanced by his involvement in the criminal justice system and relationship breakdowns with family members. This has created further difficulties in connections with others and loneliness, as he does not see himself as worthy or capable of positive peer relationships.

The use of violence, alcohol, and substances causes further difficulties for Matthew, such as experiencing debt, having to move wings, and loss of friends. Through this, Matthew often feels that he has let himself and others down. Additionally, feelings of not being able to adequately manage the situations and emotions that he experiences increases his criticalness of himself. This can make it harder for Matthew to engage in psychological work and implement positive coping techniques. Throughout his life, Matthew has managed his negative life experiences through alcohol and illicit substance use. Therefore, Matthew has often not talked about the difficult experiences in his life. It appears that talking about his emotions and problematic behaviours is a challenge for Matthew.

Protective Factors: Matthew can build positive relationships with others including peers and staff. It is evident that he can present with a friendly and kind personality. Matthew has maintained a positive relationship with his sister, and his brother's partner. He maintains contact with these family members, and they are a good support network for Matthew. Additionally, Matthew has shown a commitment to engaging with therapy and moving to the PIPE unit. Despite it being difficult for Matthew to discuss challenging life experiences, he shows courage and determination in working to overcome this and the ongoing impact that these have on him. Matthew has shown an ability to be reflective and open about his life experiences.

3.3. Intervention

3.3.1. Compassion Focused Therapy

It was recognised that Matthew experiences significant difficulty with shame, self-criticism, and emotion dysregulation. The behaviour that is displayed due to his emotion

dysregulation includes violence towards others and himself. Therefore, a CFT approach was implemented to assist Matthew in managing the difficulties outlined. As discussed previously, CFT can be utilised with individuals with a history of trauma, presenting with personality difficulties, experiences of shame, and emotion dysregulation difficulties. This was delivered on an individual basis given that Matthew's criticism and shame were barriers to developing compassion and this would have likely been increased in a group setting.

Matthew engaged with 23 individual weekly therapeutic sessions implementing a compassion focused therapy approach. Alongside individual therapy, Matthew began residing on and engaging with the PIPE service within the prison following 4 sessions. Through residing on the PIPE wing, Matthew's isolation and lack of connectedness would be supported by the core PIPE principles, such as Matthew engaging with socially creative and structured sessions, as well as the wing being an enabling environment and Matthew having access to keywork sessions with an operational team member. Additionally, through the PIPE model of the operational staff having additional supervision and training, it was proposed that this would allow Matthew to have further support in accessing compassionate approaches than on general wings within the prison.

It was recognised that Matthew presented with some hesitancy to discuss his life experiences due to it being appearing painful for him. A consideration was that Matthew presented with significant shame regarding his behaviours and the impact this may have on his engagement with therapeutic work. The importance of working with the fears, blocks and resistances (FBRs) were recognised. The guidelines for working with FBRs includes developing a shared formulation to reiterate that FBRs are 'not your fault', use de-shaming psychoeducation, and create a collaborative approach to discussing FBRs as they arise (Steindl et al., 2022). There are key phases within CFT however these are not necessarily linear (Gilbert, 2014). There is an acknowledgement that in forensic settings, for CFT a balance of content and attention to the process and relationship dynamics that emerge should be strived for, as the process of therapy is important (Taylor & Hocken,

2021b). Through adopting a flexible structure, the responsivity of clients increases (Taylor, 2021).

Session 1-3: Initial Formulation

A crucial focus of CFT is understanding the function of the individual's difficulties in terms of safety strategies, so the first aspect of compassion comes from the formulation which emphasises that such difficulties are 'not their fault' (Gilbert, 2009). Through the formulation process, the individual gains insight into how their early life experiences created threat, drive and soothing based capacities (Gilbert, 2014). It involves exploring the individual's history through a diagrammatic structure to illustrate the individual's safety strategies and the unintended consequences that exacerbate the problem (Lucre & Corten, 2013).

Within initial sessions with Matthew, an initial CFT formulation was created. This included consideration of Matthew's perception of himself as 'not being good enough'. It appeared that Matthew found the discussions regarding his life experiences challenging initially as he would give vague answers and not maintain eye contact. He was more animated when discussing current issues that he was experiencing within the prison, such as the use of substances and alcohol. Through discussion of these incidents, Matthew spoke of having a 'bad temper' and that it had come out recently. The exploration of these incidents allowed his coping styles to be highlighted.

During this period, due to Matthew's behaviour he had been moved from his residence on the substance misuse wing and relocated to a general population wing. The challenges that this represented for him were explored, as well as the unintended consequences of his behaviour. A functional analysis of behaviour occurred, considering the feedback loops. This involved considering the factors that had led to the incident, which appear related to feeling unheard and desperate due to a lack of finances and debt. He shared that he was worried about engaging in problematic behaviours, such as drug use, violence, and self-harm, whilst on the new wing. This heightened his desire to move to the PIPE.

Session 4: PIPE settling session.

Between session three and four, Matthew was moved onto the PIPE wing. It has been identified that in order to achieve positive outcomes with OPD services, it is beneficial to have shared understandings of expectations of the service (Webster & Gardener, 2021). Therefore, a joint session with Matthew's new key worker took place to set out the expectations of the service and consider any anxieties that he was experiencing. Additionally, this provided an opportunity for Matthew to share his needs with the key worker, with psychological support.

Session 5-9: Psychoeducation

To assist with promoting understanding of human challenges, psychoeducation components are presented within CFT. The key components covered included the evolved nature of the human brain and tricky brains, emotion regulation systems, the role of life experiences, and the concept of compassion (Matos et al., 2022). This embedded an evolutionary framework that demonstrates that emotional, behavioural and cognitive patterns develop in response to threat (Taylor, 2017). There is importance in contextualising how evolution has shaped the human mind for specific motives, emotions and behavioural dispositions (Gilbert, 2017). This has particular relevance in forensic services as there is a recognition of core processes that drive the readiness to harm (Taylor & Hocken, 2021a). The psychoeducation component allows for the recognition that much of what goes on in our brains is not our fault but our behaviours is very much our responsibility (Gilbert, 2017).

Matthew's current understanding of compassion was considered and the CFT definition of compassion was presented. Upon reflecting on compassion, Matthew discussed that he has learnt to deal with a lack of compassion, and that he did not feel compassion from others before coming to prison. Therefore, he has learnt to try and block out his emotions so that he does not feel the pain of the lack of care and compassion he receives. His experience of compassion within prison was explored. Matthew discussed that when he presents with self-harming behaviours he is placed on the relevant documentation. Through this, the prison staff are required to complete observations on him. It was reflected by Matthew that he experiences this as compassion from the prison officers.

The different flows of compassion were considered. The barriers for compassion were identified as being critical of self, not caring and having always been that way, people letting him down, and not liking the other person.

Matthew was introduced to the three emotion systems and his experience of these were explored. He recognised that he doesn't feel that he has ever felt contentment and safeness, in the soothing system. It was identified by Matthew that he does not give himself kindness or affection or get it from others. In relation to the threat system, Matthew discussed that he has been in many threatening situations, including towards himself and family. When in the threat system, Matthew recognised that he could feel angry, annoyed, upset and anxious. He responds by fighting or locking himself away and this results in social isolation. When exploring the drive system, Matthew stated that he wants to try and stay out of prison in the future and make a better life for himself. He discussed 'having enough of the life that he is living' sharing that he felt he is not doing that well in making the better life for himself but he is improving. Additionally, the thoughts, feelings, and behaviour within each of the systems were explored.

Session 10 - 12: Mindfulness

Mindfulness is also essential within compassionate mind training. Within CFT, it is raised that mindfulness helps individuals to begin to understand their different emotion systems and how they can learn to be more mindfully aware of them and develop bodily awareness of different emotions (Gilbert, 2017). It is essential that compassion and mindfulness are taught and modelled in the context of a safe therapeutic relationship that allows the client to explore and work with scary emotions and life experiences (Kolts, 2016). Mindfulness means intentionally directing our present moment awareness in a way that allows us to see what is before us, both in our external environment and in our minds, exactly as it is (Germer & Barnhofer, 2017). Therefore, this includes being non-judgemental and non-critical.

Mindfulness was introduced through presentation of its key components. The importance of recognising and accepting thoughts and feelings without judgement was presented. Mindfulness activities were demonstrated and practised. This included

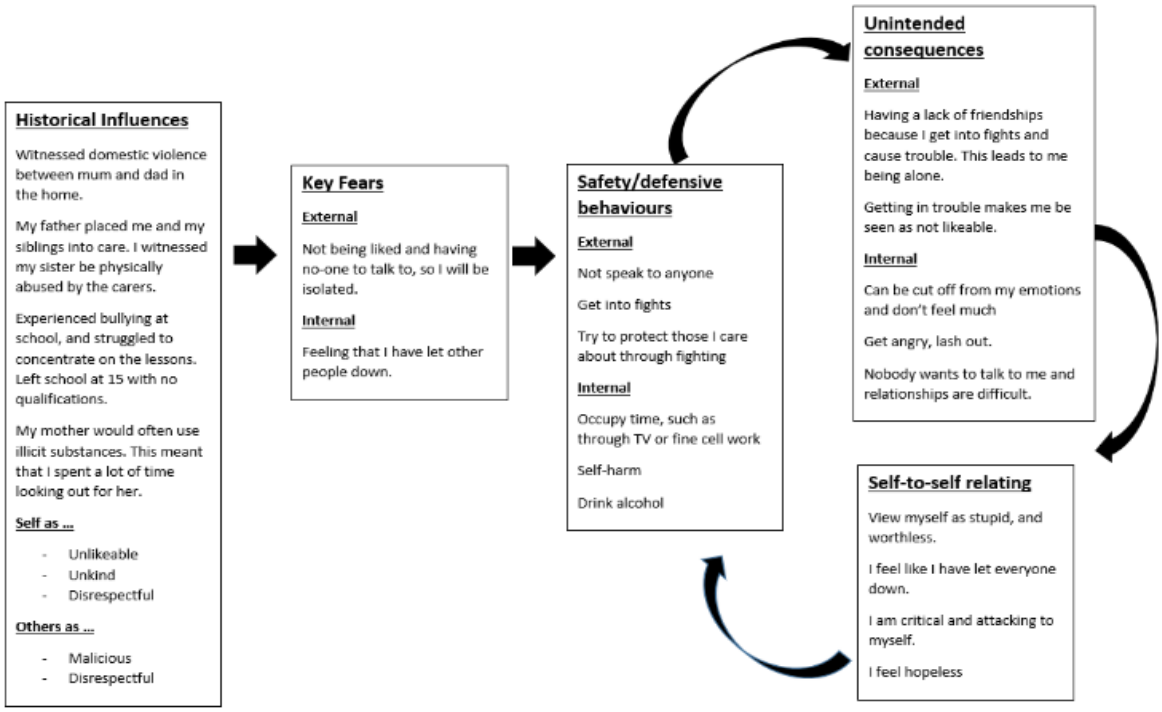
consideration of the compassion ladder (Irons & Beaumont, 2017). Matthew participated in a body scan, as well as tai chi movements. The benefits of mindfulness were discussed, highlighting that having non-judgemental self-awareness decreases self-criticism and decreases the ability to become overwhelmed by our emotions.

Session 13- 16: Formulation

It is recognised that formulation unfolds throughout the CFT journey and that the stages of formulation will be moved between all the time (Gilbert, 2022). Therefore, it was considered that it would be beneficial to return to completing an in-depth CFT formulation following psychoeducation. Additionally, it was recognised that it appeared that a safeness in the therapeutic relationships had been achieved, which would assist with the further formulation stage. This allowed for the historical factors that had impacted on Matthew to be explored, which he presented as open to discussing.

Various adverse childhood experiences were identified by Matthew, including being accused of rape by a family member, being placed into care by his father, experiencing abuse from his mother's partners, and experiencing neglect from his care givers. It was evident that although Matthew showed willingness to discuss these life experiences, they caused him significant pain. The manners in which he had learnt to manage and cope in these situations were noted. A key process was that he and his family did not talk about their difficulties but would instead ignore them and move on. The diagrammatic formulation is shown below (figure 3).

Figure 3: Matthew's diagrammatic CFT formulation



Sessions 17 – 20: Working with Fears, Blocks and Resistance (FBR), as well as emotion regulation.

Blocks to compassion are identified as being due to lack of information, misunderstanding or lack of opportunity. A source of encountering FBRs can be when individuals are trapped in situations that are harmful to them (Gilbert, 2022). It appeared that Matthew was presenting with blocks to compassion and emotion dysregulation that could be considered due to the familiar situations of threat that he encountered.

Within these sessions, Matthew presented as highly distressed due to difficulties he was experiencing within the prison environment, particularly getting himself in debt. During this, Matthew presented as unmentalised and hopeless. It appeared that Matthew presented as being submissive and that he required the support of others to get him out of his difficulty. Another avenue that Matthew adopted, was stating that he would have to 'kick off' or that he was going to harm himself. This included Matthew disclosing that he had a blade on him. Safety procedures were taken to encourage Matthew to hand over the blade and monitor his thoughts of self-harm.

It was important within these sessions to maintain a compassionate, empathetic, and validating approach. This was supported through referring back to the formulation and recognising that his automatic responses to manage these situations make sense given the way he has previously learnt to manage such situations. It was noted that Matthew presented with a desire to learn new ways of coping with his difficulties and avoid these challenging situations. The courage that Matthew had taken in overcoming his difficulties were acknowledged and emphasised. Following recognition of these factors, it appeared that Matthew was able to tolerate exploration of his difficult emotions. His coping styles were explored, with Matthew identifying positive techniques he can use as being listening to music, completing craft activities, and seeking support. Additionally, the triggers for the different emotion systems were noted.

Session 21- 22: Compassionate Mind training

Compassionate mind training (CMT) aims to help people develop compassion and the ability to self-soothe, regulate emotions, and assist with reducing the activation of threat mode (Gilbert & Irons, 2005). Within this, a change of the internalised dominating-attacking style that elicits a submissive response is sought to allow for a caring and compassionate response to be achieved (Laithwaite et al., 2009). It also assists clients with being more aware of what is going on in their own minds and bodies (Taylor & Hocken, 2021b). This often involves body and imagery practices (Matos et al., 2022). Matthew participated in the compassionate mind activities. This included writing a compassionate letter. Approaches to decreasing his threat, and increasing his soothing were focused upon. Techniques identified as beneficial for this were phoning people, watching television, listening to music, drawing, having a job, and communicating with others. Further behaviours identified by Matthew to assist with feeling safe, calm, soothed, and content were to withdraw himself from the challenging situation, write things down, and talk to someone.

Session 23: Final/Summary session

Unfortunately, due to an instance of violence from Matthew towards another member of the PIPE, he was removed from the wing and placed on a generic prison wing. This occurred at the time of the planned final session of the individual therapy work, however

Matthew would be supported with further psychological interventions through the PIPE team on an outreach basis. In the final session, a summary of the work was shared, as well as a compassionate letter being shared to the client (see appendix B) and Matthew sharing his own letter/story (see appendix C).

3.3.2. Psychologically Informed Planned Environment

As raised above, Matthew resided on the PIPE wing for a period of five months. Matthew engaged in various PIPE activities whilst residing on the wing. Following moving to the wing, Matthew quickly became involved in attending the farms and gardens. He showed a great enjoyment and commitment to working there. This led to Matthew being allocated a rep job that involved overseeing aspects of care of the animals. Additionally, Matthew attended socially creative activities. He showed similar enthusiasm for these. The activities he attended included smoothie making, bingo, arts and crafts, quizzes, and choir sessions. During these sessions, Matthew demonstrated his positive interactions with staff and residents. His involvement in various activities showed his willingness to try new things.

From his involvement in PIPE activities, it appeared that Matthew had been able to integrate himself into the PIPE community. He showed positivity in participating in the various elements of the PIPE. This allowed him to build positive relationships with others. However, it was noted that Matthew continued to struggle with interpersonal relationships with peers. Particularly Matthew had a group of residents that he would mainly associate with. Difficulties in these relationships occurred, which resulted in both a threat of violence and an assault occurring. Due to the violence towards another resident, Matthew was suspended from the PIPE wing, and he was required to a general location wing within the establishment.

3.4. Results

3.4.1. Psychometrics

Several psychometrics were administered pre- and post- intervention. The analysis of the psychometrics assessed the effectiveness of the intervention. Reliable Change Index (RCI) values were calculated using subscale-specific Cronbach's alpha, and Minimal

Clinically Important Difference (MCID) was estimated using a distribution-based method (0.5 x SD). The clinical cut off was calculated using criterion C (Jacobson & Traux, 1991).

Difficulties in Emotion Regulation (DERS; Gratz & Roemer, 2004)

Table 3: Pre- and Post-intervention DERs score and analysis - Higher scores indicate greater problems with emotion regulation.

	Pre-intervention mean score	Post-Intervention mean score	BPD Norm mean (SD)	Healthy control Norm mean (SD)	Cronbach's alpha	Change	RCI	MCID	Clinical Cut off	Interpretation
Non-acceptance of emotion responses	2.83	2.33	3.04 (1.02)	1.91 (0.81)	0.85	-0.50	-0.89	0.405	2.41	Not statistically reliable change. Greater change than MCID Has moved to below the clinical cut off.
Difficulties in engaging with goal-directed	3.6	4	3.78 (0.83)	2.44 (0.77)	0.89	+0.40	1.02	0.385	3.08	Not statistically reliable change Greater change than MCID Remains in clinical range
Impulse control difficulties	4.16	3.33	3.37 (0.95)	1.86 (0.66)	0.86	-0.83	-1.65	0.33	2.47	Statistically reliable change. Greater change than MCID Remains in clinical range
Lack of emotional awareness	3.83	4	3.01 (0.83)	2.44 (0.77)	0.8	+0.17	0.32	0.385	2.71	Not statistically reliable change Change is not greater than MCID Remains in clinical range
Limited access to emotion regulation strategies	3.63	3.25	3.75 (0.81)	1.93 (0.65)	0.88	-0.38	-0.96	0.325	2.74	Not statistically reliable change Greater change the MCID Remains in clinical range
Lack of emotional clarity	3.4	3	2.82 (0.95)	1.79 (0.70)	0.84	-0.40	-0.74	0.35	2.23	Not statistically reliable change. Greater change than MCID Remains in clinical range
DERs Overall	3.58	3.14								

* Norm group taken from Salgo et al., 2021

Matthew's scores on the DERS demonstrated an improvement across most domains, with the overall DERS score decreasing, reflecting a general reduction in emotion dysregulation. However, subscale-level analysis demonstrated varying degrees of change. Only the subscale 'Impulse Control Difficulties' showed a statistically reliable improvement, as well as having a greater change the MCID, indicating meaningful clinical progress in this domain. However, scores on this subscale remained above the clinical cut off. The subscales of 'non-acceptance of emotional responses', 'limited access to emotion regulation strategies' and 'lack of emotional clarity' did not demonstrate statistically reliable change, however the change in scores were greater than the MCID. For 'non-acceptance of emotional responses' a move to within the clinical range was observed. A change greater than the MCID that increased was observed for 'difficulties in goal-directed behaviour' and 'lack of emotional awareness' reflecting worsening emotion regulation in these areas, however they were not statistically significant.

Although most changes were not statistically reliable, Matthew demonstrated clinically meaningful improvement in impulse control, access to emotion regulation strategies, and emotional clarity. Clinically meaningful deterioration was indicated in goal-directed behaviour and emotional awareness. These results suggest that modest improvements in emotion regulation were present.

Self-Compassion Scale (SeCS; Neff, 2003)

Table 4: Pre and Post SeCS scores and analysis - The higher the total score, the greater the self-compassion (opposite for non-reversed items): 1-2.49 (low), 2.5-3.5 (moderate), and 2.51-5 (high)

	Pre-intervention mean	Post-Intervention mean	BPD Norm	Healthy control Mean (SD)	Cronbach's alpha	Change	RCI	MCID	Clinical Cut-off	Interpretation
Positive subscales	2.7 Low	1.6 Low	2.21 (0.64)	3.27 (0.66)		-1.1		0.33		
Negative subscales (not reversed)	3.3	2.46	3.95 (0.53)	2.25 (0.69)		-0.84		0.345		

Self-kindness	2.4 Low	1.6 Low	1.89 (0.64)	3.24 (0.88)	0.88	-0.8	-2.55	0.44	2.71	Statistically reliable change Greater change than MCID indicating a deterioration in self-kindness Remains in clinical range
Self-judgement (reversed)	2.6 Moderate	3.2 Moderate				-0.60				
Self-judgement (not reversed)	3.4	2.8	3.89 (0.69)	2.34 (0.86)	0.88	-0.60	-1.77	0.43	3.2	Statistically reliable change Greater change than MCID indicating an improvement. Moved to non-clinical range.
Common Humanity	3 Moderate	2 Low	2.12 (0.73)	3.19 (0.93)	0.80	-1	-2.80	0.465	3.21	Statistically reliable change Greater change than MCID indicating a deterioration. Remains in clinical range
Isolation (reversed)	2 Low	4 Moderate				+2				
Isolation (not reversed)	4	2	3.97 (0.72)	2.18 (0.71)	0.85	-2	-5.07	0.355	3.07	Statistically reliable change Greater change than MCID indicating an improvement. Moved from clinical range to non-clinical range.
Mindfulness	2.75 Moderate	1.25 Low	2.63 (0.73)	3.37 (0.70)	0.85	-1.5	-3.75	0.35	3.01	Statistically reliable change Greater change than MCID indicating a deterioration Remains in the clinical range
Over-identification (reversed)	2.75 Moderate	3.5 High				+0.75				
Over-identification (not reversed)	3.25	2.5	3.98 (0.60)	2.23 (0.74)	0.88	+0.75	-2.55	0.37	3.20	Statistically reliable change Greater change than MCID indicting an improvement. Moved from above the clinical cut off
Overall self-compassion	2.6 Moderate	2.4 Moderate				+0.2				

* Norm group taken from Salgo et al., 2021

Statistically reliable change were observed on all of the subscales. Improvements in scores, along with clinically meaningful change as indicated by the MCID, were observed for the subscales of isolation, self-judgement, and over-identification. Additionally, a move from above the clinical cut off indicating being within the clinical range, to below the clinical cut off which indicates being within the healthy norm range was shown for these subscales.

Across the positive subscales, a clinically meaningful deterioration was observed, as shown by the RCI and MCID scores. These subscales also remained within the clinical range. Self-kindness remained in the low range, whilst common humanity and mindfulness declined from the moderate to low range. These deteriorations indicate ongoing self-critical attitudes, and a reduction in perceived shared human experiences and mindful awareness. These subscales remaining in the clinical range indicate persistent psychological difficulty.

Fears of Compassion Scales (Gilbert et al., 2011)

Table 5: Pre and Post Fears of Compassion scores - Higher scores reflect difficulties in the subscale area.

	Pre-intervention score	**Post-Intervention score**	**Clinical norm mean (SD)**	**Non-clinical norm mean (SD)**	***Cronbach's alpha***	**Change**	**RCI**	**MCID**	**Clinical Cut-off**	**Interpretation**
Fear of expressing compassion for others	22	16	23.23 (10.56)	17.17 (8.03)	0.78	-6	-0.85	4.02	19.787	Not a statistically reliable change Change exceeds the MCID indicating a clinically meaningful improvement Post-score is below the clinical cut-off
Fears of responding to compassion from others	28	35	25.02 (12.19)	12.90 (9.49)	0.87	+7	1.13	4.75	18.21	Not a statistically reliable change Change exceeds the MCID indicating a clinically meaningful deterioration Both scores are above the clinical cut-off
Fear of self-compassion	15	33	24.17 (14.86)	10.30 (10.25)	0.85	+18	2.21	5.13	15.96	Is a statistically reliable change Change exceeds the MCID indicating a

										clinically meaningful deterioration Both scores are above the clinical cut-off

* Norm group of personality disorders taken from Castilho et al., 2017

A statistically reliable change, as well a change greater than the MCID was identified for the subscale of 'fear of self-compassion'. As the post-intervention score increased, this indicates a deterioration in self-compassion. Both the pre- and post-intervention scores were above the clinical cut off. This reflects that Matthew experiences significant difficulties with his ability to be compassionate towards himself. A further clinically meaningful deterioration as indicated by the MCID was shown for the subscale of 'fears of responding to compassion from others'. However, statistical reliability for this change was not found. The pre- and post-intervention scores were within the clinical range. A non-statistically reliable improvement was identified on the 'fear of expressing compassion for others'. It is noted that a clinically meaningful change occurred and the post-score was below the clinical cut off.

The forms of self-criticising/attacking and self-reassuring scale (Gilbert et al., 2004)

Table 6: Pre and Post scores and analysis for the forms of self-criticising/attacking and self-reassuring scale: Higher scores on inadequate-self and hated-self reflect greater difficulties in the subscale domain. Lower scores on reassured self reflects greater difficulties in the subscale domain.

	Pre-intervention score	**Post-Intervention score**	**Norm mean (clinical males)**	**Healthy control mean (SD)**	**Cronbach's alpha**	**Change**	**RCI**	**MCID**	**Clinical Cut-off**	**Interpretation**
Inadequate-self	16	24	26.61 (7.19)	16.42 (7.44)	0.90	+8	2.48	3.72	21.60	Statistically reliable change Greater change than MCID indicating a deterioration Moved into the clinical range

Reassured self	17	13	10.66 (4.72)	21.20 (5.27)	0.86	+4	-1.60	2.64	15.64	Not a statistically reliable change Greater change than MCID indicating an improvement. Moved below the clinical range
Hated-self	11	11	12.13 (5.19)	3.36 (3.71)	0.86	0	0	1.86	7.02	Not a statistically reliable change No change observed. Remains in the clinical range.

* Norm group taken from Baião et al 2014

A statistically reliable increase and a change that exceeded the MCID threshold was found for the 'inadequate self' indicating a deterioration in this domain. Matthew's score also moved into the clinical range. This may suggest that the intervention had either unintended consequences or external factors contributed to increased self-criticism. However, no statistically reliable or clinically meaningful changes for the 'hated-self' were found. A clinically meaningful improvement in self-assurance was found. This was demonstrated by the MCID being above the threshold, and the post-intervention score moving into the non-clinical range. This should be interpreted with caution as the RCI indicates that the change was not statistically reliable.

3.4.2. Observed Changes

Across the period of residence on the Provision PIPE, it was observed that Matthew showed a willingness to integrate himself into the wing community. This was evidenced through his engagement with the activities provided. He had a particular eagerness in attending the farms and gardens, as well as the socially creative sessions which are of a relational and informal manner. It appeared that Matthew utilised the opportunities available on the wing to build connections with others. Additionally, as these sessions were co-facilitated between clinical and operational staff it allowed Matthew to build positive relationships with staff. It is considered to be in contrast to his previous coping style of isolating himself that he displayed when he was located on general location wings.

When experiencing emotional difficulties, Matthew would seek guidance and access support from the PIPE staff team. Across the individual intervention, improvements in Matthew's presentation were noted. It was recognised that he demonstrated an increased ability in tolerating difficult emotions and discussing his difficult childhood experiences. At the beginning of the intervention, Matthew appeared to struggle with communicating his emotions, thoughts, feelings and life experiences. He appeared to find it difficult making eye contact. Towards the end of the intervention, Matthew was able to make eye contact, create a collaborative formulation including sharing his life experiences and perspectives on these. In the sessions, it appeared that Matthew's reflective capabilities increased and he would bring relevant topics to discuss.

3.5. Discussion

This case study was based on an intervention with a 29-year-old male who exhibited personality difficulties. He presented with emotion regulation difficulties, as well as with high levels of shame and self-criticism. The client, Matthew, had a history of trauma and offending behaviour. The assessment, formulation and treatment for Matthew took place within a category B high secure prison. The intervention included residing on the PIPE wing, as well as compassion focused therapy.

Matthew was motivated to engage with therapy and the PIPE service. Initially Matthew presented as reserved in exploring his life experiences. He demonstrated difficulties in his emotion identification and exploration. Matthew also presented as highly critical and shameful regarding his behaviour. However, Matthew participated in the session content and developed an openness to considering the impact of his experiences, and developed insight into his unhelpful ways of coping. CFT aims to de-shame and normalise emotional difficulties, recognising this resulting in part from the way our brains have evolved, the propensity to respond from our threat system, and the social and emotional learning experiences (Cuppage et al., 2017). The benefit of adopting this evolutionary perspective to human development and formulation was beneficial in promoting a non-judgemental and compassionate approach to the therapy that allowed Matthew to engage.

It has been discussed that within custodial environments, the formulations are brought to life in context of current experiences and is fundamental to understanding threat sensitivities (Taylor, 2017). Previous research has identified that individuals that did not experience safeness in childhood, are more likely to be "threat focused", seeing others as a source of threat (Gilbert, 2004). Additionally, among these individuals' experiences of closeness may be conditioned to evoke feelings of threat (Kolts & Gilbert, 2018). This was reflected within this case study, in which threat sensitivities were evident. It was apparent that the delivery of therapy and ability to engage with the PIPE were complicated by Matthew's interpersonal difficulties with other residents of the PIPE wing, emotion regulation difficulties, and coping style of self-harm. On a number of occasions, Matthew attended sessions, and his focus was on the difficulties that he was experiencing on the PIPE wing and the need to resolve these issues. It is considered that the focus on interpersonal relationships between Matthew and peers on the PIPE created an experience of threat and evoked attachment difficulties. This may have been heightened due to aversive memories being stimulated along with the memories and desires for connectedness (Liotti, 2013). It is recognised that having utilised a Power Threat Meaning Framework as the initial formulation would have beneficial. This would have allowed greater consideration of the challenges and difficulties that may have presented in the wider context of residing on the PIPE, which is an environment focused on relationships. The PTMF encourages greater emphasis on the context, and examination of how the system itself has the potential to induce threat responses and may exacerbate risk (Ramsden & Beckley, 2022). There is an acknowledgement that mental health and behavioural problems can be understood as consequences of negative operation of power, the threat and meanings posed by this leads to distress, and behavioural problems can be understood as responses to protect themselves for negative operation of power (Willmot, 2023). Having this collaborative understanding from the outset, which includes significant focus on the context, and the behavioural responses, would have been advantageous. It is recognised that the use of PTMF in prison settings allows for individuals to make sense of their experiences and behaviour in a non-judgemental and curious stance, whilst recognising the disempowering position of being in prison and the threat due to the hostile nature of such settings (Reis et al., 2019). Adopting a PTMF approach to formulation assists with promoting ownership, self-compassion, and self-

belief (Reis et al., 2019). Utilising this approach as an initial collaborative formulation would have encouraged greater discussions and understandings regarding the potential power, threat, meaning, and threat responses that Matthew may have encountered previously, as well as those envisioned by residing on the PIPE. Also, it would have been a useful foundation for compassion-focused therapy as it aligns with the core beliefs of the model.

Despite the challenges that occurred for Matthew whilst residing on the PIPE, he was able to explore such situations in relation to the CFT principles and practice CMT exercises. This is something that Matthew showed great commitment to. Throughout his engagement with therapy and the PIPE service, Matthew showed an ability to seek out staff support. This allowed a supportive level of containment to be achieved. As this case study included the exploration of the impact of the trauma-informed environment of the PIPE wing, greater focus on the relationships with staff on the unit, and the environment itself would have been valuable. This would have allowed for insight into the relationships created with staff working on the unit, that have training on psychologically informed approaches. The use of psychometric questionnaires to explore and measure this would have been beneficial. The Epistemic Trust, Mistrust and Credulity Questionnaire (ETMCQ; Campbell et al., 2021) globally measures a person's trust in communication and communicated knowledge. The ETMCQ assesses three dimensions: Epistemic Trust (ET), defined as an adaptive stance in which the individual can appropriately learn from social communication, being able to be open to new information; Epistemic Mistrust (EM), defined as the tendency to consider incoming information as untrustworthy and/or not relevant; and Epistemic Credulity (EC), defined as a lack of discrimination in relation to social communications, in which the individual is blindly trustful and prone to manipulation. Analysis of epistemic trust allows for exploration of views and attitudes towards relationships with others, this would be insightful as when others are perceived as not reliable and trustworthy it can lead to a reduced capacity to learn from and adapt, and generate a vicious relational cycle in which negative beliefs about the trustworthiness and dependability of others are confirmed (Milesi et al., 2024). Analysis of factors relevant to Matthew's experience of epistemic trust whilst residing on the PIPE

unit would have provided understanding of his perception towards others. Additionally, to explore Matthew's therapeutic relationship with his keyworker and clinician as part of the PIPE unit, it would have been insightful to measure the working alliance. This could have been achieved through the Working Alliance Inventory (WAI; Horvath, 2020). Utilisation of the WAI would have allowed for the working alliance experienced by Matthew to be investigated at various points in treatment. Additionally, a measure focusing more specifically on the therapeutic environment of the PIPE, and the experience of this by Matthew should have been used to gain insight into his experiences of the PIPE and potential impact. The EssenCES (Essen Climate Evaluation Schema; Schalast *et al*, 2016) assesses the social and therapeutic atmosphere of forensic environments, through dimensions of therapeutic hold, inmates' cohesion and mutual support, and experienced safety. This would have allowed for the social climate as experienced by Matthew to be incorporated into the case study, reflecting the experience of the PIPE wing.

Due to interpersonal difficulties, as well as emotion dysregulation, Matthew was violent towards another PIPE resident. This resulted in him being suspended and removed from the PIPE wing and moved to a general location wing. It was important to consider the function of Matthews behaviour. It is recognised that emotional and behaviour patterns developed in response to threat would have served a survival function and become entrenched, particularly for those in forensic settings (Taylor & Hocken, 2021a). Research has discussed that conceptualised shame includes a self-perception of being deeply flawed, incapable and unacceptable (Tagney & Dearing, 2003). Given that Matthew presented with high levels of shame, it appears that the suspension from the PIPE wing was experienced as a confirmation of these factors. Additionally, this change likely stimulated experiences of aloneness, being unlovable, and vulnerable to abuse (Kolts & Gilbert, 2018). It is noted that the harm that may result from entrenched survival behaviours can then induce a further shameful experience that leads to attributions of defectiveness, which create a sense of pessimism and hopelessness (Taylor & Hocken, 2021b). Discussions took place with Matthew and the clinical lead of the PIPE wing to explore his continual contact with the OPD treatment service whilst not residing on the

PIPE wing and plans for his return to the PIPE wing following his suspension in an attempt to maintain hope and boundaries.

The post intervention outcome measures were conducted at a time when Matthew had been suspended from the PIPE and therefore had been moved to a general prison wing. The post-intervention outcome measures demonstrated some statistically reliable, and clinically meaningful changes. Improvements in emotional functioning and compassion were also observed through Matthew's scores moving into the non-clinical range. However, this was to varying degrees across improvements as well as deteriorations being found. Therefore, results should be interpreted with caution due to variation in statistical reliability. The deteriorations also had instances of statistical reliability, clinically meaningful change, and moving into the clinical range. Clinically meaningful improvements were observed among impulse control, acceptance of emotional responses, emotion regulation strategies, emotional clarity, isolation, self-judgement, over-identification, and expressing compassion for others. Whilst clinically meaningful deteriorations were found for acceptance of emotional responses, emotional awareness, goal-directed behaviour, self-kindness, common humanity, mindfulness, self-compassion, and responding to compassion from others. These results indicate a complex presentation and impact of the CFT-informed sessions, engagement with the PIPE, and removal from the PIPE wing. It appears that there are contrasting improvements and deteriorations. Observationally, Matthew showed a willingness to participate in the PIPE activities. This appeared to assist him with building connections with peers and staff. In addition, Matthew's coping styles seemed to improve as his isolation reduced and he began seeking staff support. Within the intervention sessions, his ability to engage with the content was noted to improve.

It is noted that the removal from the PIPE wing likely had a significant impact on Matthew's ability to express and experience compassion, particularly as he may have interpreted that such compassion when on the PIPE may have increased his vulnerabilities. The post intervention outcome measures were conducted at a time when Matthew had been suspended from the PIPE and therefore had been moved to a general prison wing. This is likely to have had significant impacts on Matthew's ability to express

and experience compassion, particularly as he may have interpreted that such compassion when on the PIPE may have increased his vulnerabilities. It is highlighted that the institutional climate of forensic settings is often experienced as a strange and threatening environment (Auty & Liebling, 2020). The case study indicates that due to previous life experiences, and current context, Matthew's threat defence was likely activated. Following removal from the PIPE wing, a deterioration in his coping abilities compared to when on the PIPE were observed. It is positive that despite these complications to his residence and engagement with the PIPE service, improvements following the intervention were noted.

3.6. Limitations

The limitations of the approach in this case study are:

1) Individual therapy was delivered due to the barriers to developing compassion that were identified, as well as this providing a period of stabilisation for Matthew. However, group CFT may have been beneficial. It has been found that group CFT can result in a greater increase in compassion for self, compared to individuals receiving treatment as usual (Asano et al., 2022). Additionally, CFT groups may reduce stigma and social isolation (McManus et al., 2018). Such outcomes would have been beneficial to Matthew as social isolation has been an ongoing challenge for him. Additionally, it is considered that had he engaged in a group intervention, that this may have assisted in him feeling he had better connections with other residents on the PIPE wing. This could have resulted in him not acting in a violent way to his peers. Although, it should also be noted that Matthew presented with anxiety regarding sharing information with others, and this may have limited his ability to engage purposefully in group sessions. Unfortunately, the CFT group was not being facilitated at the time of Matthew's residence on the PIPE wing.
2) As noted above, the post-intervention psychometric testing occurred at a time when Matthew had been suspended from the PIPE wing. It is probable that this impacted Matthew's scoring on the psychometrics. It would have been beneficial to have conducted psychometric testing at different periods during the implementation of the intervention. Additionally, a longer term follow up would

have been insightful. Furthermore, the psychometric tests were self-report. Matthew may have scored himself in a way in the post intervention psychometrics in a manner that would continue to elicit care and treatment from others.

3) The intervention for Matthew included compassion focused therapy, as well as residing on the psychologically informed planned environment wing. The aim of the PIPE was to provide a trauma-informed environment and approach to his care. Alongside this, Matthew accessed the treatment service in which his experience of trauma and ongoing impact was addressed more directly. Whilst this case study provides insight into the application of trauma-informed care alongside psychological treatment, it is not possible to distinguish the benefits and challenges of each aspect of the intervention. However, it is noted that for many individuals with trauma histories their treatment pathway may include both a trauma-informed approach, along with trauma-focused interventions.

3.7. Conclusion

Overall, a complex presentation following engagement with the PIPE and CFT sessions were present. It is noted that the intervention did appear to have a positive effect in improving Matthew's emotion regulation and decreasing his perceived self-judgement, isolation, and over-identification. However, it appears that Matthew experienced ongoing difficulties in relation to his ability to be compassionate towards himself. Matthew demonstrated a positive approach to treatment and utilised the opportunities available through attending individual therapy sessions, as well as attending socially creative activities on the PIPE. Throughout individual therapy sessions utilising a CFT based approach, Matthew showed commitment to understanding himself further, including evolutionary perspectives of humans and the impact of his experiences. This case study demonstrates the complexity of applying CFT based approaches to an individual with personality difficulties and engagement with a PIPE service. The importance of the threat system and its interaction with the environment in the prison, and the management of risk to self and others is of essential importance.

Chapter Four: Use of the Attitudes Related to Trauma Informed Care (ARTIC) scale within forensic settings: A psychometric critique.

Abstract

Developments have been occurring in the implementation of trauma-informed care across various settings (Bargeman et al., 2022). This has extended to forensic services, with it being recognised that significant trauma histories are present in such settings (Branson et al., 2017). The Attitudes Related to Trauma Informed Care (ARTIC) scales were developed to assist with the evaluation of the implementation of trauma-informed care (Baker et al., 2016). It is a measure of professionals' and paraprofessionals' attitudes towards trauma-informed care. This psychometric critique evaluated the psychometric properties of the ARTIC scales. The psychometric properties evaluated included reliability, validity, and its applicability within forensic settings. The findings indicated that the ARTIC scales do have some good psychometric properties. Psychometric evaluations conducted by the developers of the ARTIC found that it has between excellent and very good internal consistency (Baker et al., 2016; Baker, 2021). Whereas a modest internal consistency reliability was found in relation to the Japanese version of the ARTIC-10 (Kataoka et al., 2022). Evaluations of validity identified categories that matched the ARTIC-35 structure (Stokes et al., 2020). Among previous research of the ARTIC, it has been found that the population, setting, and participant factors likely impact on the measurement of trauma-informed care attitudes (Keesler et al., 2024; Mendez et al., 2023; Stokes et al., 2022). Similarly, it is argued that the atypical environment of forensic settings can impact the cultural context, and likely impacts on attitudes towards trauma-informed care (Ferdik & Smith, 2017). Recommendations to make the ARTIC scales more applicable to forensic settings are identified.

4.1. Introduction

As discussed in chapter one, over the past few decades there has been an increased acknowledgement of the prevalence of trauma within individuals' lives and communities. The long-term negative consequences of trauma that can result in medical and psychological difficulties is recognised (Dye, 2018). This increased recognition has

contributed to the development of trauma-informed care (Bargeman et al., 2022). A trauma-informed care approach includes being aware of the history of the trauma within service users' lives and using that understanding to design services that accommodate the vulnerabilities of trauma (Harris & Fallot, 2001). The organisational and staff approach is crucial within trauma-informed care. Particularly, the staff teams understandings and attitudes are essential within the development and application of trauma-informed care. The effectiveness of trauma-informed approaches often focuses on changes in staff knowledge (Branson et al., 2017; Champine et al., 2019). However, there is much to be learnt about how trauma-informed care is defined and evaluated (Berliner & Kolko, 2016). To achieve successful operationalization of trauma-informed care, policies must include conceptual clarity regarding the definition of both trauma and trauma-informed care (Bargeman et al., 2022).

Individuals with significant trauma histories are disproportionately represented in child welfare, criminal and juvenile justice systems (Branson et al., 2017). In response to this awareness, the application of trauma-informed care is beginning to be explored and implemented within forensic settings. It is argued that forensic services should adopt trauma-informed care in order to assist service users to understand themselves and the multiplicity of personal struggles, which would increase their ability to participate in personal development and offending behaviour interventions (McCarten, 2020; Mulcahy, 2018). To achieve these outcomes that promote desistance and re-integration for forensic service users, a culture shift is required. Therefore, it is important to consider forensic professionals' attitudes towards trauma-informed care as this will have a significant impact on its implementation and effectiveness. As identified in the systematic review chapter, there appears to be hesitancy among staff members in forensic services to 'buy-in' to trauma-informed care (Seel & Austin, 2023; Seitanidou et al., 2024). This emphasises that understanding the attitudes towards trauma-informed care, within the context of forensic settings, would be beneficial.

The BPS (2017) outlined that psychometric tests should be supported by evidence of their reliability and validity for their intended purposes. Additionally, it is highlighted that the internal structure of a test may vary across different populations (Flora & Flake, 2017).

Therefore, it is advised that a scale's psychometric properties are re-evaluated before applying it to a new population (Flora & Flake, 2017). The importance of demographic variables must not be underestimated in forensic examinations because of the potential differences with the normative groups (Greene, 2007). It has previously been recommended that agreement among clinicians on consistent outcome measure use for the purposes of forensic mental health research is required (Chambers et al., 2009). This is reflected further in a systematic review on instruments available for use as outcome measures specific to forensic contexts, which found that despite there being many instruments available the evidence base for their use is limited (Ryland et al., 2021). This review argued that new instruments are needed for forensic services to enable the measurement of service outcomes (Ryland et al., 2021). The importance of routine collection of quality and outcomes data as part of an organisational culture, which is underpinned by robust and reliable data was outlined in the implementing the five year forward view for mental health vision (NHS England and NHS Improvement, 2016). Treisman (2018) identified that several organisations referenced the benefit of having an evaluation process from the beginning to get a baseline of trauma-informed care and that this supported the organisation to monitor progress and outcomes, advocate for more resources and funding, and develop their practice. However, it is noted that evaluation and research concerning trauma-informed care and organisational change still requires a vast amount of thought, work and development (Treisman, 2018).

4.1.1. Aims

This critique aimed to evaluate the Attitudes Related to Trauma Informed Care (ARTIC) scales within forensic services. An overview of the ARTIC scales will be provided. Secondly, the psychometric properties of the scales will be examined, with consideration of its application to forensic services and staff members. Through this psychometric critique, there is contribution to the thesis aim of developing understanding of the application of trauma-informed care to forensic services. Through having an awareness of the applicability of a psychometric that measures attitudes related to trauma informed care in forensic services, it allows for further research of trauma-informed care in forensic services to occur.

4.1.2. The Attitudes Related to Trauma Informed Care (ARTIC) scale

The Attitudes Related to Trauma Informed Care (ARTIC) scale was developed by Baker et al (2016). It is a measure of professionals' and paraprofessionals' attitudes towards trauma-informed care. There are variations in wording across versions of the scales for human services and education settings. Three versions were created within these to reflect the stage of trauma-informed care implementation of the organisation or service that the professionals work within. The ARTIC has five core subscales of: underlying causes of problem behaviour; responses to problem behaviour and symptoms; on-the-job behaviour; self-efficacy at work; and reactions to work. As well as two supplementary scales of personal support of trauma-informed care, and system-wide support of trauma-informed care.

The ARTIC-10 is the short-form version for use within settings that have not begun implementing trauma-informed care and provides one total score. The ARTIC-35 is designed for use in settings that have not begun implementation of trauma-informed care and includes the five core subscales. Whereas the ARTIC-45 is for use with settings that have begun implementing trauma-informed care, so this includes the five core subscales and the two supplementary subscales. All versions are self-report, with respondents being asked to score their agreement on a 7-point bipolar Likert scale. The bipolar Likert scale has a favourable attitude to trauma-informed care statement paired with a statement representing an opposite attitude. The scores are calculated to determine the participants' average attitude toward trauma-informed care. A higher score represents a more favourable attitude toward trauma-informed care.

The ARTIC is based upon an earlier measure of trauma-informed care, which was the trauma-informed care belief measure (Brown et al., 2012). To develop the ARTIC scales, a partnership-based approach was adopted with content experts being involved in a mixed-methods item re-development process, as well as a review of the literature relevant to trauma-informed care. The development and psychometric evaluation study by Baker et al (2016) included a sample of 760 service providers. This included 595 individuals working in human services, community-based mental health, or health care, with the remaining individuals working in schools. These participants were 83% female,

92% were white, and 96% have completed college, or a graduate school. There is no normative data for the ARTIC.

4.1.3. Use of the ARTIC scale within Forensic Services

Although the evaluation and development of the ARTIC did not include participants working within criminal justice settings, it is reported that the ARTIC was designed to be relevant in other settings such as these (Baker et al., 2016). Current use of the ARTIC scales remains limited in forensic settings. However, it appears that this is increasing with the culture shift towards such settings becoming trauma-informed. The few studies that have utilised the ARTIC scale in forensic settings will be outlined.

The ARTIC scale has been utilised in research conducted among police officers to examine their attitudes towards trauma-informed care and the impact of trauma-informed training. Ford et al (2017) found that the pre-training scores, as measured by the ARTIC-35, identified moderate attitudes towards trauma-informed care. Significantly higher ARTIC-35 scores were found among females, police community support officers (PSCOs) and staff that had been in their role less than three years. These differences were no longer evident in the post-training scores. The ARTIC-35 scores were significantly higher following training. Similarly, in Brodie et al's (2023) research in Scotland, they found that female police officers held higher levels of favourable trauma-informed care attitudes. Females were the only group to demonstrate statistically higher attitudes towards trauma-informed care when exposed to the training. Additionally, they found that the police officers held more favourable attitudes towards trauma-informed care in relation to victims of crime than suspects of crime.

The ARTIC scale has also been administered in research exploring the impact of the enhanced case management (ECM) project. The ECM project is a psychology-led approach in youth offending teams (YOTs), which uses formulation to understand the needs of the children who present with trauma and complex needs. YOT workers attended training on trauma-informed approaches. In Glendinning et al's (2021) project, the ARTIC-45 was completed with YOT workers pre- and post-training. They found statistically significant increases in favourable trauma-informed care attitudes in the

subscales of underlying causes of problem behaviour and symptoms; responses to problem behaviour and symptoms; self-efficacy at work; personal support of trauma-informed practice; and system-wide support of trauma-informed practice. They did not show statistically significant increases in attitudes towards on-the-job behaviour and reactions to the work. The ARTIC-45 was also administered to ECM case managers in the Opinion Research services (2023) evaluation of an ECM in a different location. The scores for the case managers were at least five out of a maximum of seven on all dimensions, with an average score 6.15 across all dimensions. This was considered to reflect that the participants expressed very positive attitudes towards trauma-informed practice, with small variations across the sub-scales. It was noted that the participants in this study scored higher overall on the ARTIC, than those that completed the scale in the previous ECM evaluation in Wales (Glendinning et al., 2021).

McKinsey et al (2024) explored attitudes of and experiences of trauma-informed practice among ninety-one judges in the U.S. court system. The ARTIC-45 was used to assess this. Findings indicated that judges working in juvenile court had more favourable attitudes to trauma-informed care than those working in adult courts. Those working in juvenile justice courts also had a greater engagement in trauma-informed practice. They also found strong positive correlations between favourable trauma-informed practice attitudes and support for rehabilitation and restoration.

As the studies within forensic settings examining the ARTIC scales are lacking, evidence from non-forensic populations will be provided to evaluate the properties of the scale. Aspects relevant to the generalisation to forensic settings will be considered throughout this psychometric critique.

4.2. Psychometric Properties

4.2.1. Reliability

Reliability is identified as one of the most significant components of test quality (Hajjar, 2018). Internal consistency and test-retest reliability must be demonstrated for a psychometric measure to be reliable (Kline, 2015). It is noted that the majority of the

research demonstrating reliability is reported by the developers of the ARTIC (Baker et al., 2016; Baker et al., 2021) so these should be treated with caution.

4.2.1.1. Internal Consistency

When developing the ARTIC, Baker et al (2016) found the scales to have strong internal consistency. They demonstrated that internal consistency was excellent for the ARTIC-45 (α = .93) and ARTIC-35 (α = .91) and very good for the ARTIC-10 (α = .82). Additionally, they identified subscale alphas ranging from respectable to very good. A later validation of the ARTIC (Baker et al., 2021) found the same alpha scores for the ARTIC-45 and ARTIC-35. For the ARTIC-10 scale α = .81 was found, which represented a very good internal consistency reliability. Within this research, they specified that the Cronbach's alphas for the human services ranged from very good to excellent (ARTIC-45 α = .93, ARTIC-35 α = .93, ARTIC-10 α = .85). However, an evaluation of the Japanese version of the ARTIC-10 showed that it has modest internal consistency reliability of α = .56 (Kataoka et al., 2022). It was considered that 40% of respondents chose the midpoint for items and this may be reflective of cultural differences in Japan compared to Western Cultures.

4.2.1.2 Test-Retest reliability

Baker et al (2016) reported the ARTIC-35 and ARTIC-45 composites, the seven subscales, and the ARTIC-10 as having strong test-retest reliability. These scales were completed within a six-month period. For the ARTIC-45 they had a correlation of .84 at 120 days, .80 at 121–150 days, and .76 at 151–180 days. The ARTIC-35 and ARTIC-10 also demonstrated good temporal consistency, with correlations of .84 and .82, respectively, at 120 days, .75 and .73 at 121–150 days, and .77 and .65 at 151–180 days. No further studies examining test-retest reliability of the ARTIC scales were identified.

4.2.2. Validity

Raykov & Marcoulides (2011) highlight that it is crucial to consider whether an instrument is measuring what it intends to evaluate. Validity is an integrated evaluative judgement based on empirical evidence and theoretical rationales regarding the adequacy and appropriateness of inferences drawn from scores of the instrument (Messick, 1995).

4.2.2.1. Content Validity

Content validity is concerned with whether the psychometric measure covers all crucial and relevant aspects of the measured concept (Rubio, 2005). Principal components analysis (PCA) contributes to the understanding of content validity of a measure (Aladwani & Palvia, 2002). A PCA was conducted by Stokes et al (2020) for the ARTIC-35 scale. This identified a nine-factor solution. Within this, it was found that some factor loadings were similar to the ARTIC scale framework. However, other loadings were dissimilar and several items cross-loaded to different factors. For example, they found that five of the seven items in the subscale of underlying causes of problem behaviour loaded on factor 1, while one of the two remaining factors loaded only on factor 5 and the other loaded as a lone factor on factor 9. As the PCA did not provide a firm structure for the scale, Stokes et al (2020) went on to conduct an inter-item qualitative analysis of the scale. The inter-item qualitative analysis structure supported five factors/subscales with five to seven items in each subscale and three remaining outliers. It yielded almost identical categories to the proposed ARTIC-35 structure (Stokes et al., 2020). Due to the variations between the PCA and inter-item qualitative analysis it was deemed that the ARTIC-35 items may require further analysis and refinement.

To achieve content validity, it is crucial to have a clear and consistent definition of the construct (Haynes et al., 1995). Concerns have been identified regarding the lack of clear operational definitions of trauma-informed care (Hanson et al., 2018). As there is a lack of universal definition, organisations and practitioners create their own definitions (Menchuner & Maul, 2016). However, a general consensus of trauma-informed care is recognised to be frameworks, programs and organisations that wish to reflect their awareness of trauma and the actions they have taken to mitigate the impact of complex trauma within their domain (Hanson & Lang, 2016). The definition of trauma-informed care that is commonly drawn upon is that by the Substance Abuse and Mental Health Services Administration (SAMSHA). This definition outlines trauma-informed care as a programme, organisation, or system which realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks

to actively resist in re-traumatization (SAMSHA, 2014). The ARTIC's seven subscales represent the current thinking about important elements of trauma-informed care, including in healthcare settings (Abdoh et al., 2017).

The ARTIC scales were developed through building on a previous instrument, with the input of a team of experts in trauma-informed care, community mental health, study design and methodology, and utilised data from participant observations conducted within sites implementing trauma-informed care, and findings from a cognitive interviewing process with service providers (Baker et al., 2016). Additionally, a literature review of the theoretical, empirical, and measurement literature relevant to trauma-informed care, with an emphasis on what works and what is considered foundational to the field was considered in the development of the ARTIC scales. It is evident that significant efforts were made to consider all aspects relevant to trauma-informed care in the development of the ARTIC scales.

Despite this, it is noted that the ARTIC scale fails to include the larger role of the organisation. It is recognised that the adoption of trauma-informed care is a culture change, and it must factor in the complexities of the organisation, and it does not appear that the ARTIC does this (Thirkle, 2021). It has been argued that measures of trauma-informed care do not examine structural factors, such as inequalities that impact on people's lives including racism and poverty (Wathen et al., 2023). However, it is recognised that the ARTIC scale focuses on the individual-level knowledge rather than claiming to incorporate the wider system and organisational role.

4.2.2.2. Construct-Related Validity

Construct-related validity is the degree to which explanatory concepts or constructs account for performance on an instrument under consideration, and whether its scores are indicative of behaviour that integrates well with the theory (Raykov & Marculides, 2011). A typical way to establish construct validity is through factor analysis. This helps to determine whether each scale contributes to the scale outcome or whether there are other factors that contribute to the outcome (Kline, 2000).

A confirmatory factor analysis was conducted by Mendez et al (2023). The results from this suggested a good fit with a chi-square of $x^2 = 2761.62$. However, the root mean square error of approximation (RMSEA) (0.07 [0.07, 0.08]) and the confirmatory factor index (CFI) (0.72) indicated a poor model fit. An exploratory factor analysis (EFA) using maximum likelihood estimation was conducted to assess the number of distinct ARTIC-45 factors in their sample of individuals working to provide services to substance-using parents. This indicated potentially ten factors for their data. A forced factor EFA was also conducted. The results from both EFAs suggested a unidimensional factor structure as 40-43 of the 45 items loaded at 0.3 or greater onto factor 1. A qualitative inter-item analysis of factors was conducted resulting in nine factors, with these having some similar and differing themes from the original ARTIC. It was identified by Mendez et al (2023) that their analyses indicated that the ARTIC-45's seven factors and corresponding items did not fit with their population of staff. They considered that the measurement of trauma-informed care attitudes and beliefs may vary according to the field of practice and ethno-racially diverse workers, as well as that the ARTIC scales may not be accurately measuring trauma-informed care attitudes among all populations. This is complicated by that a diverse workforce was not represented in the sample group for the development of the ARTIC scales. The participants in the development sample were mostly female (83%), white (92%) and highly educated (96%) (Baker et al., 2016).

Similar concerns of the applicability of the ARTIC scales to different populations has been raised. Stokes et al (2022) discussed that for nurses, they may have a particular lens that results in them perceiving and interpreting items slightly differently to other mental health and human service workers. They outlined that the current version needs revision for use with nurses. Similarly, it is argued that the perception of trauma-informed care embedded in the ARTIC scales is influenced by the medical model (Keesler et al., 2024). Within intellectual and developmental disability services, there is a focus on boundary setting and professional relationships with clients (Keesler et al., 2024). Such a stance appears to be in contrast with the ARTICs operationalisation of trauma-informed care. This is evident in the 'responses to problem behaviour and symptoms' subscale which

prioritises relationships, flexibility, kindness and safety placing these in contrast to rules, consequences, and accountability.

Within forensic services, where there can be a high risk of violence, there is a need for clear rules, consequences, and accountability to manage this risk of violence and re-offending. Forensic nurses identified that being firm, setting limits and defining boundaries were their main strengths and skills (Bowen & Mason, 2012). Forensic mental health services are characterised by a high level of security (Carroll et al., 2004). Similarly, within prisons there is a balance of managing safety, security, and rehabilitative support, which is based upon officers maintaining control and trust, and promoting boundaries to ensure the peaceful co-existence of people with very complex lives and needs (Bosworth & Ashcroft, 2022). It is considered that the complexity of managing risk and promoting rehabilitation, which is vital in forensic services, is not acknowledged within the ARTIC scales.

It is argued that culture is complex and so is the facilitation and evaluation of trauma-informed care (Zakszeski et al., 2017). To evaluate and monitor the implementation of trauma-informed care, these complexities must be acknowledged (Thirkle et al., 2021). The application of instruments measuring trauma-informed care likely requires customisation, as the meaning of words varies across cultures and the instrument may not retain its meaning across cultures if it is non-specific (Bassuk et al., 2017). Yet, it is still considered that instruments that are easily modifiable to accommodate different contexts are seen to be favourable (Thirkle et al., 2021). Richardson et al (2012) discussed that among different contexts, the path to change may be different but the ultimate destination looks very similar for every site. This means that processes may vary according to context, but the outcome measurement, and the purpose of the instrument being developed, will remain constant regardless of context. This may be reflective of services that are working towards being trauma-informed will be working towards similar core values so hope for the same outcome.

The complexities of the contrasting elements within the ARTIC that should indicate favourable trauma-informed care attitudes and unfavourable trauma-informed care

attitudes has been identified. Stokes et al (2020) discussed that the 'bipolar Likert scales' of the ARTIC scales often overlap in meaning and can be viewed as congruent statements. Double-barrelled statements were also noted which could create confusion over which element of the question to answer.

4.2.2.3. Concurrent Validity

Concurrent validity is assessed by considering the extent to which a measure correlates with other validated measures assessing the same construct at the same time (Kline, 1998). Using data from staff working in services with intellectual and developmental disorders, Keesler et al (2024) examined correlations between the ARTIC-10 scale with other measures. Their analyses supported the concurrent validity of the trauma-informed climate scale (TICS-10: Kusmaul et al., 2015) and the ARTIC-10. This reflects the relationship between organizational environment (i.e., TICS-10) and staff attitudes (i.e., ARTIC-10) associated with trauma-informed care.

Additionally, Keesler et al (2024) found a positive, but weak, relationship between the ARTIC-10 with the professional quality of life (ProQOL: Stamm, 2010) subdomain of compassion satisfaction (r = 0.18, p < .01), and an inverse relationship with the subdomains of secondary traumatic stress (r = -0.20, p < .01), and burnout (r = -0.20). Further concurrent validity was identified when the Japanese ARTIC-10 was compared with five other scales associated with attitudes related to trauma-informed care (Kataoka et al., 2022). The total score of the ARTIC-10 scale positively correlated with the Japanese Version of the Moral Sensitivity Questionnaire 2018 (J-MSQ 2018; Maeda et al., 2019), and negatively correlated with the stress underestimation beliefs (SUB; Izawa et al., 2013), the Negative Acts Questionnaire-Revised (NAQ-R; Tsuno et al., 2010), the Patient Health Questionnaire-9 (PHQ-9; Muramatsu et al., 2007), and the Generalized Anxiety Disorder-7 (GAD-7; Muramatsu et al., 2009). These results were concordant with the study hypotheses.

In the development study for the ARTIC scales, it was identified that the scores varied slightly by demographic characteristics, including that female, racial/ethnic majority, better educated and more experienced participants and those that had less face-to-face

contact with clients had more favourable trauma-informed care ARTIC scores (Baker et al., 2016). Furthermore, the ARTIC-45 composite scores were strongly related to personal familiarity with trauma-informed care (r = .34– .45) with the ARTIC-35 and ARTIC-10 showed similar patterns. Surprisingly, feelings of support at the workplace were not related to scores on the ARTIC-35 and ARTIC-10.

Among the research conducted in forensic services, relationships between the ARTIC scores and other factors were noted. Ford et al's (2017) study on the impact of trauma-informed training in policing teams found that scores on the ARTIC-35 were significantly higher following training. In addition, post-training they found an increased confidence in responding to vulnerable people, using professional judgement, and understanding of ACEs and ACE-informed approaches. Similarly, Glendinning et al (2021) found increased scores on both the ARTIC-45 and in surveys measuring YOT workers' confidence in working with children who have adverse childhood experiences. This demonstrates that increased favourable trauma-informed scores on the ARTIC scales have been associated with increased confidence in responding to different client presentations and understanding of trauma-informed approaches. The ECM evaluation by Opinion Research Services (2023) observed average scores of 6.15 across all dimensions on the ARTIC-45, as well as perceived improvements in a range of psychosocial outcomes, and positive gains in emotional wellbeing and development for the children supported by the ECM.

As noted previously, it has been found that female police officers held more favourable trauma-informed care scores on the ARTIC-45 (Ford et al., 2017; Brodie et al., 2023). Also, Brodie et al (2023) found that age (p=.047) and years served as a police officer (p = .018) were positively correlated with trauma-informed attitudes (as measured by the ARTIC-35) towards suspects/perpetrators but not towards victims/witnesses. It was considered that this was to be expected due to the police forces focus on protecting and improving the safety of their local communities (Brodie et al., 2023). Additionally, it was noted there is a significant focus on the trauma-informed police interactions with victims in the literature (Rich, 2019). Similarly, McKinsey et al (2024) found that ARTIC scores for judges working in juvenile justice were significantly and positively correlated with all types of

trauma-informed practice, whereas for non-juvenile justice judges their ARTIC scores were only significantly and positively correlated with the communication/demeanour trauma-informed practice. It was found that judges working in juvenile justice reported more favourable attitudes towards trauma-informed care than non-juvenile justice judges. This likely reflects that much of the literature on trauma-informed care in courts is focused on juvenile justice (Branson et al., 2017; Ezell et al., 2018).

4.2.3. Other trauma-informed care psychometrics

As trauma-informed care is in its infancy, there are few instruments to evaluate its implementation (Berger, 2019). A review by Thirkle et al (2021) of instruments for exploring trauma-informed care identified the key instruments as Attitudes Relating to Trauma-informed Care (ARTIC) (Baker et al., 2016), the TICOMETER (Bassuk et al., 2017), the Trauma-informed Practice Scales (TIP Scales) (Goodman et al., 2016), and the Trauma-Informed System Change Instrument (TISCI) (Richardson et al., 2012). This was because these four instruments have substantial research into their development, whereas many others did not and lacked accompanying background information. The most commonly used measure to collect data was the ARTIC (most often the ARTIC-35; Baker et al., 2016). It was identified that the domains of the four identified key instruments all share similarities in that they are all derived from trauma-informed care. Also, they all reflect the domains provided by creating cultures of trauma-informed care (Fallot & Harris, 2009), which are: 1. safety, 2. trustworthiness, 3. choice, 4. collaboration, 5. empowerment, and 6. trauma screening process.

The TICOMETER (Bassuk et al., 2017) measures trauma-informed care in health and human service organisations. It was developed to determine the staffs' perceptions of the degree to which trauma-informed care has been implemented. It utilises the entire organisation to gather data. It has five essential trauma-informed domains: 1) building trauma-informed knowledge and skills, 2) establishing trusting relationships, 3) respective service users, 4) fostering trauma-informed service delivery and 5) promoting trauma-informed policies and procedures.

The Trauma-Informed Practice scales (TIP scales; Goodman et al., 2016) was developed for utilisation in programs for victims of domestic violence. Whilst the Trauma-Informed System Change Instrument (TISCI; Richardson et al., 2021) was created for use within child welfare systems. Therefore, both measures are context dependant and are not relevant to the application within forensic settings.

The Trauma-Informed Climate Scale (TICS) measures staff perceptions of the service environment and practices (Kasmaul et al., 2015). This is assessed across five subscales of safety, trustworthiness, choice, collaboration, and empowerment, which represent principles of trauma-informed care. Response options are based on a 5-point Likert scale. Higher scores reflect greater organizational alignment with trauma-informed care as perceived by the staff. The original measure includes 34 items. A shorter version, the TICS-10, has been developed (Hales et al., 2019). Confirmatory factor analyses support the scale's construct validity and reliability (α = .91) (Hales et al., 2019).

The reliability for the trauma-informed care scales are presented below in table 7. This indicates that the scale for with the highest internal consistency is the ARTIC-45. The scale with the highest internal consistency is the TICOMETER.

Table 7: Reliability for trauma-informed care scales

Scale	Internal consistency (α)	Test-Retest correlations
ARTIC-45 (Baker et al., 2016)	.93	.84
ARTIC-35 (Baker et al., 2016)	.91	-
ARTIC-10 (Baker et al., 2016)	.82	-
TICOMETER (Bassuk et al., 2017)	.92	.90
TICS-10 (Hales et al., 2019)	.91	-

4.2.4. Additional Considerations

It is recognised that traumatic experiences can have long-lasting negative effects on individuals and organisations, and if not addressed it can create unsafe cultures with constant arousal, untrusting relationships, and the use of coercive measures (Berring et al., 2024). This is significant given that trauma-informed care is based on an

organisational approach. Therefore, due to the impact of the organisational culture and context, it is essential to consider the application of the ARTIC scales to forensic settings and organisations.

For individuals working within secure forensic services there are additional risks of violence and exposure to trauma. Correctional officers experience hazardous environments that place them at heightened risk for exposure to vicarious trauma as well as being subject to direct trauma (Ferdik & Smith, 2017). Also, professionals working in forensic mental health settings are at a heightened risk of vicarious trauma due to being exposed to traumatised patients and distressing material (Newman et al., 2024). It is acknowledged that those working in the forensic subfields may be even more susceptible than professionals working in other fields to developing problems associated with vicarious trauma, compassion fatigue, and burnout given the intensive nature of their work (Pierelli et al., 2020). Additionally, residents of custodial settings experience disproportionately more trauma in comparison to noncustodial populations (Liu et al., 2021). When considering the applications of frameworks, such as trauma-informed care, to forensic services it is essential to acknowledge and respond to the atypical work environment.

Due to such an atypical work environment, correctional officers are identified as a more cynical occupational group due to feeling under threat (Ferdik & Smith, 2017). This is likely to impact on their willingness to accept the implementation of trauma-informed care, and their attitudes towards trauma-informed care. This highlights that the context in which an intervention takes place is intertwined with its implementation and thus its effectiveness (Damschroder et al., 2009). The consolidated framework for implementation research (CFIR; Damschroder et al., 2009) discusses core domains relevant to context in intervention implementation. It identifies that the outer setting includes the economic, political and social context of the organisation. Whilst the inner setting is the cultural, structural, and political context within the organisation. For individuals working with people who have committed offences and that are subject to restrictive conditions, there is likely to be hesitancy towards adopting a trauma-informed approach due to the political and social context of forensic settings. It could be argued

that within the ARTIC-10 and ARTIC-35 there is a lack of significant acknowledgement of organisational culture and context given it is a significant factor impacting intervention implementation.

4.3. Conclusion

This critique evaluated the psychometric properties of the ARTIC scales, with consideration of its application to forensic settings. Research utilising the ARTIC scales within forensic settings is limited, so psychometric evaluations that occurred in other settings were drawn upon. Evaluations of the psychometric properties of the ARTIC scales conducted by the developers (Baker et al., 2016; Baker et al., 2021) demonstrate good psychometric properties. This includes strong internal consistency and test-retest reliability. Additionally, it is evident that significant efforts were made to consider all aspects relevant to trauma-informed care in the development of the ARTIC scales. The ARTIC's seven subscales represent the current thinking about important elements of trauma-informed care, including in healthcare settings (Abdoh et al., 2017).

The psychometric properties of the ARTIC scale when applied to different populations than those utilised in the development were considered. Modest internal consistency was identified for the Japanese version of the ARTIC-10 applied to physicians and nurses (Kataoka et al., 2022). An inter-item qualitative analysis structure supported the five factors and yielded almost identical categories proposed by the ARTIC-35 structure (Stokes et al., 2020). However, due to the variations between the PCA and inter-item qualitative analysis, it was deemed that the ARTIC-35 items likely require further refinement. Further analyses identified concurrent validity between the ARTIC-10 and other relevant measures of trauma-informed care (Keesler et al., 2024). Furthermore, research conducted in forensic services highlighted relationships between the ARTIC scores and other relevant factors.

The findings discussed demonstrate challenges with applying the ARTIC scales across settings and populations. This reflects the argument that trauma-informed care is not a 'one size fits all' (Walker et al., 2021). It is suggested that measuring trauma-informed care attitudes and beliefs likely varies due to the workforce and professional field (Mendez et al., 2023). It was noted that professional identities and perspectives may

influence the interpretation of items on the ARTIC scales (Stokes et al., 2023; Mendez et al., 2023; Keesler et al., 2024). Additionally, the political, social, and cultural context of intervention implementation is crucial (Damschroder et al., 2009). This is important as forensic services have an atypical environment that is characterised by incidents that might create trauma, as well as heighten risk for vicarious trauma. When applying the ARTIC scales to forensic settings, it will be crucial to acknowledge and appreciate the context further. This should include a recognition of the high levels of trauma that staff members experiences, as well as the balance of risk and rehabilitation, therefore the need to balance control, boundaries and professional relationships with trauma-informed care. It is noted that the adaption of the trauma-informed care approach to fit specific settings can be an advantage of its broad and holistic approach (Berring et al., 2024). A review identified a need for a simplistic and unanimous approach to implementing trauma-informed care, as well as taking into account the organisational context (Berring et al., 2024).

It appears that the ARTIC scales provide a simplistic psychometric measure of staff members' attitudes towards trauma informed care. This could be considered beneficial as it is created on the foundational elements of trauma-informed care, such as the core elements identified by SAMSHA (2014). These should be applied across different settings and populations. However, the various factors specific to the different participant groups is overlooked. Further research is required on the implementation of trauma-informed care in forensic services to inform the evidence base and development of psychometric measures further. It is recommended that amendments are made to the ARTIC scales to make it more applicable to forensic settings. This would include considering what trauma-informed care would and should present like within these settings, considering the high levels of risk management processes and boundaries in place. Such amendments require an appreciation of the professional perspectives that may be present with such settings. Additionally, as suggested by Stokes et al., (2020), the bipolar Likert scales should be reconstructed to be clear opposites with no double topics included. The ARTIC scale should be applied with caution to forensic settings.

This psychometric critique contributed to the thesis aim of developing understanding of the application of trauma-informed care to forensic services. It provided insight into the difficulties of applying general trauma-informed care principles, and measures, to forensic services. This is due to the unique demands and presentations of these services. A particular element that is significant to applying trauma-informed care to forensic services, is the appreciation and integration of risk management. It is evident that further appreciation of the key characteristics of forensic services and their role, along with the application of trauma-informed care in these settings is required. Amendments to trauma-informed care scales to incorporate concepts relevant to trauma-informed care in forensic services will be of benefit. This would allow for such measures of trauma-informed care in forensic services to be researched.

Chapter Five: A Comparison of Trauma-Informed Care Attitudes at a PIPE and a Non-PIPE Approved Premises, with Exploration of Staff and Residents' Experiences

Abstract

The purpose of this study was to compare the trauma-informed care attitudes, and experiences, of staff at a Psychologically Informed Planned Environment (PIPE), and a non-PIPE, approved premises with consideration of residents' experiences. The ARTIC-35 (Baker et al., 2016) was utilised to explore and compare attitudes towards trauma-informed care among staff members at a PIPE and a non-PIPE approved premises. Eleven PIPE staff members, and nine non-PIPE staff members completed the ARTIC-35 scale. To gain insight into the application of trauma-informed care in practice, semi-structured interviews took place among staff and residents at the approved premises sites. Interviews were conducted with five PIPE staff members, six non-PIPE staff members, six PIPE residents, and five non-PIPE residents. The interviews were transcribed verbatim and analysed using interpretative phenomenological analysis. The findings of the ARTIC-35 indicated that staff at both sites held more favourable trauma-informed attitudes, than unfavourable trauma-informed attitudes. The PIPE staff members had statistically significant higher scores on the self-efficacy subscale than the non-PIPE staff members. There were not statistically significant differences across the other subscales of the ARTIC-35. From the interviews, three themes were identified. These were 'staff trying their best', 'resident needs', and 'the approved premise environment and culture'. Limitations of the study included the subjective approaches adopted, which may have given rise to socially desirable responses. This study highlighted the good practice of building therapeutic working relationships between staff and residents in approved premises, which was fostered on understanding residents' needs and the impact of imprisonment, and adopting a holistic approach to risk management. The difficulties with managing the complex presentations of the residents for the non-PIPE staff with limited organisational support was indicated. The clinical importance of a framework to assist the staff members in working with complex individuals when returning to the community is highlighted.

5.1. Introduction

When adopting a trauma-informed approach to forensic services, it is essential to consider all systemic factors around an individual's criminogenic behaviour (Rowles & McCartan, 2019). This is of further significance given that the implementation of trauma-informed care is an organisational and systemic endeavour. Trauma-informed organisations integrate understanding of trauma, and trauma-informed care, into their policies, practices, and procedures, with the goal of avoiding re-traumatisation (Robey et al., 2020). The transformational change required for trauma-informed care can be challenging as there are deeply held beliefs (Sundborg, 2019). These beliefs and the culture of forensic services can present challenges to the application of trauma-informed care. Often relationships in such settings are based upon control and security (Jewkes et al., 2019). This likely contributes to there being a climate of fear, mistrust and negative attitudes within forensic settings, heightened by these settings inherently having punishment at its core (Crole-Rees, 2019). It is evident that these contributory factors to the culture in forensic settings is not conducive to trauma-informed care.

The Offender Personality Disorder (OPD) pathway represents an organisational shift to embedding a psychologically informed approach, and trauma-informed care, to meet the needs of individuals with personality difficulties in forensic services. A holistic approach, that incorporates trauma-informed approaches, with a focus on relationship building, and workforce development is adopted by the OPD pathway (Skett & Lewis, 2019). In the national evaluation of the OPD pathway, the key underpinnings to the therapeutic work were identified as a focus on relationships, a focus on mental health, trying less punitive approaches, instilling hope and building trust, and creating a safe environment (Moran et al., 2022). This represents a stark contrast to the factors that contribute to the culture outlined above. To assist with creating a different culture in forensic services, is Psychologically Informed Planned Environments (PIPEs) which are situated within the OPD pathway. A key aspect of PIPEs is a change in the attitudes and cultures among the staff and residents to create a therapeutic setting (Benefield et al., 2018). PIPEs are residential settings characterised by specific environmental principles that aim to enhance outcomes of risk reduction, improving wellbeing, and promoting desistance (Greenacre, 2019). Through the range of services, and the culture adopted, the OPD

pathway provides enabling, compassionate, healthy transitions (Logan & Ramsden, 2015).

The transition from custody to community can be a time of increased risk of re-offending, with this being particularly problematic for those experiencing complex needs (O'Meara et al., 2019). When individuals transition from prison to the community, particularly approved premises, they may feel a sense of control being exerted over them, as well as physical and structural barriers (Shingler & Stickney, 2023). In addition to these barriers, individuals that have spent a significant period of time in prison may lack effective coping strategies. This is complicated by the coping styles that have been developed for survival whilst incarcerated that may be harmful and not sustainable (Crewe, 2024). Upon release individuals may present with institutionalised personality traits, social-sensory deprivation, and temporal and social alienation (Liem & Kunst, 2013). It is evident that individuals transitioning from prison to the community will require support to achieve effective re-integration and continuation of rehabilitation. There is a need to consider the psychological needs, as well as risk management.

Individuals that are deemed as a high or very high risk for serious harm are often placed in approved premises when released from prison. Approved premises have an essential role in supporting to help rehabilitate individuals and protecting the public within the individual's first few months in the community following a prison sentence (HM Inspectorate of Probation, 2017). Across different approved premises, there are stark differences in the relationships of staff and residents (Doggett, 2017). Variations in policies and practices across approved premises have been identified as having a significant role in relationships and transitions (Irwin-Rogers, 2017). Within approved premises, knowledge of residents has been demonstrated to allow staff to be able to notice changes in behaviour and presentation that could reflect a change in risk level (Cherry & Cheston, 2006). There is a recognition that therapeutic and supportive relationships between staff and residents of approved premises have the ability to assist with transitions to the community, as well as with risk management. Desistance and rehabilitation can be achieved within approved premises through the connections created (Reeves & Marston, 2023). Positively, probation practice has evolved to

incorporate psychologically informed approaches and environments, including responding to personality difficulties and having an understanding of trauma (Burke et al., 2022).

An increasing challenge of working within approved premises is the complex presentation of residents with personality difficulties (Beetles et al., 2016). With consideration of this challenge, and the need to provide these individuals a pathway through custody to the community, the PIPE model has been applied to approved premises. PIPE approved premises provide expert psychological input from NHS clinicians and provide support to manage individuals with suspected personality difficulties. The PIPE staff teams are provided with additional training to assist them with developing psychological understanding of the service users (Bennett, 2017). Without this psychological understanding, negative attitudes to personality difficulties can create divisions within teams leading to staff using punitive management strategies (Shaw et al., 2011). It is considered that pro-social and motivational regimes within approved premises will enhance public protection, and rehabilitative work should be valued as an integral part (Cherry & Cheston, 2006). Decreased rates of recall have been found when the staff working in approved premises were provided with psychologically informed consultation (Clark & Chuan, 2016).

5.1.1. Aims

Despite the long-standing presence of approved premises, they are considered to be one of the least visible and least well-known areas of the criminal justice system (Reeves & Marston, 2023). In addition to this, there is an appreciation that little is known about the post release experiences for those released from prison (Youseff, 2023). Furthermore, there is limited research exploring the application of trauma-informed care in forensic services. To address some of this gap in the literature, this study compared the trauma-informed care attitudes, and experiences, of staff at a PIPE and a non-PIPE approved premises, with consideration of residents' experiences. The adoption of trauma-informed care approaches in forensic settings is considered through the PIPE model that has been applied at the approved premises.

5.2. Method

5.2.1. Participants

Participants were recruited from a PIPE approved premises and a non-PIPE approved premises. Both of the sites were run by the National Probation Service. The PIPE approved premises had NHS clinicians based there to provide psychological input, as well as staff receiving training and supervision. Both sites provided twelve-week placements for individuals with criminal histories, mainly those returning to the community from prison. A purposive sampling technique was utilised to recruit participants. All staff members at each site were invited to participate in the research. An email was circulated to the team to outline the aims, and procedures of the project, with an invitation to participate. Eleven staff members from the PIPE approved premise, and nine staff members from the non-PIPE approved premises completed the ARTIC-35. Five staff members from the PIPE approved premises, and six staff members from the non-PIPE staff members participated in an interview. Resident participants were recruited through community meetings. To participate in the research, they had to screen into the OPD pathway and have resided at the approved premises for at least 4 weeks. All participants were assured of anonymity and confidentiality, provided no individual was at risk of harm. From the PIPE approved premises, six residents participated in interviews. Five residents from the non-PIPE approved premises participated in interviews.

5.2.2 Procedure

A cross-sectional mixed methods approach was adopted. This study was provided sponsorship by the University of Nottingham. Ethical approval was provided by the NHS research ethics committee, as well as by HMPPS ethics committee. All staff members at the two approved premises sites were invited to complete the ARTIC-35 scale, as well as participate in an interview regarding their experience at the approved premise.

Interviews were conducted on an individual basis with staff members and residents from the two approved premises sites. These took place in person at the approved premises. Participants were provided with information sheets regarding the research and signed consent forms prior to participating. A protocol was developed for this study, to allow for a semi-structured interview. The questions provided opportunity for participants to

discuss their experiences and reflections on the approved premises. This included consideration of the key aspects of the service, elements that have been helpful to them, and challenges they have encountered at the approved premises. Each interview lasted approximately one hour. The interviews were audio-recorded and transcribed by the researcher.

The ARTIC-35 was analysed through identifying the mean scores for each subscale, and an overall mean score for each site. These were analysed through a *t*-test. For the interviews, the researcher conducted a comparative thematic analysis. The steps for thematic analysis outlined by Braun & Clark (2006) were followed. This included familiarization with the data, generating initial codes for each interview, searching for themes, reviewing themes, and defining and refining themes. This was conducted for each subgroup of participants, PIPE staff, PIPE residents, non-PIPE staff, and non-PIPE residents. Through this, themes were identified for each of the subgroups of the participants. Following this, a comparison across themes was conducted which included exploration of similarities and differences within the presenting themes. Additionally, this study adopted a comparative approach across the quantitative and qualitative aspects. Through this the staffs' attitudes towards trauma-informed care, and the shared experiences and discrepancies within their perspectives and experiences could be explored.

5.2.3. The Attitudes Related to Trauma-Informed Care (ARTIC) scale

The ARTIC scale assesses professionals' attitudes that are relevant to trauma-informed care. It has five core subscales of: underlying causes of problem behaviours and symptoms; responses to problem behaviour and symptoms; on the job behaviour; self-efficacy at work; and reactions to the work (Baker et al., 2016). The ARTIC-35 was utilised as it is designed for use in settings that have not begun implementation of trauma-informed care. This includes 35 items. Each item has opposing statements of a favourable attitude towards trauma-informed care and a statement representing the opposite attitude. It is a self-report measure, with participants scoring their agreement to the statements on a 7-point bipolar Likert scale. The scores are calculated, with a mean

being scored, to determine the participants' average attitude toward trauma-informed care. A higher score represents a more favourable attitude toward trauma-informed care.

5.3. Findings

5.3.1. Quantitative Findings

It is observed that the ARTIC-35 mean scores were slightly higher for the PIPE staff overall, as well as for the subscales of underlying causes of problem behaviours and symptoms, response to problem behaviours and symptoms, self-efficacy at work, and reactions to the work. The non-PIPE mean for the ARTIC-35 subscale of on the job behaviour was higher than the PIPE staff mean. The differences in the means were not statistically significant, except for the subscale of self-efficacy at work. However, accounting for six statistical comparisons, the Bonferroni correction suggests a cut-off point of 0.008. Therefore, the application of Bonferroni correction results in the self-efficacy subscale being non-significant.

Table 8: Mean ARTIC scores and t-test results of the ARTIC-35 scale

	Underlying causes of problem behaviours and symptoms		Response to problem behaviours and symptoms		On the job behaviour		Self-efficacy at work		Reactions to the work		Overall scale	
	PIPE	Non-PIPE	PIPE	Non-PIPE	PIPE	Non-PIPE	PIPE	Non-PIPE	PIPE	Non-PIPE	PIPE	Non-PIPE
Mean	4.27	4.32	4.75	4.63	5.20	5.46	5.50	4.92	5.32	4.93	5.01	4.85
SD	1.01	0.502	1.14	0.821	0.67	0.30	0.77	0.42	0.89	0.41	0.73	0.21
One sided *p*	0.449		0.402		0.148		0.028		0.122		0.258	
t	-0.131		0.252		-1.075		2.04		1.204		0.669	

Higher scores reflect more favourable trauma-informed attitudes

5.3.2. Qualitative Findings

The themes for each subgroup of participants, which are PIPE staff, PIPE residents, non-PIPE staff, and non-PIPE residents, are presented. The similarities and differences within the themes that emerged for the groups will then be discussed.

Note: NPS = non-PIPE staff; NPR = non-PIPE resident; PS = PIPE staff; PR = PIPE resident.

5.3.2.1. PIPE staff themes

1. **Working at a higher level through the PIPE model**

The PIPE model provided a structure to the work that the staff team were already completing. This encouraged feelings of enhancing their previous work and allow them to perform to a better standard:

> ‘before it became a PIPE, you would do some of the things that we're doing now, but I think now we'll do it in a better way, more professional way, and with the skills that you're getting from training and stuff, you really perform a good job. You know at a higher level than before’ (PS4)

> ‘We’re supporting them, going out with them now. We do more activities with them. […] We definitely get more input from the psychology side’ (PS1)

Being able to receive guidance from the PIPE psychologist through informal means, individual supervision, or group supervision provided an important element of confidence for staff members:

> 'We've been given some sort of ideas about how we manage with people. So, it could be certain words to use, certain prompts, buzzwords, to help people and again we have supervision with (the PIPE psychologist) on a one to one. We have groups supervision […] I always find that (the PIPE psychologist) has got an answer’ (PS2)

Additional confidence was provided to the PIPE staff through contact with wider agencies. They illustrated appreciation of being able to access emotional support and guidance for the residents. PS1 describes that:

> ‘we have a mental health nurse that comes in once a week and also got (the psychology team). Sometimes we have had a bit of a bad night, and you know say it might be helpful if you had a chat to so and so, he was a bit upset last night’.

The PIPE staff narratives indicated that the PIPE model, as well as connections with other agencies allowed the PIPE staff to feel competent supporting the residents of the approved premises.

2. **The needs of the residents and the PIPE approved premises role**

Within the PIPE staff narratives, they placed importance on recognising the experiences and needs of the residents of the approved premises. The impact of imprisonment on the residents was particularly noted:

> '(residents) had a bit of a bad show in prison' (PS2)

> 'prison is incredibly disempowering' (PS3)

The PIPE staff identified that through being at the approved premises it allowed the residents the opportunity to realise that 'they can also contribute to their life in the community when they go back' (PS4). For the PIPE staff, they emphasised the importance of taking an individualised approach to the residents:

> "It can vary from resident to resident. It's different needs for different people" (PS2)

> "Looking at ways we might work with a particular individual, if there are any adjustments we can make" (PS5).

The PIPE staff had a focus on providing individualised opportunities for the residents that would assist them in their lives, despite their life histories. This seemed to reflect the ability to look and plan into the residents' future with hope by the PIPE staff.

3. **The careful balance of the PIPE model and risk management**

The PIPE staff presented with a desire to highlight that they remained aware of risk. There was an indication that incorporating risk management into the PIPE model did occur but could be challenging. PS1 reflected on the mental health focus:

> 'It is important to address it. Sometimes everything seems to be focused on that and not risk. But I think if their mental health is poor, there risk is going to increase, so is it important. It used to be much more about monitoring them'

This signifies an element of uncomfortableness with the PIPE approach in regards to risk management. However, the beneficial impact of the holistic approach for risk management was emphasised:

> 'Risk management is at the root of it, seeing someone as a whole person' (PS3)

> ‘There is so much more to a person than their offence. […] We are conscious of what they’ve done and the risk associated with that but it is building on the parts of that person so that they identify more with that person that can integrate with society’ (PS5)

> ‘It's about changing that culture of probation is there to help you. The PIPE, in a sense is to help you get through things and get in the community and not offended again’ (PS2)

The PIPE staffs’ narratives signified that they were keen to demonstrate that although they had adopted to the PIPE model, they remained aware and responsive to the residents’ risks.

5.3.2.2. PIPE resident themes

1. **Adjustment from prison**

Among the PIPE residents, there was an appreciation of *“we’ve got a roof over our heads, we've got stuff to do”* (PR1). The approved premises provided the necessities for the first step into the community. The significant difference to prison was recognised:

> ‘It didn’t feel hostile. […] Coming out of prison, that quite a loud place. Coming here was very quiet. It was nice’ (PR3)

> ‘I certainly thought it would be busier, a lot less supportive, less friendly, to be honest a lot like prison’ (PS1)

The physical environment of the approved premises signalled a period of stability following release from prison. The residents reflected upon the impact that prison had on them:

> ‘Prison is quite traumatising […] so you don’t come out of prison the same as you went in. You do come out, I would say, a little bit more screwed up’ (PR4)

> ‘When you come out of jail, the world's changed. Instead of just thrusting you onto the world, it's working with you. When you’re coming back here, you’re readjusting to the world’ (PR6)

Imprisonment impacted on the PIPE residents' perception of their own abilities to cope in the community. The challenges of re-entering the community were appreciated. Residence at the approved premises appeared to provide psychological safety:

> 'it's a great deal of load off my mind, because I was worried about a lot of things, it's given me the opportunity to relax' (PR1)

> 'they're here to try and help you survive in society' (PR2)

The opportunity to 'relax' at the approved premises may indicate a period of adjustment of coming from the prison environment. Additionally, the approved premises seemed to have provided PIPE residents with hope that they would be able to cope in the community.

2. Valuing staff support

The PIPE residents reflected upon the relationships with staff. The residents seemed to trust the staff and viewed that they were able to understand and respond to their needs:

> 'personality traits and things are supported. It was one of the first things I was asked here. That was right off the bat, which was nice' (PR1)

> 'Staff will notice you are a little bit off and be a bit more curious, ask you questions and so on. [...] Knowing that support is there is normally enough, and I can go and get it' (PR3)

> 'I think several of the staff have been very understanding and helpful and that has been very much appreciated' (PR5)

It is highlighted that the PIPE residents experienced the staff as caring towards them. This allowed for the residents to experience containment and support from the staff which appeared to be appreciated. Staff support was especially valued by PIPE residents that had prior engagement with therapy:

> 'it's a bit like coming home for me. I'm used to doing therapies [...] here you have got a chance of being on the straight and narrow' (PR6)

> ‘Before I did therapy in prison, I was a closed down book. It is the opportunity in using skills I learned in prison. So, the staff here you can talk to any one of them’ (PR2)

The PIPE residents’ narratives indicated an experience of being understood and supported by the staff team. The opportunities to access support from the staff was appreciated by the PIPE residents.

3. Awareness of risk management and monitoring

An awareness of risk management was evident within the PIPE residents’ narratives. PR3 discussed how as soon as he walked into the approved premises ‘you notice the national probation service’ as well as noting that staff can ‘remove your bed’ and ‘feeling the threat of losing your place and getting recalled’. Being a national probation service may have represented a threat for PR3 and emphasise the control he remained under. Despite the awareness among the PIPE residents that the staff had a requirement to monitor the risk, it was felt that they wanted the residents to succeed in the approved premises and community:

> ‘It’s not just about our risk to the public. It's also making sure we're actually able to support ourselves’ (PR1)

> ‘There’s knowledge that you're not going to be just kicked out [...] you gotta do something a bit drastic to be kicked out. Its secure as long as you don’t mess up’. (PR2)

> ‘I don’t think it matters too much if you have a bit of a slip here. They’re not like going to throw you on your ear hole or send you back to jail. It's about whether you're willing to work with them’ (PR5)

The PIPE residents demonstrated a recognition that risk management and monitoring would be occurring, but also that they had a role in their future. Rather than working against the staff as they have risk management responsibilities, the residents showed a desire to work with the staff to achieve the best outcomes.

5.3.2.3. Non-PIPE staff themes

1. **Understanding of the residents**

The non-PIPE staff valued having an awareness of the needs of the residents and being able to support them. A key element was observing and understanding the residents' behaviours, noticing any changes and responding appropriately:

> 'sometimes you think 'oh that's unusual for you' and then you might just go and have a chat with them and say "everything alright?"' (NPS6)

> 'Trying to understand it rather than judging, well you can't judge behaviours at all here because there's always something behind it' (NPS2)

> 'Being open to having that conversation and understanding the people and their behaviours and they may be acting out in a way that's not necessarily the way they're feeling. Just sitting down and giving people some time, and having a conversation' (NPS3)

This appreciation of understanding and responding to behaviour presentations was likely enhanced by teams' acknowledgement of the impact of previous experiences that the residents had:

> 'I can see that people have to adapt and cope in various ways. It's very difficult family environments, care environments, prison environments' (NPS4)

> 'The majority of people that come from here have not always had positive life experiences' (NPS3)

They demonstrated a desire to be able to support the residents of the approved premises. This was approached through trying to understand the behaviours that the residents present with and acknowledging that these behaviours may be a result of previous challenging life experiences.

2. **Feeling 'unqualified'**

Among the non-PIPE staff members, they discussed not being qualified to manage complex resident presentations such as mental health and personality difficulties. This was illustrated by a challenging encounter that NPS3 recounted:

> ‘I always feel when it is complex mental health, it’s always the area I feel less confident in [...] I'm trying everything I know all my techniques I use to try and talk to someone, try and help calm them, whatever and nothing's really, I just feel like there's nothing more I can do. It becomes quite scary’

Further experiences of feeling incompetent and disappointment in their approaches not working were present:

> ‘sometimes I even think ‘have I said the right thing?’ have I just said something that's now going to make him go and do something worse or have I now planted a seed that he is now going to go away and think about and then that's going to escalate to something else’ (NPS5)

> ‘We can understand when somebody needs some help but we're not professionals. We do our absolute best [...] sometimes it feels like we bang our head against a brick wall because we just don't know what to do with them’ (NPS6)

The experiences of not being able to support complex residents was likely amplified by the lack of interaction with other agencies. Difficulties with accommodation and mental health provisions for the residents were raised:

> ‘there is just a lack of housing, especially for our guys who are high risk’ (NPS3)

> ‘mental health is extremely poor in getting those links in and getting support. You've got a battle and you get nowhere with it’ (NPS1)

The reference by non-PIPE staff members as ‘not professionals’ represents the lack of skills they view themselves as having in managing the complexity that they can be presented with. It is apparent that they can feel unable to help these residents and have a fear of escalating the situation. The lack of access to further services in wider society appeared to be significant to the non-PIPE team, likely due to feelings of not knowing what to do to support and manage residents’ needs.

3. **Supportive Risk Management**

There was a clear focus among the non-PIPE staff regarding their role in risk management. They clarified the distinction between their role and the role of the community probation officer:

> ‘Here I’m not managing their licence. I’m not in charge of that. So that’s an added bonus [...] makes my interaction with the guys a lot easier as well’ (NPS1)

> ‘What I view as the difficult decisions, come from the probation officer. So that doesn't then break down the relationship here’ (NPS5)

The non-PIPE had an appreciation that the decision making relevant to licence conditions were the responsibility of the community probation officer. This seemed to allow for positive working relationships with the residents to be fostered. Despite this, the non-PIPE staff remained aware of the focus on risk management. They noted the benefit of approaching risk management through a supportive approach:

> ‘The best way to protect the public is through knowing our residents, their triggers, their problems, their issues and what their risks are’ (NPS4)

> “Officially my key role would be managing risk [...] We are here ultimately to try and help these guys ... to just be a support I guess and try help them where we can” (NPS3)

The non-PIPE staff presented as confident in remaining aware of the risk management element of their role and balancing this with more supportive aspects.

5.3.2.4. Non-PIPE resident themes

1. **Approved Premises as a safety net**

A key aspect that emerged for the non-PIPE residents was the approved premises providing the opportunity to adjust when re-entering the community. They discussed that the approved premises is:

> ‘a good sort of stepping stone coming out of prison to the community’ (NPR2)

> ‘One of the main things it gives is a safety net’ (NPR3)

> ‘To be able to have the settling down period ready to be able to move on’ (NPR5)

These narratives reflect that the non-PIPE residents experienced the approved premises as being able to assist with managing the challenges of returning to the community. The approved premises being a safety net appeared to be enhanced by the support they received from the staff team. The residents discussed that they felt that the staff were supportive and non-judgemental which was of significance to them:

> ‘In prison you were just a number. Here, you’re a human being and be treated as such’ (NPR1)

> ‘I think it is just knowing that you’ve got the backing of the staff here. They don't seem to have any sort of judgement towards you, and that's made me feel very relaxed and at ease here’ (NPR2)

> ‘I feel like my key worker is on my side in the sense that she wants me to get through this, to just be able to go and get on with my life’ (NPR4)

> ‘If you're struggling and you need to talk with somebody there, there's always somebody’ (NPR5)

There seemed to be an element of residents trusting the staff and feeling cared for by them. The placement at the approved premises was recognised as providing a safety net, and this seemed to be increased through interactions with the staff team.

2. Perception of risk management

The central element and role of risk management at the approved premises was reflected upon within the non-PIPE residents’ narratives. NPR3 identified the main role of the approved premises as ‘risk control’. The awareness that information was fed back to probation and the challenges of this were considered by NPR2. He discussed that as staff ‘will write it all down’ he feels ‘pushed to do stuff’ such as attending the group when he does not want to. However, the interpretation of the control, and risk management varied among the residents, with some finding the control supportive:

> ‘It's more like having support from someone than someone coming round and checking to make sure you've done what you're supposed to do’ (NPR4)

> ‘Now I’ve got the safety measure in place that I know I'm on daily breathalysers now. Now I’ve have actually got it in control’ (NPR5)

‘They do anything to stop you getting recalled’ (NPR1)

It appeared that some residents felt that although the staff had a requirement to monitor the risk, they wanted the residents to succeed in the approved premises and in the community. There seemed to be a belief that staff would provide support rather than revert to a recall quickly. This belief and trust in staff is significant given the residents remained under licence conditions and likely reflected the positive working relationships that had been fostered in the approved premises.

3. Resident needs, and needing more

The ongoing varying needs of the non-PIPE residents were evident. This included recognition of the impact on prison:

> ‘Everyone should have their mental health discussed if they’ve been in prison for the time I'd be in prison’ (NPR3)

> ‘Being in prison for a few years, it does change the way you think’ (NPR4)

Many non-PIPE residents also reflected upon other life experiences that has impacted them:

> ‘My past is affecting my future [...] That is just a mask. That is something I put up as a barrier’ (NPR2)

> ‘I’ve been violent and that’s like it’s rooted in my childhood, and I can't, well I wasn’t able to process my emotions properly’ (NPR4)

> ‘The past, and the things that I’ve been through. I’ve never dealt with the problems, I just buried it into boxes and held onto it until it exploded’ (NPR1)

Residents at the non-PIPE approved premises discussed that they *“required counselling”* (NPR2) and that they needed support with *“Personality disorder, mental health, anything like that”* (NPR3). This represents that they felt a need for further emotional support that they were not currently receiving.

A further crucial aspect that was raised as an area that the non-PIPE residents needed further support with was securing accommodation. NPS2 explained how he felt he had been ‘left in a bit of limbo’ with regards to accommodation and moving on. Similarly,

NPR3 raised that ‘so many people have got housing issues’ at the approved premises. NP5 raised that he had significant challenges with accommodation and how he had been ‘hitting brick walls’.

This theme highlighted the ongoing vulnerabilities that the non-PIPE residents were experiencing. Of importance to them were being able to access ‘professional’ support with their emotional needs, as well as accessing accommodation.

5.3.2.5. Integration of themes

Throughout the themes that emerged for the subgroups of participants, there were similarities and differences in the perceived experiences. Across both the staff participant groups, emphasis was placed upon being able to understand and support the residents of the approved premises and this being a crucial aspect of their roles. However, a significant and apparent difference with the staff narratives, was the belief that they had in themselves in being able to support the residents. The PIPE staff presented with optimism regarding their work, which had been enhanced through the PIPE model, input from the psychology team and other agencies. This contrasted with the non-PIPE staffs’ experiences of feeling ‘unqualified’ when working with residents presenting with complex behaviours. It seemed that they felt they did not have the adequate skills, or the resources due to lack of connections with other agencies, to manage the residents’ needs. The non-PIPE staff narratives signify that there is a focus in getting people through their limited time at the approved premises and into the community as successfully as possible. For the PIPE staff, a greater focus on the approved premises providing ‘opportunities’ for the residents that would assist them in their lives were illustrated. This seemed to reflect the ability to look and plan further into the residents’ future with hope by the PIPE staff.

These experiences of the staff teams appeared to be reflected in the residents’ narratives. For both the PIPE residents and the non-PIPE residents, the support of the staff members at the approved premises was appreciated and vital in their perception of the approved premises as a positive place. This appeared to be particularly prominent for the PIPE residents, with the staff team providing containment and care towards the residents. The

therapeutic environment of the PIPE approved premises was important to PIPE residents that had previously engaged with therapy.

It was highlighted within the non-PIPE residents' narratives that the support of the staff was a crucial element in the approved premises being a 'safety net' for them. The non-PIPE residents highlighted that the environment of the approved premises gave them the opportunity to readjust to the community. This was also raised by the PIPE residents. The approved premises appeared to have provided psychological safety and security. The environment of the approved premises allowed for the residents at both sites to feel supported into the community.

A difference in the resident participants narratives, was the vulnerability expressed by the non-PIPE residents in terms of their recognition of their ongoing needs. The non-PIPE residents shared that their previous life experiences, including having been in prison, has an ongoing impact for them. It was expressed by the non-PIPE residents that they required further emotional support, as well as support with securing accommodation. These experiences likely reflect that the non-PIPE staff did not perceive themselves as equipped to support such needs with the residents.

The interpretation of risk management was present across all participants' narratives. It is considered that for the PIPE staff they felt they had to justify their way of working, and approach to risk management more than the non-PIPE staff. Both staff groups expressed the benefit of taking a supportive approach to risk management. They emphasised that taking a holistic approach, including having knowledge and understanding of the residents, improved risk management. It is noted that the non-PIPE staff presented as confident in remaining aware of the risk management element of their role and balancing this with more supportive aspects. This symbolises that having the PIPE model may place the staff under greater scrutiny by those outside of the approved premises for their way of working which appears to move away from traditional 'risk management' and control. Within both the PIPE residents and non-PIPE residents' narratives, they demonstrated an awareness of the approved premises role in risk management. The residents expressed

an acknowledgement of the control present, however they also felt that the PIPE staff wanted them to succeed.

5.4. Discussion

This study compared the trauma-informed care attitudes and experiences across a PIPE and a non-PIPE approved premises. The perspectives of both staff and service users were sought. The ARTIC-35 scores for staff members did not identify statistically significant differences between the PIPE and non-PIPE staff members. The subscale of self-efficacy at work produced a significant result prior to applying a Bonferroni correction. Following applying Bonferroni corrections, the self-efficacy scale did meet the threshold provided by the corrected significance value. Despite the lack of statistically significant results on the ARTIC-35, it was observed that the PIPE staff had a higher mean on the overall scale, response to problem behaviours and symptoms, self-efficacy at work, and reactions to the work. Whilst the mean for the subscale on the job behaviour was higher for the non-PIPE staff team. All mean scores were above 4.27. The overall mean score for the PIPE staff was 5.01 and 4.85 for the non-PIPE staff. It could be considered that there were moderately supportive attitudes towards trauma-informed care across both approved premises sites. These scores are discussed in relation to the themes from the interviews below.

A prominent aspect that emerged throughout the themes was the value placed on the relationships between the staff and residents of the approved premises. The staff highlighted the importance of having an understanding of the residents in order to support them. This appeared to be valued by the residents and there was an appreciation for the support provided by the staff teams. This reflects previous research that has emphasised the significant impact that professional relationships have in supporting resettlement (Shingler & Purvis, 2024). Through these positive professional relationships, psychological safety can be developed (Crole-Rees, 2023). An important aspect within the relationships, was an experience of investment in the residents from the staff. The importance of approved premises staff displaying commitment and motivation in their roles has been demonstrated in previous research, which was assisted by the positive and constructive climate on the approved premises (Irwin-Rogers, 2017). Additionally, as

demonstrated in research on a specialist psychological OPD unit, a sense of mattering can be developed through meaningful and trusting relationships in environments that are perceived as safe (Howard & Pope, 2019). Similarly, the evaluation of the male OPD pathway programme reflected that clients expressed an appreciation for the high level of support, being able to talk to staff, feeling respected and staff being attuned to their mood (Moran et al., 2022).

Throughout the narratives and the themes that emerged, there was an appreciation of the residents' previous experiences and the impact this may have on their needs and presentations. It appears that staff at both sites were attempting to view behaviours through a trauma lens. This was particularly evident through the acknowledgement of the impact of imprisonment on the residents. The ongoing impact of imprisonment was significant for the residents at both approved premises sites. This is in line with previous research that notes that the experience of prison can be deeply transformational (Hulley et al., 2016), and the incarceration experience is fundamental in understanding the experience of release (Visher & Travis, 2003). Having an awareness of the impact of imprisonment for the residents is essential in being able to support their resettlement into the community. This is due to life in the community being unfamiliar and uncertain when compared with prison, as well as the coping strategies required in prison are often the opposite of those required for successful navigation of community life (Shingler & Stickney, 2024).

There were differences in the staffs' experiences of being able to support and manage the complexity of the residents at the approved premises. The staff at the PIPE approved premises spoke highly of implementing the PIPE model. Through this, the staff were able to feel more confident and skilled in their work of supporting the residents. Central to this was having the psychology team available for guidance and supervision, having additional training, and having agency support. This was significantly different from the non-PIPE teams narratives regarding their ability to manage resident complexity. They presented a concern that they were not suitably qualified and would make situations worse. Such experiences of feeling unequipped, unprepared and under skilled to manage and deal with the complexities that men with personality difficulties in community

probation services has been found by Lad & Walker (2024). A perceived lack of skills and worry among staff at a lower level of seniority about capacity to work with trauma in forensic mental health services has also been identified, with it being suggested that psychological professionals assisting staff from other disciplines to integrate trauma-informed care skills would be beneficial (Seitandiouu et al., 2024). The benefits of psychological guidance and training in the staff members feeling capable and skilled to assist clients with trauma is evident. Previous research has demonstrated that staff in approved premises that have been trained in psychologically informed practice had higher levels of personal accomplishment (Bruce et al., 2017). The need for staff support to be embedded in service implementation and ongoing delivery, and the benefit in assisting staff to deliver high quality services and promote resilience has been outlined (McNaughton Nicholls et al, 2010). Specifically, it has been found among approved premises staff that reflective practice sessions allowed them to offload, share and develop practice, process emotions, and relieve pressures related to the work (Webster et al., 2020).

It appears that the personal accomplishment for the staff at the non-PIPE approved premises were further limited by the challenges they experienced in assisting residents with their mental health and accommodation issues due to societal limitations. When individuals return to the community from prison, there are multiple hurdles for them, and a crucial aspect of forensic services in the community is scaffolding agencies around the client (Orpwood & Ryan, 2022). These hurdles are likely enhanced by the wider political and social culture of underfunding in areas such as welfare support and housing (Cracknell & Flinterman, 2022). Such challenges created a feeling of isolation among the non-PIPE staff members in managing the complexities of their residents and needs, with it instead feeling that they had a ‘battle’ to get residents the support they require. This was also reflected among the non-PIPE residents who expressed that they required additional support with both their emotional needs and in securing accommodation. Whereas for the PIPE staff and residents, there seemed to be a sense of containment through the PIPE model, supervision, and the agency support. This reflects that to achieve sustainable change, staff need to be equipped with appropriate skills, as well as organisations need to embed changes in policies and strengthening relationships between organisations

(Benson et al., 2018). This would include formal requirements on other services to identify how they will assist the residents of approved premises (Reeves & Marston, 2023).

The approach taken within the approved premises sites and how this was experienced by the participants was highlighted. Interestingly, it appeared that this was similar across the PIPE and non-PIPE approved premises. The residents presented as grateful for the 'roof over their head' provided by the approved premises. They also reflected on the importance of the approved premises giving them an opportunity to resettle into the community at a good pace through the assistance of the staff at the approved premises. Staff presented with a similar perspective as the residents on this. It is noted that the transition to the community from prison can be incredibly overwhelming (Liem, 2016; Crewe, 2024). The process of slowing things down following release and creating psychological space through working relationships is crucial (Shingler & Stickney, 2024). This process of slowing down and containment through the relationships were evident in the narratives in this research. However, it seemed that for both set of residents, they experienced a sense of hope in being able to get to the community through residing at the approved premises. This element of the approved premises providing a sense of hope for residents is crucial as it is identified that holding on to hope for people can be key to success in the community (Maruna, 2001).

A challenge that appeared to be present for the PIPE staff was the adoption of the PIPE model and still being seen to be holding on to risk management. Through the PIPE staff narratives, it was evident that they were able to appreciate that a holistic approach to residents' needs would be beneficial to their risk management. It seemed that there was a concern about losing sight of this through the PIPE model. This was not evident for the non-PIPE staff who appeared capable in balancing of the risk management and holistic approach. It should be recognised that the work conducted by the different sites may have varied, contributing to the differing perspectives that emerged. Working with individuals with criminal histories can present a range of contradictions for staff such as meeting high level needs and managing high levels of risk (Fellowes, 2018). There can be an element of staff needing to negotiate anxious organisational cultures that find holding

both elements of this work difficult (Fellowes, 2018). This appeared to be present for the PIPE staff who seemed to show a greater need to prove they remained aware of risk than their non-PIPE colleagues, as they may be considered to be working in a different style than traditional risk management. Such experiences have been found among probation officers trained in the OPD pathway by Ramsden et al (2016). They found that staff felt compromised and isolated by working in a different way, which could be uncomfortable for the staff. There was a tension around the potential for the project to detract from risk management and public protection and to impact negatively on their role identity.

The manner in which the staff members worked with the residents to manage their risk of offending were highlighted. It appeared that through taking a supportive approach this allowed residents to feel hopeful and able to cope in the community and overcome feelings of being controlled. The residents remained aware that they were under licence and noted the impact this had on a sense of control over them. For individuals under licence, they are aware of the potential for recall, and this can create feelings of powerless, uncertainty, and an absence of safety and scrutiny (Purvis & Devine, 2024). However, it appeared that through the relational approach adopted, a sense of safety, security and support in risk management was present. This reflects a psychologically healthier environment that was sensitive to the residents' adverse life experiences, where staff work to be compassionate, transparent, and cooperative (Hocken et al., 2022). The service acting as a 'container' of risk and associated anxiety has been noted to be crucial (Orpwood & Ryan, 2022). People need a supportive, stable space where they feel safe to identify when they are struggling and ask for help, and to feel heard, without fear of recall (Jarvis et al., 2022). These factors were reflected within the experiences of the residents, as well as in the staffs approaches, included in this study.

Across this study, there is evidence that trauma-informed care is beginning to be adopted. However, improvements are still required to embed a trauma-informed care approach within approved premises. There was no reference to the recognition of cultural issues. This is of significance given that challenges to re-entry are likely increased due to gender, age, race and class and there is a need to adopt an intersectional lens to resettlement (Bunn, 2019). Additionally, self-efficacy is crucial in achieving commitment

to change, such as trauma-informed care (Sundborg, 2019). To be trauma-informed, staff require training, appropriate leadership, and supervision (McCartan, 2020). This must include an organisational shift and commitment to trauma-informed care, rather than only focusing on the individual level of staff. Within forensic services, the organisational change must be responsive, evidence-based and needs led, recognising the high risk of stress of the working environment (Crodwell, 2020).

5.5. Limitations

A limitation of this research is the subjective methods that occurred through the use of a self-report questionnaire and interviews. Participants may have felt the need to present themselves in a favourable light and provide socially desirable responses (Tan & Grace, 2008). In an attempt to overcome this, residents' perspectives were incorporated through interviews. However, it is considered that residents may have also presented the approved premises in a positive manner. A further limitation is that only one PIPE and one non-PIPE approved premises were included in the study. It is recognised that no two approved premises are the same (HMIP, 2017). It was referenced during the interviews with the non-PIPE approved premises staff that they pride themselves on their approach to working, which may have been different to other non-PIPE approved premises. Additionally, the two approved premises were from a similar geographical location. Whilst the use of qualitative methods allows for rich data, a limitation is that it could be subject to be biased by the researchers' experience of working with clients in the OPD pathway. Given the specific focus of the study, caution should be taken when generalising findings. Additionally, the small sample size likely contributed to the self-efficacy subscale not being significant when Bonferroni correction was applied. There may not have been sufficient power to detect difference.

5.6. Conclusion

This study adds to the understanding of experiences of working and residing in approved premises, with comparison between a PIPE and a non-PIPE approved premises. The ARTIC-35 (Baker et al., 2016) scores demonstrated that staff at both sites had attitudes supportive of trauma-informed care, with scope for more favourable trauma-informed

care attitudes to be developed. There were not statistically significant differences in these scores. It emerged that the PIPE staff appreciated the application of the PIPE model, with it being perceived to increase their confidence in their ability to support the residents. The non-PIPE staff experienced difficulties in managing the complexities of the residents, and a perceived lack of skills in dealing with complex resident presentations.

The themes that emerged from the qualitative aspect of this project highlighted that PIPE and non-PIPE staff were attempting to implement a supportive and non-judgemental approach to their manner of working. It is considered that elements of trauma-informed care were beginning to be implemented. This included embedding a culture in which the residents experience physical and psychological safety, a collaborative approach, and understanding of their behaviours, with consideration of previous life experiences. A particular challenge within the non-PIPE approved premises was the limitations of further support for the residents with accommodation and mental health support, which was experienced by residents and staff. This may be due to the lack of containment and wider agency support received at this site. Both approved premises assisted the residents with the transition from prison to the approved premises, with hope being maintained for them being able to cope in the community. Risk management remained a crucial aspect for staff members at both sites, with it being conducted in a supportive manner rather than punitively. This was reflected in the residents' narratives.

Differences in experiences for both staff and residents across the non-PIPE and PIPE approved premises sites were noted. It appeared that the PIPE model provided both the staff and residents an additional element of containment and guidance. This was provided through the psychology team presence at the approved premise, supervision, reflective practice, as well as good links with further agencies. There is indication that having a framework to assist with the management of complex individuals is beneficial to both staff and residents of approved premises.

Chapter Six: Discussion

6.2. General discussion of findings

6.2.1. Chapter Two

The systematic review presented in chapter two aimed to explore forensic services that includes adult male service users that had implemented trauma-informed care. To the author's knowledge, this was the first systematic review to review trauma-informed services including male service users. Previous systematic reviews of trauma-informed care in forensic services had only identified studies including women and young people (Martin, 2017; McAnallen & McGinnis, 2021; Simjouw et al., 2021). Following searches, eight studies met the eligibility criteria. Among the included studies, the trauma-informed approach varied, as well as the setting. Three studies were mixed methods, with the remaining articles having a qualitative approach. A narrative synthesis was conducted.

The review identified key areas relevant to the application of trauma-informed care in forensic services for male service users. Organisational culture was present throughout the included articles as a crucial element to the implementation of trauma-informed care in forensic settings. Aspects important within this were: leadership support of trauma-informed care (Dagenhardt et al., 2024; Dion et al., 2019; Seitanidou et al., 2024); understanding of clients' behaviour through a trauma perspective (Seitanidou et al., 2024; Mueller et al., 2023; Taylor & Akerman, 2022; Dion et al., 2019; Dagenhardt et al., 2019); and an acknowledgement of the potential for vicarious trauma (Dion et al., 2019; Seitanidou et al., 2024). Challenges of trauma-informed care in forensic settings were noted. This centred around resistance among professionals and organisations. Factors identified as contributing to this included the perception among participants that the trauma-informed approach did not seem to align with other organisations focus on punishment (Mueller et al., 2023). Across the articles, there was a focus on re-humanisation for the clients of the service. Essential aspects of this were identified as promoting autonomy, peer-support, and collaboration (Mueller et al., 2023; Seel et al., 2023; Petrillo & Bradley, 2022).

The findings of this systematic review align with previous research. It has been identified that organisational culture is deeply embedded within the prison narrative, and this can be difficult to change (Prescott, 2021). Prisons have a philosophy that is retraumatising and increases hostility and violence (Bloom & Bradshaw, 2022). For effective program implementation, the institutional level needs attention (Mueller et al., 2023). In forensic services, an institutional shift is required to create a significant change in the culture and philosophy of the services. This systematic review also highlighted the limited research conducted on trauma-informed care in practice within forensic services for male service users.

6.2.2. Chapter Three

Chapter three provided insight into a client experience and outcomes of trauma-informed care and therapeutic treatment. The aim of the case study was to explore the impact of engaging with a trauma-informed PIPE wing and psychological treatment. A single case study of Matthew described the assessment, formulation, and intervention facilitated. Compassion focused therapy was utilised as this allowed for the development of a non-judgemental and supportive therapeutic approach to be developed. This allowed Matthew to explore and increase his emotion regulation skills. The intervention also included Matthew's residence on the PIPE wing. It is suggested that through the therapeutic approach, psychoeducation, and residing on the PIPE wing increased Matthews' ability to engage meaningfully with the intervention.

However, it is illustrated that for an individual with a complex trauma history in prison, there can be numerous fears, blocks, and resistances to meaningful engagement with interventions. It was evidenced that the prison environment and Matthew's coping styles, created ongoing difficulties for him. This was highlighted by an incident of violence that Matthew was involved with, which occurred on the PIPE, and resulted in him being moved from the PIPE location. This supported previous research which discusses that in custodial settings, that the challenges, coping styles, and threat sensitivities presented in an individual's formulation will be evident (Taylor, 2017).

Through residence on the PIPE, Matthew began to build compassionate relationships with peers and staff. This reflected a development from his previous approach of isolating himself. However, it is observed that this also gave rise to interpersonal conflicts. It has previously been raised that individuals that have experienced childhood trauma are more likely to be threat focused and see others and closeness as a source of threat (Gilbert, 2004; Kolts & Gilbert, 2018). It appears that due to the threat sensitivity, and interpersonal difficulties, this resulted in Matthew being violent towards another PIPE resident and moved to a general location wing. Furthermore, it is considered that the suspension from the PIPE may have resulted in difficult feelings and interpretations of rejection for Matthew. This reflects that entrenched survival behaviours can induce further shameful experiences that contribute to feelings of defectiveness, pessimism and hopelessness (Taylor & Hocken, 2021a).

Clinically meaningful improvements and deteriorations, statistically reliable, and movements across the clinical cut-off were found. The outcome measures for the intervention were conducted following Matthew having been suspended from the PIPE wing and therefore locating on a general prison wing. Observationally, it appeared that Matthew developed insight into his own difficulties, and coping techniques. Overall, this case study demonstrated the complexity and challenges of a trauma-informed care approach, along with psychological treatment of compassion focused therapy. There is a need within trauma-informed care approaches to continue to monitor and work with the threat system, exploring its interaction with the environment in the prison.

6.2.3. Chapter Four

Chapter four presented a critique of the attitudes related to trauma-informed care (ARTIC) scales (Baker et al., 2016), considering its application to forensic services. The ARTIC scale is a self-report measure of professionals' and paraprofessionals' attitudes towards trauma-informed care. Concerns were raised regarding the validity of the ARTIC scales when applied to different staffing team populations. It was identified through analyses that the field of practice and the demographics of the staff team may influence the measurement of trauma-informed care (Mendez et al., 2023). The impact of the

variety of professional stances on trauma-informed care were noted. This contributed to an exploration of the contextual factors within forensic services, and the staff teams, that may influence their trauma-informed attitudes. The atypical working environment of forensic settings was recognised. This includes the high level of threat for correctional officers which increases cynicism (Ferdik & Smith. 2017). Additionally, professionals working in forensic services are more likely to develop vicarious trauma, compassion fatigue and burnout (Pierelli et al., 2020). There appeared to be a lack of acknowledgement among the ARTIC scales of varying professional stances, applications and organisational cultures to trauma-informed care. This psychometric critique identified that there are limited psychometrics for measuring trauma-informed care.

It was raised through this review that whilst the contextual factors specific to forensic services are not considered, it appears that the ARTIC scales provide a simplistic psychometric measure of staff members' attitudes towards trauma informed care. The need for a simplistic and unanimous approach to implementing trauma-informed care, as well as taking into account the organisational context is highlighted (Berring et al., 2024). To increase the validity and reliability of the ARTIC scales in forensic settings, further research is required on the implementation of trauma-informed care in forensic services, as well as consideration of forensic professionals' perspectives and the forensic context.

6.2.4. Chapter Five

The study presented in chapter five compared the trauma-informed care attitudes, and experiences, of staff at a PIPE and a non-PIPE approved premises, with consideration of residents' experiences. Staffs' attitudes towards trauma-informed care were measured by the ARTIC-35 (Baker et al., 2016) scale. The ARTIC-35 scores indicated that across the PIPE and non-PIPE staff held more favourable trauma-informed attitudes, than unfavourable attitudes. This indicates that staff at both sites were more in favour of trauma-informed care than they were against it. There were not statistically significant differences across the subscales.

Themes were identified from interviews with staff and residents at the two sites. The PIPE staff expressed that the PIPE model provided them benefits to their work. This was assisted through psychological guidance, supervision, and additional training. Whereas the non-PIPE staff appeared to feel unsupported and unequipped to manage complex residents. This supports previous findings of community probation workers of clients with personality difficulties (Lad & Walker, 2024). Despite feeling unequipped, the non-PIPE staff, along with the PIPE staff, maintained the importance of having an understanding of the residents' needs and applying this to their approach. This seemed to allow staff to interpret residents' behaviours through a trauma lens.

The physical and psychological safety of the approved premises were crucial to the residents in assisting with their transition to the community. It appeared that this allowed them to feel supported in their transition, maintain hope, as well as the opportunity to slow down and relax. The importance of these factors has been highlighted in previous research regarding the transition from prison to the community (Liem, 2016; Crewe, 2024; Shingler & Stickney, 2024; Hocken et al., 2022; Orpwood & Ryan, 2022; Jarvis et al., 2022). However, the balance of risk management with a wider holistic approach appeared to create some uncomfortableness for PIPE staff. Similar findings were found among OPD staff who identified feeling isolated by working in a different way to their organisation, and that this created uncomfortableness and a challenge to their role identity (Ramsden et al., 2016).

These findings suggested that both the non-PIPE approved premises and PIPE approved premises were able to achieve positive working relationships with their residents. This assisted with the residents experiencing support in their transition to the community, and risk management. It is considered that elements of trauma-informed care are beginning to be adopted and implemented across the approved premises sites. A significant difference among the sites, was that the PIPE staff felt more equipped, capable, and supported in their management of their residents. It was apparent that the non-PIPE staff did not perceive themselves as being able to effectively support and manage the complex presentations of residents that they would be met with at the approved premises. It

appears that the PIPE model provided a beneficial structure to the staff team at the PIPE approved premises, which increased their confidence in their work.

6.3. Interpretation of Key Findings

Across the research within this thesis, it is recognised that the application of trauma-informed care to forensic services for male service users is in its infancy. It appears that this paradigm shift has begun and there is a desire among staff and service users to adopt this approach. This was evidenced within the systematic review, in which all the included articles were published between 2019 and 2024. The adoption of trauma-informed approaches appears to be reflected in the primary research as the staff working within both of the approved premises held favourable attitudes towards trauma-informed care. The participants within the systematic review, and the primary research study, indicated that they view there to be benefits to both staff and residents when applying trauma-informed care approaches.

Despite the movement towards embedding trauma-informed care into forensic services, it was apparent that a number of challenges remain in its application. The most evident challenge presented across all research chapters, was the integration of trauma-informed care with risk management. It is unsurprising that this was a key concern present as forensic services are designed for individuals that have a risk of offending and causing harm to others, as well as risk management being a central role within forensic services. The systematic review demonstrated that it could be experienced that trauma-informed was not welcomed by forensic services due to it not fitting with the ethos of risk management. Due to this, as well as concerns regarding increased workloads and a move away from standard practice, there was hesitancy among organisations to implement or consider trauma-informed care as way of working within forensic services. Similarly, in the review of factors impacting the feasibility of the applicability for the ARTIC scales (Baker et al., 2016) it was identified that staff working within forensic services have an atypical working environment. Through this they may develop coping strategies that does not align with trauma-informed care. Such coping strategies are considered to create reluctance among the staffing teams in forensic services to implement trauma-informed care. The importance of considering varying professional stances was emphasised. For

staff working in forensic services, the professional stance on risk management is expected to have a significant impact. This was reflected further in the primary research. Among the PIPE staff, there appeared to an uncomfortableness with the focus on factors relevant to emotional wellbeing. They presented with a need to express that although they adopt a holistic approach to risk management, this is of benefit to managing risk, and that they remain aware of risks. Whereas, for the non-PIPE staff team they appeared to feel secure in their supportive and holistic approach to risk management. They did not seem to present with the same desire to emphasise that they remain aware of risk. In addition, the challenge of managing risk of harm whilst providing a trauma-informed service was evident in the case study. Matthew was involved in a violent incident and therefore removed from the PIPE wing. This indicated that consideration is required in how the threat system continues to operate within trauma-informed environments. It was apparent that risk management needed to be prioritised, and this can impact upon psychological experiences and interpretations of the self and others.

The role of the organisation, and the organisational culture, in the implementation and success of trauma-informed care was evident. This was emphasised within the systematic review. As noted above, it was experienced by the studies' participants that the organisational culture of other services could be detrimental to the willingness to work in a trauma-informed way. It was also identified that the organisational culture of the forensic service implementing the trauma-informed approach is crucial. There was a need for leadership support, as well as the recognition of potential for vicarious trauma and the opportunities for reflection. The impact and role of vicarious was also reflected upon in the psychometric critique, as this may contribute to an organisational culture that is unable to hold favourable attitudes towards trauma-informed care. It was apparent that when working with subgroups of forensic service users, more favourable trauma-informed attitudes were present. This is likely to be influenced by the organisational culture, as well as societal views on the subgroup. The cultural, structural, and political context of the organisation needs to be considered, as argued in the psychometric critique. The nuances of forensic settings, and organisational culture and approaches, did not appear to be considered and incorporated explicitly into the ARTIC scales (Baker et al., 2016). This may impact upon its ability to be applied to forensic

settings. The role of cultural and structural context was apparent within the primary research. It was identified that the PIPE model allowed the staff to feel capable and supported in working with complex presentations. The residents also appeared to feel contained through the PIPE model. Whereas the staff within the non-PIPE approved premises perceived themselves as unskilled and uncapable of managing difficult and challenging presentations of residents. This enhanced feelings of being unsupported. This was also reflected by the non-PIPE residents who discussed their felt need for more emotional support. However, the residents at both approved premises demonstrated an experience of feeling supported by the staff members and this assisted with them feeling able to re-integrate into the community. Additionally, it was highlighted within the systematic review and the primary research study, that reflective spaces were highly valued. The importance of self-reflection, as well as psychological guidance when working with individuals that may have experienced trauma was highlighted.

6.4. Limitations

Limitations have been discussed individually for each chapter, however an overview of some of these will be provided here. A limitation throughout this thesis is the recognition of the lack of clarity on a definition of trauma-informed care that outlines exactly what the concept entails (McCarthy et al., 2020). This can result in the manner that trauma-informed care is implemented varying. Within this thesis, trauma-informed care was explored through the PIPE model. Due to this, all clients would have presented with personality difficulties. Therefore, it is acknowledged that this is one variation of trauma-informed care with a particular client group. The case study in chapter three outlines the issues with the psychometric outcome measures were administered pre- and post-intervention. It would have been beneficial to have conducted further measures during the intervention, as well as having a longer follow-up period. A limitation of the empirical study was the singular sites of a PIPE, and a non-PIPE approved premises being included in the research. Having a larger sample across various PIPE and non-PIPE approved premises would have allowed for greater insights regarding trauma-informed care. Unfortunately, that was wider than the scope of this project. Additionally, the ARTIC-35 scale (Baker et al., 2016) was utilised. It was outlined in chapter three that there are limitations of the ARTIC-35 scale in measuring trauma-informed attitudes among

different populations. However, it is considered that the ARTIC scales are the most appropriate measure currently available. Across this thesis, the use of self-reported measures occurred. This may have given rise to socially desirable responses (Paulhus, 2017).

6.5. Implications and Recommendations

It is apparent that when considering the application of trauma-informed care to forensic services for male service users, there is a need to integrate this with risk management. It appears that trauma-informed care approaches can be experienced as conflicting with risk management and reducing the acknowledgement of risk. However, there is also some appreciation for trauma-informed care allowing for greater understanding of service users' needs and risk factors and responding effectively. For implementation of trauma-informed care in forensic services to continue, greater understanding and acknowledgment of the way risk management is incorporated within trauma-informed care is required. This would allow for an appreciation for the potential adaptions to trauma-informed care that occur, and are needed, in forensic services to manage risk of offending and harm. An understanding of this would allow for appropriate measures to be created, such as including an appreciation of forensic risk management in a trauma-informed care manner in the ARTIC scales (Baker et al., 2016). The role and potential benefit for risk management through a trauma-informed approach requires further exploration. This would allow for greater understanding of the coherence of trauma-informed and risk management approaches to be shared among organisations and professionals working in this field. It would be beneficial for core components of trauma-informed care to be distributed within forensic services to allow for a coherent working strategy that creates collaboration rather than conflict. It is considered that this may reduce hesitancy and reluctance among various forensic staff members, as well as produce an increase in confidence in the approach.

Further exploration of the current organisational cultures within forensic services is required as it is apparent that this has a significant impact on the implementation of forensic services. The current structural models and essential aspects, such as within the PIPE model, that allow for a trauma-informed approach need researching further.

Through this understanding, and incorporation of risk management approaches, it would be beneficial for a definition of trauma-informed care within forensic settings to be determined. This should include an acknowledgement of the crucial aspects of the organisational culture and structures in forensic services that support trauma-informed care. Having further clarity of the interplay of forensic organisational culture in the implementation and continuation of trauma-informed care, would allow for clearer strategies. It would include developing insight into the aspects of the organisational culture that creates hesitancy to trauma-informed care and responding to these with systemic processes and adaptions to create opportunities for trauma-informed care to be implemented and embedded. This would assist with the development of psychometric measures further as it there would be appropriate appreciation for the relevant organisational factors and adaptions to the psychometrics required. A crucial aspect within the organisational culture that requires further exploration is reflective practice and supervision. It would be beneficial to have greater understanding of the role of such support for staff teams when implementing trauma-informed care, as well as exploration of the barriers to accessing supervision spaces available within forensic services.

Currently, the evidence-based is focused upon female or young individuals within forensic services. Additional research should consider the trauma-informed approaches for various trauma presentations among male service users. It appears that it would be advantageous to consider the potential challenges that occur for male service users when engaging with trauma-informed services, particularly due to trauma present within relationships and the threat that connections with others may evoke. Research conducted with a larger sample size, including various forensic services or sites, that have implemented trauma-informed care would allow for greater insight to be gained on the impact of this approach. Additionally, it would be beneficial for quantitative measures to be utilised so that the impact of trauma-informed care can be reliably measured.

6.6. Conclusion

In conclusion, this thesis reflects the examination of the application of trauma-informed care within forensic settings. The application of trauma-informed care to forensic

services for males is an important area of exploration. This thesis extends the knowledge of the crucial aspects, challenges and benefits of trauma-informed care in forensic services for males. It is evident throughout this thesis that research on trauma-informed care in forensic settings for male clients is lacking. The application of trauma-informed care in these settings requires further research. Findings presented within the thesis consider the impacts and challenges of trauma-informed care in forensic settings. It is highlighted the aspects which are particularly valued are having an understanding of clients' histories and needs being promoted, and staff being given guidance and support. It appears that working in a trauma-informed manner assists staff with increased confidence in working with individuals that have experienced trauma, as well as provides staff support through supervision and reflective practice. Residents in the empirical study highlighted appreciation for the supportive manner adopted and the approved premises assisting them in their journey to the community. Challenges in trauma-informed care in forensic services can include the perceived contradictions of trauma-informed care to risk management, and resistance to embedding trauma-informed care. Overall, specific consideration is required in applying trauma-informed care to forensic settings due to organisational cultures and demands of such settings, as well as the high levels of trauma present.

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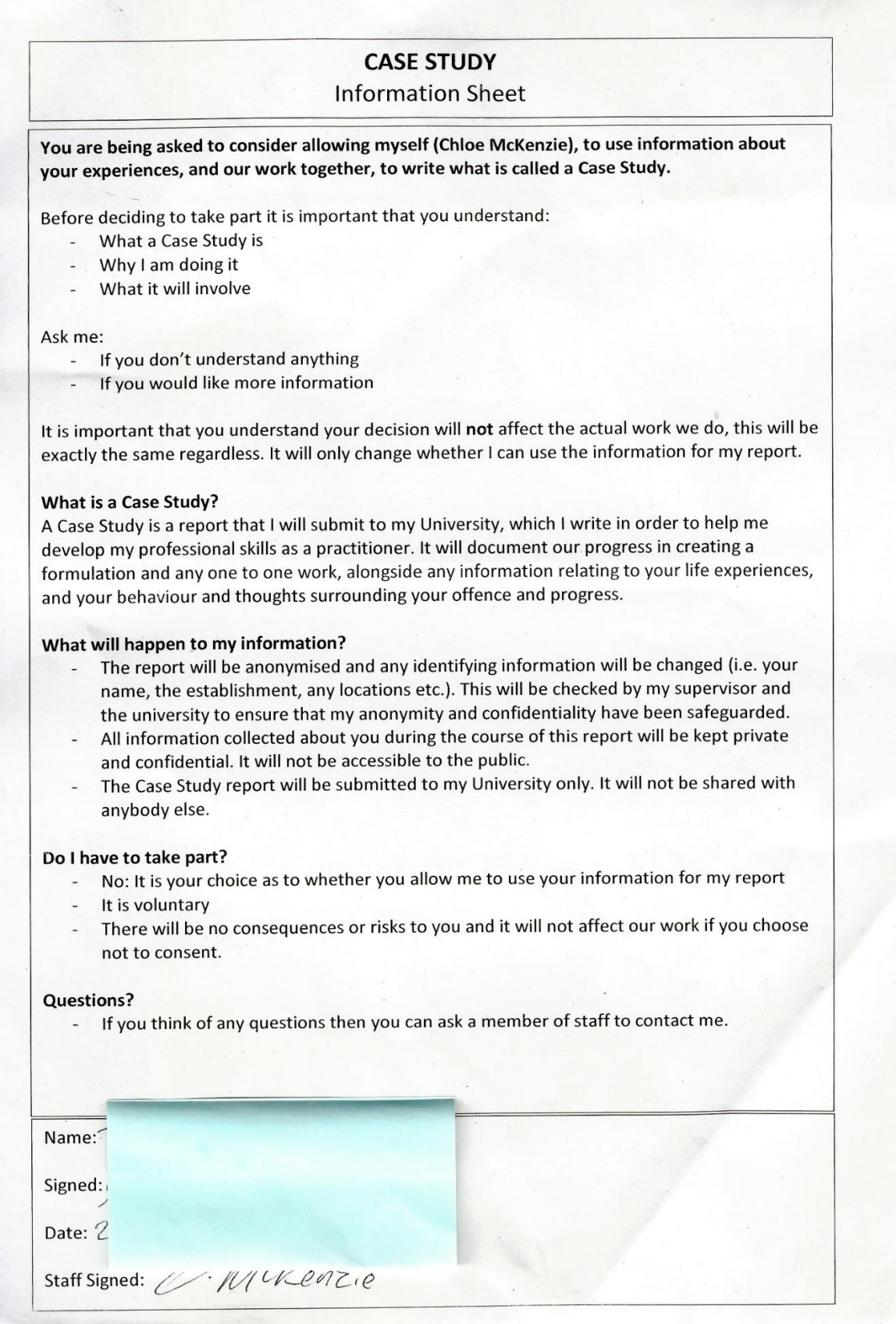
Appendices

Appendix A – Case study consent form



CASE STUDY
Information Sheet

You are being asked to consider allowing myself (Chloe McKenzie), to use information about your experiences, and our work together, to write what is called a Case Study.

Before deciding to take part it is important that you understand:

- What a Case Study is
- Why I am doing it
- What it will involve

Ask me:

- If you don't understand anything
- If you would like more information

It is important that you understand your decision will **not** affect the actual work we do, this will be exactly the same regardless. It will only change whether I can use the information for my report.

What is a Case Study?
A Case Study is a report that I will submit to my University, which I write in order to help me develop my professional skills as a practitioner. It will document our progress in creating a formulation and any one to one work, alongside any information relating to your life experiences, and your behaviour and thoughts surrounding your offence and progress.

What will happen to my information?

- The report will be anonymised and any identifying information will be changed (i.e. your name, the establishment, any locations etc.). This will be checked by my supervisor and the university to ensure that my anonymity and confidentiality have been safeguarded.
- All information collected about you during the course of this report will be kept private and confidential. It will not be accessible to the public.
- The Case Study report will be submitted to my University only. It will not be shared with anybody else.

Do I have to take part?

- No: It is your choice as to whether you allow me to use your information for my report
- It is voluntary
- There will be no consequences or risks to you and it will not affect our work if you choose not to consent.

Questions?

- If you think of any questions then you can ask a member of staff to contact me.

Name:

Signed:

Date: 2

Staff Signed: C. McKenzie

Appendix B – Case Study: compassionate letter to client

To Matthew

I write this letter to you as an attempt to summarise the therapeutic work that we have completed over the past 7 months. During our sessions you have demonstrated a commitment to exploring your difficulties and working towards helpful strategies to overcome these. I acknowledge that this has been challenging for you at times, with the sessions evoking uncomfortable feelings for you. Despite this, you have attended the sessions and showed a great willingness to progress.

When we began working together you described a very critical sense of yourself, as well as sense of loneliness. Our focus in our sessions has been to make sense of this criticalness, working towards a compassionate approach, and exploring interpersonal relationships. Some key presenting difficulties for you seemed to managing your emotions, drug use, and self-harm behaviour.

To make sense of your struggles, we looked at your life experiences. This demonstrated a chaotic upbringing in which you were not provided with consistent care and love. You witnessed a variety of violence and use of illicit substances. It appears that through these experiences you learnt to manage your emotions through similar means of violence and illicit substances. Additionally, the lack of consistent relationships in your life appears to have contributed to your negative view of self. It appears that you lacked guidance in seeing the positive aspects of yourself, but instead you experienced criticalness from others. Also, through the disruptions in your relationships with others you began to take a protective stance. This has also contributed to you using violence.

Within our sessions, I introduced psychoeducation on emotion regulation and the brain, and compassion was explored. We reflected on the three emotion regulation system, compromised of threat, soothing and drive. You identified that you don't think you've ever felt the soothing system of contentment and safeness. It was acknowledged that you don't give yourself kindness or affection, and don't get this from others. With regards to the threat system, you recognised that you have been in many threatening situations, this has included physical threats towards yourself as well as to family members. A further threat was noted to be social isolation. In this threat system, you discussed associated feelings as anger, being annoyed, upset and anxiousness. For the drive system, you identified goals as being try to stay out of prison and make a better life for yourself. It was discussed that you feel that you've had enough of the life that you are living and want to

begin making improvements, which you feel you are doing. It was considered that these experiences can be recognised as threat-drive, rather than solely drive which is associated with excitement and pleasure. Additionally, to this, you explored and identified your thoughts, feelings and behaviours for the threat, soothing and drive.

When exploring compassion, you identified with times when you believe that you have been uncompassionate and 'heartless'. You recognised that you have learnt to deal with a lack of compassion from others, which has included blocking out feelings. An important recognition was that you perceived that you had not felt care and compassion before entering prison. With recognition of this, you explained that people will show care and check in with you when you are on an ACCT. You noted that you can be sensitive to your own suffering, however are critical of yourself. This seems to be based on a belief that you are not good enough. Despite acknowledgement of times when you have felt that you are compassionate to others, it was also important to consider that there have been times when you have shown great compassion to others. This has often been towards your mother. Additionally, it was noted that you can be driven to alleviate the suffering of others. This often results in violence.

We explored ways in which you can increase feelings of being safe, calm, soothed and content. An important aspect you identified was withdrawing yourself from situations, as well as writing things down, ringing and talking to someone, focusing on positive factors, listening to music and drawing. You have been able to identify barriers to compassion to yourself as being critical of yourself, feeling that you have let people down, and not caring. A variety of compassionate exercises were introduced to you, which you was always willing to try. Further practice of these when experiencing difficulties, or when attempting to access your soothing system would likely be beneficial.

When you experienced difficulties whilst on the PIPE wing, you demonstrated an ability to explore the impact of this of your emotions and behaviours. You shared that you felt annoyed at yourself for being in challenging situations that you have been in before, and that this brings you upset and a belief that you need help from others. It could be identified that in these situations you may fluctuate in your compassion towards yourself and wanted the compassion from others in order to be supported. In such situations you

identified feelings that others were unsupportive, as you perceived that they were not doing enough to help you, and this led to frustration towards them.

Also, whilst on the PIPE you showed willingness to build connections with others, and enjoyment with this. You showed a positive attitude to being involved in various aspects of the PIPE, including the socially creative activities. It was evident that this was a positive change from feeling lonely for you. However, this was not without it's challenges and ruptures. The relationships could at times be difficult to navigate, with you describing that you are used to friendships going wrong. It was considered that this can reinforce feelings of being cut off and distant from other people, however it seems that you are able to overcome this. Despite challenges, you have shown commitment to building positive relationships with others. This is something that would likely be useful for you to continue exploring.

I would like to recognise your achievements in having showing courageousness, and commitment to exploring your life experiences and difficulties within our session. I recognise that this is something that can be hard for you at times, despite this you have continued to share and reflect within our sessions. I hope in time that your ability to explore the difficult emotions you may experience becomes easier for you. It has been positive for you to begin to foster a more compassionate approach towards yourself. I would encourage you to continuing practicing this. I wish you all the best in the future.

Kind Regards

Chloe

Appendix C – Case Study: Client compassionate letter to himself

Everybody struggles in life and everyone goes through things that change the way you act and think. You've gone through a lot of things in life, some good but mostly bad. You've not had the support from your parents, the love and the helping hand in life to get through it in the best way possible but you should never let that get you down on a daily basis. Your mum probably never said she loved you but that doesn't mean deep down she doesn't love you. Maybe she's just like you not able to show compassion or show emotions.

As you never had a good relationship with your parents or your brother's and sister's or really had any friends that you can trust and maybe that's part of the reason you push people away and not get close to you because you're scared of being hurt just like you have been in the past.

You've got to realise that you shouldn't let your experiences define the person you become. You are polite, happy, friendly, smart, and worthy. You are better than you think you are but it is time to change. Prison can't destroy your life there's always something better out there for you.

It's going to be difficult but if you're not too ashamed to ask for help then there is help out there for you. Even though it is hard for you to ask for help or to accept it, it's not a sign of weakness to show people that you're struggling because there are people that are going to be willing to help you. There may be a few that judge you but that's always going to happen in life. It's the way you deal with it and handle it in the positive way that matters.

Just think that from where you was and who you are now you've come a long way. You may have blips.

There comes a time in life where we all have to grow up, accept our past without regrets and handle your presence with confidence and face your future without fear.

So, that's my story.

Appendix D – University of Nottingham Sponsorship form

University of Nottingham
UK | CHINA | MALAYSIA

Research and Innovation
University of Nottingham
East Atrium, Jubilee Conference Centre
Triumph Road
Nottingham
NG8 1DH

Our reference: R&I: 21073
IRAS Project ID: 293728

0115 8467906
sponsor@nottingham.ac.uk

Health Research Authority
Research Ethics Committee

Kevin Browne
Professor of Forensic Psychology
Division of Psychiatry and Applied Psychology
School of Medicine
Yang Fujia, Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

7th January 2022

Dear Sir or Madam,

Sponsorship Statement

Re: A comparison of the staff teams' experiences and attitudes towards trauma informed care at a PIPE approved premise and a non-PIPE approved premise, with exploration of resident experiences

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Wording has been included in the participant information sheets to address the requirements of GDPR for transparency information and has been drafted by the sponsor to ensure consistency and compliance with the University's privacy notice, HRA guidance and the expectations of other organisations, therefore the HRA template wording has not been used verbatim.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the UK Policy Framework for Health and Social Care Research will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone

Head of Research Governance
University of Nottingham

world-changing research
from The University of Nottingham

Appendix E – Health Research Authority Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Kevin Browne
Room B25 Yang Fujia Building, Jubilee Campus
Wollaton Road
Nottingham
NG8 1BBN/A

Email: approvals@hra.nhs.uk

20 September 2022

Dear Professor Browne

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A comparison of the staff teams' experiences and attitudes towards trauma informed care at a PIPE approved premise and a non-PIPE approved premise with exploration of resident experiences.**
IRAS project ID:	**293728**
Protocol number:	**1**
REC reference:	**22/LO/0111**
Sponsor	**University of Nottingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **293728**. Please quote this on all correspondence.

Yours sincerely,
Deanna Herron

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Angela Shone*