the british
psychological society
division of forensic psychology

Forensic Update

Issue 139

December 2021

ISSN: 2050-7348 (Online)

Forensic Update

Statement of purpose

Forensic Update is a publication of the British Psychological Society's Division of Forensic Psychology (DFP). Its aims are to:

- Communicate current information on professional and practice matters to practitioners and researchers;
- Publish current and topical research and reviews in forensic psychology and related areas in concise and easily readable form;
- Act as a forum for discussion and debate on a broad range of practical, professional and ethical issues within criminal and civil justice systems;
- Act as a forum for dissemination of knowledge from other branches of the criminal and civil justice system, executive and legislature;
- Act as a forum for discussions with a broad range of other criminal and civil justice professionals and agencies.

Contents

Editorial

Martin Fisher

WELCOME to the fourth edition of *Forensic Update* for 2021. This is the first year in a while that we have brought you four editions – maybe evidence of the impact of the pandemic on how we are now more agile and flexible in the use of our precious time.

This issue contains a series of articles arising from co-production – working with our service users to explore and describe processes, systems, situations and experiences from more than a practitioner's point of view. In total this brings us 14 articles ranging from art in our first article through poems from service uses about their experiences and also practitioner articles. Across this range of writing, we can see a full spectrum for expression – from the visual to regular practitioner accounts. This is the first time we have encouraged content from across this spectrum and from the results readers will see that it is an area where we are encouraging, and asking for further submissions.

Following our co-production articles we present a short series of poster presentations from our conference over the summer – the range is wide and we hope that colleagues will contact the authors for further information about what are intense infographics.

Finally, we conclude this edition with our book reviews.

Wishing all our readers and members of the DFP the best possible festive period – we look forwards to 2022 with hope and aspiration for what it will bring.

Martin Fisher
On behalf of the Co-Editors
December 2021

Chair's Notes

Geraldine Akerman

THESE NOTES are written just after our final two afternoons of the annual conference. Once again, they were packed with fascinating presentations. These online conferences took a good deal of organisation and planning but that all paid off. Thanks to Laura Jacobs and the committee for all their hard work. Presenters would be welcome to write a summary for inclusion on *Forensic Update* for those who were unable to attend. The posters can also be sent in for future editions. Next year we will be in person in Solihull June 14–16 and submissions are already open so let's make up for lost time. Division of Forensic Psychology Annual Conference 2022 | BPS

This is a very important time to think about who we should nominate for our own DFP awards so that they are inclusive as possible. Our categories are:

Excellence in Forensic Psychology Practice;
Excellence in Forensic Psychology Research;
Excellence in Forensic Psychology Practice or Research-Early Career;
Lifetime contribution to Forensic Psychology;
Student prize for excellence in Forensic Psychology.

The nominations for these awards will open very soon, so please look for details on the BPS website.

In addition, the BPS Professional Practice Board has three categories. All information is on the website but in brief:

Award for Innovation in Practice
This annual award is aimed at psychologists in recognition of a particularly innovative and creative project design and/or delivery in practice and will be open to pilot programmes or projects of any size showing particular innovation. This award can be made to psychologists at any stage in their career.

Award for Distinguished Contribution to Practice
This annual award recognises practitioner psychologists for work that has made an outstanding and lasting contribution to a particular area, for the benefit of people and organisations.

This award will likely be made to a psychologist in mid to late career.

Lifetime Achievement in Psychology Award
This annual award recognises and celebrates exceptional and sustained contributions in a career as a practitioner psychologist.

It is anticipated that this award will be made to a psychologist near or after the end of their career.

In addition to the awards a means of promoting the work of forensic psychology all aspects of our work is evidence-based. The committee continues to work with other forensic psychologists on enhancing equality, diversion and inclusion. This remains a major focus for us as we move forward and encourage people into the profession. We are also putting evidence together in regards to the age of responsibility for children being increased from 10 years. Furthermore, we are considering the impact of the IPP sentence.

Emily Jones, Michelle Smith and Sophie Ellis have worked hard to provide reflective spaces online and these have been well received. Please look out online for further details.

Hon Professor Dr Geraldine Akerman
Chair Division of Forensic Psychology Executive Committee

Forensic Update Call for submissions – Co-Production in Forensic Psychology

Do you want to lead the way in something new? Join us at *Forensic Update* in developing the first publication written by people with Lived Experience of forensic services.

What is co-production?

Co-production is an approach that recognises that the people who use our services are the best people to help us design what we do and improve. Sometimes people who use our services are called people with 'Lived Experience'. The key principles of co-production are that we should:

1. Include the expertise of ALL people who use our services.
2. Learn how services could improve based on people's diverse lived experience, expertise, time, skills, and resources.
3. Recognise this as an ethical approach to move from professionals as 'experts' to the co-creation of services based on the expertise of ALL people who use these services.

***Forensic Update* Special Edition – We want to hear your voice!**

We are seeking to publish the first co-produced special edition of *Forensic Update* written by people with experience of using forensic services. If you would like to be a part of this first step of leading the way in co-production with *Forensic Update* then please get in touch. We are seeking submissions that provide a voice to all people who are currently using forensic services/forensic psychology or have used these in the past. We welcome all submissions in a range of formats so this could be articles, interviews, research, posters, drawings or any format that facilitates communication of lived experience. Ideas for topics could include experiences of:

- Forensic assessments
- Forensic therapies
- Forensic settings
- Courts
- Prisons
- Hospitals
- Probation
- Community services
- Victim services

We really want to hear the voices of people with lived experience so any other topics are welcomed too, these are just some ideas so don't feel limited to these.

If you are interested in contributing to this special edition please get in touch and email us at the *Forensic Update* team on forensicupdate@bps.org.uk

Westgate Unit

Kevin Toner

The new environment. The unknown the very first day on the Westage unit.

Peers and staff on hand, all of your questions they answer. All of your anxieties they understand.

With key workers, mental health, SO's, CM's and education staff here to help you progress, the goal, to see you become a success.

Once your ATNA is out of the way, art, cookery, drama amongst others will help to pass the day.

If it takes 'Understanding Me' for you to see, 'Considering Change' or 'DBT' begin the journey to who you want to be.

At times you may struggle with things from the past, but here staff and peer support always last.

The stress, the ultimate test and what you work through to become your best.

The struggles never the less, still constitute as progress.

Building positive working relationships with staff or playing them at pool, may not be for all, but don't stress too much they usually can't pot a ball.

When you're challenged or you feel they're on your case, you suddenly realise, you're in the best place.

Oh and finally here at the Westgate unit, Psychology isn't just prison mythology.

British Psychological Society – Grand Avenues Project

Delivering Recidivism through Co-Production Non-Conventionally

John Voss

CARDIFF Metropolitan University on conjunction with HM Prison and Probation Service Wales have embarked on a four-year project focussing on delivering recidivism through the medium of co-production and refocusing main efforts on the service user.

Two wards have been chosen within Cardiff to pilot this project named 'Grand Avenues' in where intergenerational reoffending patterns are deemed high. To date, the project team has assembled comprising of both academic and professional staff (HMPPS Wales) to initiate the Community Based Initiative.

One of the projects main focus is centred around Shadd Maruna and Ruth Mann's findings of 'What Works'. The research will produce an evidenced-based intervention framework for future community-based programmes that target the holistic wellbeing of individuals, their families and communities, to prevent reoffending.

This in its self isn't unique to this project as many projects have worked hard to deliver recidivism in many formats, what is different with this project is the following two major concepts in relation to psychology:

(a) Placing the service user at the centre of every activity and design.
(b) Co-Design and Production will be used at all levels of the project to ensure we capture everyone ideas, suggestions and inputs.

So, why does this matter, why should we look at this differently? As stated previously, Maruna and Mann consider 'What Works' concluding that people are more likely to desist from reoffending when they have family and community ties and experience feelings of worth, hope and meaning in their lives. One of the major barriers to engagement is that service users don't have a level of trust or hope when engaging within the criminal justice system, the lack of ownership or engagement in its self generates barriers not only in communication but also in engagement and the hope for a better future away from crime.

By placing the service user at the centre of his probation journey, this in its self gives them ownership or their space and engagement is essential for them to plan their journey. An indirect side product of this activity is to empower those individuals to make choices and own their process within defined framework as agreed with the probation staff and the individuals concerned. Empowerment is a powerful tool to connect both physically and emotionally with an individual to own the direction in which they agree to travel, more importantly, it isn't seen as the establishment enforcing change.

A major difference with this project is the introduction of co-design and production to develop a life plan (the name given to the design of the product post development which will be used with service users) at all phases of its development.

So what is co-production and design? Simply put, it is the involvement of all stakeholders in the design and production phases of a project. This isn't a new concept

as its traditions are believed to date back to the 1960s where a growing demand for greater consideration of community decision making and integration was required to fundamentally save money and improve processes.

Initial development of the concept saw many people believe that they were not being 'planned for' but 'planned at'. This in itself generated barriers of trust which impacted on the overall objectives of the projects.

It is well documented that Scandinavia developed the modern approach to system development which was known as 'collective resource approach' which brought owners, management, workers, and unions together to 'participatory design' (now known as Co-Design) bringing better working practices and wellbeing of all those within the project.

How will this impact our project? We have for many years looked at what works in relation to desistance with the common theme of 'planned for' and not 'planned at', directing service users what to do, how to do it, and when to do it. Without the trust and belief of the service user, full engagement is limited.

Therefore, placing the service users at the centre of our project, engaging them at all levels of the design and production processes along with the development of a 'Life Plan' empowers the service user to shape the future for themselves and others within the geographical area in which they live, work and socialise. Empowerment is a powerful tool which has been proven to improve wellbeing, feeling valued, trusted and motivation. If we can capitalise on this approach allowing service users to operate within a defined ethical and legal framework, the road to desistance will be achieved as trust and hope for change will be evident.

Currently we have over 230 agencies working with approximately 200 Service Users (one-to-one agency per service user) with high levels reoffending. With our new concept and approach, the service user will own their re-engagement into society with a view to owning the complete process and breaking intergenerational crime.

Fundamentally, the current process is well documented not to be working and a new concept/approach should be tried. We will be open minded and welcome fresh and proven ideas, methods and processes to promote positive outcomes to this project.

Maximising engagement with the project, will be continually monitored over the coming years and hopefully break the intergenerational cycle of crime.

John Voss
Cardiff School of Sport & Health Sciences, Cardiff Metropolitan University.

Co-production

Pod Young

MY FIRST experiences of co-production happened when I was in my last year at Broadmoor hospital. Another patient, also a friend, had been preparing to deliver a 'never been done before' event, a presentation for both staff and patients alike in an attempt to bridge the gap and make improvements to the service. I was supporting my friend in the delivery of his presentation, rehearsing hand signals as a sign to help him stay on track. I was to take notes and document the event. But what was it about? Staff restraints. My friend had designed a model in which highlighted three parties that were affected by a restraint taking place. The staff, the patient and the witnesses. Until that time this hadn't been considered and as a result of the presentation, the model was used in the actual staffs pmva training who work in Broadmoor hospital.

So, this just goes to show that when done in the right way, we service users can influence change. It was because of this that I made the decision to become an expert by experience.

Shortly after, my friend and a happy, recovery focused nurse were sat talking and we began to think of ideas on how to make care plans better and more collaborative. Unfortunately the said member of staff was injured during a restraint and retired medically and then my friend was returned to prison so I was left with the task to develop that conversation by myself. I then decided id team up with my psychologist to create a document about collaborative care planning. The document was well received and is something I give to students in a hope that they will think of co-production when they qualify.

So, what is co-production?

In my opinion co production is the meeting of minds, one of knowledge and the other of experience. Knowledge in this regard refers to training in nursing, occupational therapy, psychology and psychiatry. Experience is the people who have experienced treatment directly.

Co-production is also learning from peoples experiences, what worked? What didn't work? What was helpful? What caused conflict? It makes perfect sense to apply service user experiences to improve the services in a positive and informative way.

What co-production isn't, it isn't staff doing all the work for us, it isn't means to get privilege or to be 'owed one', it isn't brown nosing and it isn't enforcing someone else's view on behalf of said someone else.

A term that comes up a lot with co-production Is collaboration. I find this term more meaningful. Co-production is doing something along side someone whilst collaboration feels like an experience had with someone. Collaboration comes in many forms.

By allowing service users to assist in their own care is empowering, we feel valued, respected and after all we are just as involved in this as with the staff so it makes sense to contribute right? Yet when collaboration isn't used all we become is a by product of other peoples views, opinions and decisions.

When I was moved to conditions of lesser security I was actively seeking new experiences to assist in my emerging career as an expert by experience. I was approached by an assistant psychologist and asked if I wanted to collaborate on the HCR-20 risk assessment. I took him up on his offer and we both ventured into somewhat unknown territory. I was completely transparent in my

disclosures and experiences and as the weeks passed we were producing a very robust document we worked hard together and learnt a lot off each other until we presented the risk assessment to my first risk clinic. I was actually very excited, treating the document like I was unveiling an ancient artifact that had just been rediscovered, and my experience was very positive. Therefore I removed myself from being part of the problem and made myself part of the solution.

Collaboration and co-production are both huge steps towards the betterment of the services and when more service users get involved, we are all contributing to the recovery's of service users in the future.

Pod Young
Expert by Experience,
Hellingly Centre, BN27 7ER

Transforming Criminal Justice Through Co-Production

Rob Ferguson

IN RECENT years, there has been an interest in using 'lived experience' to inform and guide policy and practice within healthcare and other public sectors settings (McMullin & Needham, 2018). This has led to an upward trend towards service user involvement within the criminal justice arena (Weaver, 2019). This approach has been termed co-production. Utilising the lived experience of citizens to contribute to the design and implementation of service delivery can provide transformative outcomes for individuals, services, and broader social systems (Loeffler & Bovaird, 2020). This process promotes power-sharing at an individual level and provides a space for collaboration with experts in their field.

My lived experiences of being a peer mentor, a psychology student, and (in the past) a person on probation have led me to volunteer for co-production projects to develop digital content designed to promote desistance.

After my first experience of co-production, which involved creating digital content to accompany an intervention for men with convictions for violence, I authored a guest blog titled 'Co-producing digital media with probation' that helped me reflect on the experience and share my experiences with others. Following this project, I was approached to contribute to a Home Office funded project, which I describe below (also described in this issue of *Forensic Update* by Morris, 2021).

In this current piece, I discuss recent experiences of co-production, what I have learnt from this and how this has supported my continuing journey of personal growth since my contact with the criminal justice system. I conclude by offering my thoughts about how enabling lived experience leaders to have a more significant stake within the coordination of co-production activities can preserve the transformative potential of lived experience within public institutions such as Her Majesty's Prisons and Probation Service (HMPPS).

The co-production project that inspired the current article enabled me to advise and contribute to various stages of a design process for a series of 'Complementary Digital Media' (a digital strategy to explain desistance-focused skills and ideas to people attending interventions; see Morris & Graham, 2019). My contributions involved helping to shape the design of stories and visual strategies used within these clips to make them relatable to intervention participants.

Much of the work involved working through scripts and scenarios developed by other volunteers to shape the 'tone of voice' of the content, the scenarios encountered by characters and the presentation of psychologically-informed coping strategies. The voices of lived experience brought an authentic tone that I could relate to.

The design company developing the animations themselves needed a 'look and feel' for the series of clips. Working with other volunteers and HMPPS staff, we selected our preferred style from three alternatives and then provided further input to shape the visual appearance of the characters that would feature in the clips. Finding the right blend was more complex than first thought. The team created an inclusionary character that needed to be unique but did not distract from the messages that were being portrayed. This involvement was challenging but also

fascinating. Being involved in this process gave me insights into design processes that underpin digital media development (e.g. scripting, copyrighting, storyboarding, etc.) and made me feel that what I had to say made a valuable contribution to the end product. In the end, I felt the look and feel, the tone of voice, and the content of scenarios worked well, creating the right balance of clarity and authenticity for the animation clips.

What interested me most was the theories underpinning the visual language used to complement the coping mechanisms in the animation clips. This language was underpinned by Polyvagal Theory (Porges, 2011), whereby the main character and background scenes were designed in such a way to reflect this theory. States such as 'fight & flight', 'shutdown' and 'social engagement' were incorporated into the content to add an emotional dimension to the visuals in the animated clips. For me, this was a crucial element in the design so that participants could relate in a way that resonated with them, identifying certain emotions in the character and context relevant to their experiences. This strategy combined well with what happened in the scenarios to create a narrative that makes the participant aware of possible emotional state situations. The scenarios depicted positive emotional consequences for characters using coping strategies, highlighting the benefits of choosing more constructive ways of responding in certain situations.

The content had to be pertinent to the participants; I mean by this that the context needed to feel real and have a relatable narrative so that it could help provide a new understanding of their current reality. People with lived experience do this with ease; they use their life experiences and give insights on other ways of responding to the negative coping patterns. Interventions provide strength-based strategies that I believe all participants possess and can develop further. However, people who attend interventions often have negative ways that are ingrained in their survival state for the environment they are immersed in. By first becoming aware, having, let us say, a light bulb moment or explaining why they cope this way can provide a spark in them to want to find out more, explore and understand that they can take back control and learn to respond more constructively.

The content we co-created was designed to start conversations and create an understanding of current coping mechanisms, becoming a starting point for exploring new coping techniques alongside practitioners. From someone who harnessed a destructive and negative mindset, I could certainly identify with the emotional language in the content.

This co-production process gave me further insights into my behaviour, past and present. I describe a lot of my life as being in a hyper-vigilant state. I was always looking over my shoulder as a teen and into early adulthood. This chronic stress response was always under my awareness, and, at the time, I did not have the language to describe what these feelings and emotions were. This led me to cope and behave adversely to soothe these unconscious and uncomfortable feelings that arose. Through exploration and awareness, I understand my body's responses to trigger situations. I seek to learn more and try to take back control of these unconscious reactions I have in my day-to-day life. Having visual content within these interventions captures the complexities of participants' behaviour patterns. The animation clips in this current project should give the participants a starting point to work on their inner states and hopefully find more effective strategies for behaviour change.

The co-production process has always been constructive for me. It has brought about challenges and pushed me beyond my boundaries, highlighting strengths I did not know I had and identifying areas in which I would like to grow. However, I still feel more needs to be done to create more co-production opportunities. With the trajectory of lived experience in social justice arenas being used as a tool for positive change, a defined framework to work from, guided by evidence, incorporating

a desistance-based approach is needed. Desistance is a social movement (Maruna, 2017), so we need to find ways for people who desist to have a more prominent and legitimate stake in the design of behaviour change work. Although each person with lived experience brings an individual perspective and vital skills required to desist from crime, these assets could be put to better use by creating more pathways that develop self-efficacy through co-production and have the intention of leading to opportunities to work effectively alongside practitioners from a range of backgrounds in delivering probation work. Using the wisdom of lived experience in this way may produce more responsive prison and probation intervention services.

A general criticism of co-production, and the spaces it functions in, is the power dynamics around the individual's involvement and how these are managed (Bevir et al., 2019). Although co-production balances the power relations between lived and expert knowledge, co-creators may feel under specific expectancies and influenced in some manner that distorts or filters their contributions. Systems must be in place to counteract these potential discrepancies through reflective dialogue about the impacts of co-production on co-creators and the extent to which other contributors impact authenticity.

The potential for hidden harms such as those explored by lived experience leaders (e.g. Buck et al., 2021) may be counteracted by providing experts by experience more opportunities to structure how co-production activities are delivered by the likes of HMPPS. I feel that people with lived experience employed by criminal justice providers and peer mentors could potentially enhance and guide experts by experience through the co-production process. By training peer mentors with up to date frameworks, they can provide the information needed about the stages of co-production in advance and inform co-creators of any challenges. Mentors can be utilised to encourage and acquire people with lived experience to use their knowledge to improve future interventions to create positive pathways for people in the criminal justice system. Peers are also familiar with the spaces currently used in co-production, and for some people with lived experience, this can be a barrier or challenge to overcome. It is essential to see practitioners and peer mentors reaching harder to reach communities and using spaces familiar to them to make this process as diverse and authentic as possible, providing a greater return in investment for all parties involved.

In conclusion, the implications of co-production in practice seem positive. However, with the lack of concrete evidence around co-production in and around the criminal justice system, more work in this area can only be worthwhile. My view has always been that lived experience is far from a silver bullet and does not provide all the answers. Nevertheless, in my experience, working collaboratively creates understanding from both sides and has the potential to bring about solutions that would never have otherwise been considered. Moreover, over time, the cumulative effect of these instances of creativity have beneficial implications to a broader social system. People with lived experience have the keys to open many doors. With the expertise of professionals, this can create the knowledge to enter the right doors that can lead to a more purposeful and meaningful life for all concerned.

Rob Ferguson
Postgraduate student at the University of Nottingham undertaking a MA in social science research

References

Bevir, M., Needham, C. & Waring, J. (2019). Inside co-production: Ruling, resistance, and practice. *Social policy & administration, 53*(2).

Buck, G., Tomczak, P. & Quinn, K. (2021). This is how it feels: Activating lived experience in the penal voluntary sector. *The British Journal of Criminology.*

Loeffler, E. & Bovaird, T. (2020). Assessing the impact of co-production on pathways to outcomes in public services: The case of policing and criminal justice. *International Public Management Journal, 23*(2), 205–223.

Maruna, S. (2017). Desistance as a social movement. *Irish Probation Journal, 14,* 5–16.

McMullin, C. & Needham, C. (2018). Co-production in healthcare. In *Co-Production and Co-Creation* (pp.151–160). Routledge.

Morris, J. & Graham, H. (2019) 'Using technology and digitally enabled approaches to support desistance' (chapter 16) in P. Ugwudike, H. Graham, F. McNeill, F. Taxman & C. Trotter (eds.) *The Routledge Companion to Rehabilitative Work in Criminal Justice.* London: Routledge.

Porges, S.W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation (Norton Series on Interpersonal Neurobiology).* WW Norton & Company.

Weaver, B. (2019). Co-production, governance and practice: The dynamics and effects of User Voice Prison Councils. *Social Policy & Administration, 53*(2), 249–264.

Enabling effective probation practice using complementary digital media

Jason Morris

This article provides an overview of a recent pilot evaluation of the Skills for Relationships Toolkit (referred to below simply as 'the toolkit') (Morris et al., 2021). The toolkit is a technological adjunct designed to support probation practitioners to have conversations that promote positive relationship behaviour. This article provides a brief overview of pilot findings for the toolkit with a summary of the co-production work that underpinned its development. The article also highlights how the toolkit content was re-purposed during the Covid-19 pandemic before signposting future opportunities for digital approaches in supporting desistance.
This article has been adapted from a presentation delivered by the author at the 4th European Conference of Domestic Violence in September 2021

Developing digital content to target intimate partner violence

WITH TENS of thousands of people entering the criminal justice system every year convicted of Intimate Partner Violence (IPV) offences (see ONS, 2019), the effort to minimise reoffending remains a priority policy area for prisons and probation. Furthermore, a probation inspectorate thematic review regarding domestic abuse provision suggested the need to improve the range, volume and quality of domestic abuse interventions. It also suggested the need to ensure that shorter Rehabilitation Activity Requirement interventions were evidence-based and delivered effectively (HMIP, 2018).

The Skills for Relationships Toolkit employed a digital learning strategy called Complementary Digital Media (CDM) intended to assist practitioners in supporting the desistance of people on probation with IPV offences. Designing the content involved co-creating explainer clips that conveyed concepts and skills designed to help participants build on their strengths and overcome challenges that might be linked to their offending (see Morris & Graham, 2019). CDM clips help get conversations started between practitioners and participants during in-person and remotely delivered sessions. The clips aim to enhance participant engagement with group and one-to-one activities and to help them develop knowledge and skills that can support desistance. They can be hosted on a range of digital platforms and accessed between sessions or after interventions to extend the length of engagement.

> **Transcript:** *This is what the content of our animated clips looked like. Each clip addressed a different topic. We presented a character in a challenging situation and then we presented a skill that would help to resolve that challenge. The final step was to present the character in that challenging situation again, but using the skill to improve their relationship. The idea was that the clips would get conversations started between practitioners and participants to help them explore how they could live their life differently. (https://youtu.be/UN3IDrxBUd8)*

The clips used in the toolkit were originally created for a group intervention called 'Spectrum'. Clips were developed in partnership with probation staff and people who had completed domestic abuse interventions. Co-production was used to develop engaging, culturally competent

content relatable to either gay or straight men on probation or in prisons. Morris et al. (2019) suggested, based on the reflections of co-creators, that the experience of co-production can be consistent with factors deemed to be important in desistance. These themes include social inclusion, maturation and healthy self-narrative (see Maruna, 2001). The following animated clip and transcript capture the experiences that two Spectrum co-creators shared during an interview with one of the authors (CG) of Morris et al. (2019).

Transcript: Speaker 1 (heterosexual male): *People are committing domestic violence that don't even know it. They go through life completely wearing goggles and blinkers about the way they behave, the way they talk to people, the way they treat people.*

It's like the cartoon characters, it did a lot more for me than seeing real people. It's sounds a bit weird but it felt more. Having the voiceovers, you can hear the story, you can hear someone who's actually done it. You know the images and the words flashing up like that, it gets your appeal straight away. That's why I've taken so much interest in this, because – as I said – you can hear it, you can hear it in his voice when he's talking in the scenario, you can hear that this is real.

I don't think on the way (here) 'oh, I've got to go to this place'. There's a reason why you're going there. These people believe in you. Someone's gonna listen to you and you can say 'I did that'. I just felt accepted and wanted, I felt welcome when I came here every week. You know, I did it off my own back, took time off work to come and do it. But I felt good. Something like this. If I can give my guidance and knowledge to someone and make someone else's life better, there's nothing better than that is there?

Speaker 2 (gay male): *I made up a character called Cam. He was basically based on part of my life… bits of my life from experience that I've received from a child to now and creating a person that isn't me but kind of like me.… bringing those experiences into this room and putting them into scenarios to help other people in the future. What we're both saying is coming from our heads, from our heart and from our voice. It's real. It's true. It's not like Eastenders or Coronation Street. It's not written for you. My ex-partner, he's actually now a really good friend of mine. I showed him the videos that J sent me on email. He said to me, he said he said, 'I'm so proud of what you're doing'. Because we have had difficulties in our relationship, he could… you could see in his eyes that it's like I'm actually doing something with my life and getting to know myself again and not being the person that he knew I was when we were both together… and hearing him say I'm proud of you is… it's nice and it's like it gives you that buzz. It makes you believe in yourself. (https://youtu.be/M5zlFpoyBBs)*

The clips that were co-produced for Spectrum were designed to help participants meet several therapeutic objectives. Topics in the clips included: understanding domestic abuse; challenging attitudes relating to abuse; prosocial interpersonal skills; and emotional management strategies. Staff received guidance on how to use the clips to prompt therapeutic discussions about skills that could improve their relationship behaviour. They also encouraged participants to practice skills during sessions, complete worksheets and apply their learning in their day-to-day life.

Using digital content to structure desistance-focused supervision

After piloting them as a group intervention (called 'Spectrum'), CDM clips were repurposed as a flexible toolkit for probation practitioners (namely, the 'Skills for Relationships Toolkit'). The toolkit pilot enabled the Ministry of Justice to fulfil a commitment to test the viability of a new digital toolkit for

community-based staff that could be 'delivered as a rehabilitation activity requirement (RAR), or as a part of regular supervision with people who are unsuitable for an accredited programme or unable to participate in one' (pp.74) (HM Government, 2019).

The target group for toolkit was people on the national probation caseload who met the risk criteria for the accredited Building Better Relationships (BBR) programme but couldn't access it because of severe responsivity needs. The barriers to engagement for these men included: a range of mental health difficulties, extreme non-compliance and severe substance addiction. Years of outsourcing domestic abuse behaviour change work to specialist partner organisations often left the practitioners supervising these cases feeling ill-equipped to deliver behaviour change work during supervision.

The toolkit was intended to empower practitioners to provide structured support for people with IPV offences. It was not intended to provide equivalence to BBR, which remained the priority for people assessed as either medium or high risk on the Spousal Assault Risk Assessment (Kropp & Hart, 2000).

The Skills for Relationships Toolkit pilot evaluation

The toolkit was piloted in the North East of England in late-2019 and early-2010. The SRT pilot evaluation was published by the *Probation Journal* in 2021 (see Morris et al., 2021). The evaluation was based on analysis of quantitative delivery data and qualitative data from interviews with participants and practitioners. The evaluation highlighted some strengths of the toolkit and a few challenges.

The research found that a key strength was that toolkit enabled practitioners to develop therapeutic alliances with participants (even though participants often had severe responsivity needs). The clips may have facilitated the development of a working alliance by providing a shared focus that promoted therapeutic discussion during sessions. Practitioners described allowing participants to take control to play, pause and rewind the clips to ensure participants had a good understanding of what each clip was trying to convey. They suggested it was helpful for participants to discuss skills from a third-party perspective first, before practitioners focused in with questions that helped participants consider the personal relevance of applying what they had seen on the screen to their own life.

The flexible nature of the toolkit was also found to be an advantage that enabled practitioners to personalise delivery. Most of the content was needs-led, so practitioners would select the exercises that were most relevant to the goals of the participant. When required, they could also use alternative content to the prepared session to address live issues that participants brought to sessions on the day.

The evaluation also highlighted some challenges. There was a delay for some practitioners in adopting the toolkit into routine practice. Some practitioners described that a lack of confidence could be a barrier for practitioners adopting the toolkit into their role. Others spoke of a perception that the toolkit would take longer to prepare and deliver than what they were used to. Despite this, practitioners who used the toolkit indicated that they were quick to become confident with it and that little preparation time was required.

Another reported challenge was the need for more diversity in the narratives presented in the toolkit content. Most of clips followed the story of a central character 'Ash' who had distinct characteristics. When participants did not connect with Ash's story this was a potential barrier for them. For example, Ash abused substances in his earlier life and some participants who did not abuse substances indicated that this impacted on their ability to connect with the content.

Finally, some areas of some probation offices had a poor wi-fi connection and this created difficulties when playing clips. Practitioners at times had to find workarounds

such as using the hard copy storyboards and materials in the practitioner handbook.

Adapting interventions during a global pandemic

As the pilot process approached its conclusion, the onset of Covid-19 created profound challenges for probation. With the aim of overcoming barriers to the delivery of interventions, content from the toolkit (and other digital toolkits) was repurposed in different contexts to support the delivery of new and adapted services to enable desistance-focused work to continue during lockdown.

Colleagues at the HMPPS digital studio enabled digital toolkits (including the Skills for Relationships Toolkit) to be accessed via in-cell computers at two 'digital prisons'. People in prison on lockdown for up to 23.5 hours a day were able to view clips from in-cell computers, complete accompanying workbooks and receive feedback from programmes staff.

The Spectrum intervention (referred to above) was adapted for one-to-one remote access delivery to enable people in the community to complete it during lockdown.

As the country emerged from the first lockdown – and as part of the recovery effort for accredited programmes – HMPPS Intervention Services developed guidelines to help facilitators adopt a more flexible delivery model. Programme developers incorporated CDM into accredited programme session plans to convert them from a group delivery format into one-to-one and remote access delivered sessions.

Finally, a decision was made to roll-out the toolkit nationally to support people on probation who – because of Covid – could not complete the accredited BBR programme prior to their sentence expiring. The national roll-out commenced during the second national lockdown in November 2020. A team of HMPPS HQ staff delivered briefings to over 200 champions who managed the implementation of the toolkit office-by-office. A video briefing pack and practitioner workbook were developed to support the roll-out. A Microsoft Teams page for champions enabled information sharing and the facilitation of weekly surgeries that enabled support to be given by the central team.

Future directions

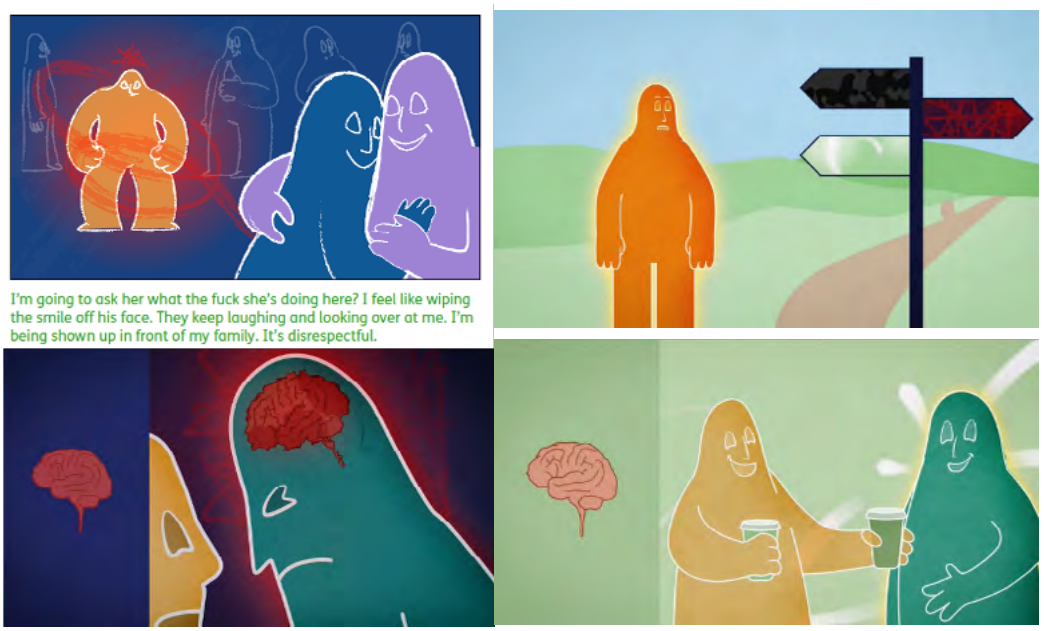
The national roll-out, aimed to incorporate the toolkit into routine probation practice. The toolkit has also been endorsed by the National Effective Interventions Panel and it is now part of an approved suite of probation practitioner toolkits.

The future development and evaluation of the toolkit will benefit from its digital format. Data analytics indicate that the Skills for Relationships Toolkit generated over 12,000 staff and participant views in the first 6 months of 2021. In future, it is hoped that a bespoke digital platform will be developed which will enable more sophisticated analytics to support future evaluation.

In line with the longer-term ambition for toolkits, and utilising innovation funding from the Home Office, a project was completed to diversify the animated content of the Skills for Relationships Toolkit. This project built upon the co-production model developed for earlier CDM projects. In total five people (four in the community and one in prison) agreed to co-create new Skills for Relationships Toolkit content. This project also built on suggestions made by a co-creator involved in a previous CDM co-production project (unrelated to Spectrum). He has also shared his experiences of this project are in the current issue of *Forensic Update* (see Ferguson, in press).

Our intention with the development of new Skills for Relationships content was to promote responsiveness to as broad an audience as possible. With the guidance of a content strategist, we increased the diversity of the narratives within the content and made the emotional states of the characters more visible. Visual strategies were adopted to create an empathic connection with participants. Visual cues signalling the emotional states of characters aimed to

Figure 1: Screenshots from upgraded SRT content.



assist participants in articulating their own emotional experiences.

As is the case with other CDM content, the outputs of the most recent Skills for Relationships coproduction project are likely to be re-purposed in several interventions and practitioner toolkits pending the approval of HMPPS governance and evaluation processes. The next iteration of the Skills for Relationships Toolkit will be subject to an implementation review as part of a wider evaluation plan for approved probation practitioner toolkits. We are also interested to hear from universities and psychologists in training to collaborate on further discrete pieces of outcome research examining research questions relating to the impact of the toolkit on people in prisons and on probation.

Conclusions

Throughout the Covid-19 pandemic, technology has been an enabler in the delivery of desistance-focused work to people on probation. SRT clips brought authentic stories and voices of relevant lived experience into socially distanced and remotely delivered intervention sessions. The design of these clips is important. Experts-by-experience are best placed to create relatable, culturally competent content. Through Complementary Digital Media, co-creators can inspire their peers to follow in their footsteps.

One of the big challenges with the use of technology in forensic settings is how it is integrated into the roles of practitioners. Complementary Digital Media is designed to be simple and familiar to practitioners by promoting core professional values and ideas rather than replacing them. The clips are designed to align with the aims and objectives of routine intervention sessions. The clinical messages they contain are not new; but the stories and delivery techniques are, and they offer the potential of a multi-faceted learning experience that is optimised for learners with a wide range of learning styles.

Finally, digital can provide opportunities for service integration within prisons and probation settings by promoting consistency in messaging across different parts of the system. Therapeutic content accessed through a computer in a prison cell or from a mobile phone in the community has the

potential to help make users' experience of therapeutic messaging more consistent and coherent across different transitions within the criminal justice system.

NB – this article provides an exposition of the views of the author and does not necessarily reflect HMPPS policy on interventions.

Jason Morris
Senior Policy Manager,
In-House Interventions, Service Design,
Probation Reform Programme,
Her Majesty's Prisons & Probation Service

References

Ferguson, R. (in press). Transforming criminal justice through co-production, *Forensic Update*.

Her Majesty's Inspectorate of Probation (2018). Domestic abuse: The work undertaken by Community Rehabilitation Companies (CRCs). A thematic inspection by HM Inspectorate of Probation. Available at: www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2018/09/Report-Domestic-Abuse-the-work-undertaken-by-CRCs.pdf (accessed 16/09/20).

Her Majesty's Government (2019). Transforming the response to domestic abuse: Consultation response and draft bill. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772202/CCS1218158068-Web_Accessible.pdf (accessed 15 August 2020).

Kropp, R. & Hart, S.D. (2000). The Spousal Assault Risk Assessment Guide (SARA): Reliability and validity in adult male offenders. *Law and Human Behavior, 24,* 101–118.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives.* Washington, DC: American Psychological Association.

Morris, J., Gibbs, C., Jonah, L. et al. (2019) Developing content to promote desistance in men who have committed intimate partner violence in same-sex relationships. *European Journal of Probation, 11*(2), 96–113.

Morris, J. & Graham, H. (2019) 'Using technology and digitally enabled approaches to support desistance' (chapter 16) in P. Ugwudike, H. Graham, F. McNeill, F. Taxman & C. Trotter (Eds.) *The Routledge Companion to Rehabilitative Work in Criminal Justice.* London: Routledge.

Morris, J., Raducu, A.A., Fuller, M. et al. (2021). Towards a desistance-focused approach to probation supervision for people who have committed Intimate Partner Violence: A digital toolkit pilot study, *Probation Journal, 68*(2), 261–281.

Office for National Statistics (2019). Domestic abuse in England and Wales: Year ending November 2019. Available at: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2019 (accessed 15 August 2020)

'Flying the plane whilst building it' A group reflection on the experience of a coproduced research steering group

Karen Stanners, Abbie Woodhouse, Fiona Wood

THE FOLLOWING reflective interview shares the experience of being part of a coproduced research project, from the perspective of the steering group involved. The project is based in partnership across TEWV and CNTW; with participants recruited from both a community learning disability service, and learning disability secure/forensic outreach and rehab services. From the outset the project has been coproduced by the steering group; made up of NHS psychological professionals, service users, and carers with lived experience of learning disability services. The research has aimed to explore how individuals with learning disabilities have experienced the Covid-19 pandemic; and whether these experiences are the same or different to how their carers think they have experienced this. It is hoped that the project will not only promote the importance of capturing the voices of individuals with learning disabilities within research; but also promote the value of coproduction within research across learning disability and forensic services.

In this piece, the steering group have provided a reflection on being part of a coproduced research project; and considered why coproduction is important in research and NHS services as a whole.
(AR – Lived Experience Researcher)

AW – To start with, I wondered if you could each think about what coproduction means to you?

KS – Well, I think it means involving different people with lots of different thoughts and experiences. So anything that's produced is collaborative and reflects more than one person's view I guess.

AR – I think for me coproduction is basically equality and equity in views, in thoughts; and being able to be valued when attending meetings. Being able to feel as though you are really part of the team, and not just somebody who is called to the odd meeting to spread your views. It's all about listening, learning, reflecting and basically just working together as a team; and all discussions are put out to all of us and we all have an equal say and view. For me, coproduction works really well when there's a lot of accountability. There are things that we bring to meetings that I think other people with lived experience are, quite rightly, able to bring. I feel specifically for this group, there's no issues with our views being shortened, with them being misconstrued, being edited or doing anything wrong. I think our views are valued to such an extent that I think the research project in itself; without this way of working and coproduction, I don't think it would have gone anywhere without us. So a tap on the back to all of us.

FW – I don't think I could explain it any better than a combination of what Karen and AR have said. I think what's really nice is that I could explain what co-production is and it would be something that I've read in an article about what it means, but I like what's been said about equality and equity as well. I suppose that's what it means to me, it doesn't really matter what somebodies background is, everybody comes together and brings their different experiences and it's what makes for a richer, better project. There's so many things that we would never have thought of had we not had this steering group, and I think AR is right, it either

wouldn't have taken off or we would have done it and it would have been poor and not as meaningful. So it just completely changes the scope of the research.

AW – Could you say a little bit about the research we are doing, and what your experience of being part of a coproduced research steering group has been like?

AR – For me the understanding of the research is all about hidden voices that need to be heard, and I think being part of this group in itself, I know that my voice is being heard and I think that we need more groups such as this so that we can hear those hidden voices. Because without listening to them we don't actually have anything were we can make things better for people; and it's great for me because services will then become a bit more responsive and look at me as not just a service user, or drain of services, or somebody with a learning disability, they'll look at me as a whole person.

KS – The research is looking at comparing people with learning disabilities experiences of Covid-19, with their carer's perception of the experiences of the individual with a learning disability. It's like how they deal with it, compared to how their carer's think they deal with it… it's been done very well! I think I came at this with no experience of being part of these things before. I understand what research is because of my job; so I didn't have difficulty understanding the idea of it; but I think getting my head around the process as we've gone along has been a development. It's definitely taken a long time to get things going, it was slow to get things started and things didn't feel so clear to me at the beginning. Perhaps people might not realise the amount of time it does take to do good coproduction research… don't expect things to happen in five minutes these things take time. But working in a coproduced way draws on everybody's strengths. We also haven't got a very big steering group, so it would be great to encourage other people with lived experience to get involved and join in with research opportunities. I think a wider set of people to offer their experiences will only be beneficial. So please get involved and help shape things for the future! I've found the process really interesting and I'd be keen to be involved again in the future. In terms of the process itself, the main involvement to this point has been around monthly meetings and opportunities to get further involved in the process as we can, with things like attending the focus groups and the research ethics committee (REC). I've also took part in training, and that's been a good way for me as a carer to make contacts with people who may be a support for myself or my son within this arena and that's really positive; widening our knowledge of services and making those links. Opportunities that arise from being part of the steering group are beneficial, and raise your awareness of other things that are out there.

AR – I think being part of the steering group in itself has almost been… as I was listening there, I started thinking of the word 'tribe'. Being part of something, where its not just the research that's about people like myself and us trying to be heard through Covid-19; but us being heard just generally. I think a lot of research projects don't let you get as involved as I feel as though you guys have. So things like the REC last week, and the focus groups, these were options. Where whenever I've done PPI before I've never been invited to or involved in at all. Even as an observer which would be fantastic. So I think it's that sense of being accepted, and that when I'm here on top of doing the actual work itself we're actually building relationships. We have a little community here. You remember things like that; you remember the challenges that we've gone through, and I think that Karen is right that having more people involved would be really helpful. There's things to remember about coproduction, it's time consuming it's also very messy; there's no one way of being able to do it and going 'wow this is the method'. I think the group that we have here has naturally been doing it. As I said the invitations to events and things like that, normally you would never get that in any kind of research project at all; and

I think to have people that have got impaired cognitive issues as well that's literally unheard of. Nobody that I've met before this has ever let this happen. So I think the way you've been working has just been natural coproduction, where there's no restrictions on both of you saying 'why do we need to invite AR and Karen to that', it's more like 'we're doing this, do you wanna come'. It's a very natural way of working. So I think its coproduction, and the feelings that go with it really make you feel more confident. I've been offered extra meetings with Fiona to help process things from the bigger meetings, and take time to express things I couldn't; and those meetings are sometimes two hours in themselves, but she lets it happen. You don't get that with other groups, it's all just email contact. Being able to see people, especially during Covid-19 when you can't see people that you gel with, it's made a difference. Being able to talk about regular lives not just the work itself. For me it's all about the relationships and going through things together as a group, not just with the research but in life in general.

KS – It's interesting hearing AR saying that, because I haven't been involved in groups like this before. I suppose I've maybe come into a group that's set the standard very high listening to that. I don't know any different, whereas AR does; so I suppose it's a good nod to you two in how you've managed the group and involved us in everything. Which to me, coming in cold to the group is the norm; you've set that standard as the first thing I've been involved in. So if I then went on to something like AR was talking about and it wasn't like that, I'd be thinking why are they not doing that. It's set a benchmark for good practice.

AR – Often with PPI you find the services seldom ask you to do something 'cos they worry they'll have to pay you the standard rate of £25 an hour. But sometimes I'll proactively email people and say 'this is really interesting can we meet up for an hour no charge' and I feel the need to put that in the emails, so they don't feel as though through a conversation they're gonna have to pay me. Whereas in this group, I didn't take payment but the opportunities that have been given in groups, and seeing how you do things, learning some skills in how you deal with people, and how you get the answers to your questions in a way that they understand. Just that you've given us that chance; it's the valuing of people. And I've felt very valued being invited to things, with no expectations from you guys for me to deliver, or turn up, or do something; there's been no agenda it's just open unlike a lot of these groups. So I think Karen you've been very lucky, the bar has been set. But yes, I think sometimes payment becomes a barrier to coproduction because people think that in order to coproduce they're going to have to pay people. But I think often people are just really into the coproduction agenda and really want to help. Like me and Karen, we're just fabulous people! We want to better our own lives, as well as our family members.

FW – It's really lovely hearing both of your reflections because it was something that was really important to me and Abbie when we set the group up, that it was coproduced from the outset. But I do think we were a bit naïve to be honest on how it would all work, and how much guidance we should give; when I think about the early days, I think I had this idealist version of coproduction where we would always make all of the decisions together, all the decisions would be from all of us. And of course that is what you aim for, but there is also something about giving people choices, and not overwhelming people; and I think that's what I really learned from the early days. It's really important for things to be collaborative and coproduced, but there also needs to be some boundaries to make things feel safer.

KS – Yes I think that's something that's helped as we've gone on. When you, as professionals, gave a bit of guidance around different processes and terminologies; I think that helped and it has its place, as long as there's the opportunity to challenge and disagree.

AW – I think that's the important thing to remember, that everyone in the group has their value. I think initially we came in with such a blank slate and just went 'right guys, what shall we do', and almost took too much of a backseat; where you guys then fed back to us 'okay but tell us what the options are'.

KS – yes I think there was too much for us in beginning that it left us not knowing what we should do.

FW – we almost came in as facilitators of the research and forgot that we also need to be an equal partner

KS – it's all been such a learning curve, and that's going to be really help for future projects.

AW – So why do you think it's important to coproduce research and what would you like other people to know about the process?

FW – It's important to coproduce research because you get a completely different project, which is inherently more meaningful than the other projects I've been involved in that wasn't coproduced. It will definitely take longer, so you need to plan for that. But I think the value in it will be immeasurable. I think I have learnt a lot about research, about people, about the things that I maybe take for granted, and the questions I don't ask from being involved in a coproduced piece of research. Hopefully in the future every other bit of work I do will be coproduced. But say even if there was work I did that wasn't; there will now be questions I ask that I wouldn't have asked had I not had this experience. So just do it, people just need to do it!

AR – I suppose for me it's always been about that fundamental question of do you really want to make a difference or is this just lip service. To get your name on a piece of paper and everyone to go 'wow fantastic you're a researcher'. There's different motivations for doing this work, and I think if you do things in a coproduced way, truly coproduced, not just saying that you have; to really do it and invest your time and energy, the results are immeasurable. I think it really sets the standard and I think we've all learnt skills all round. I think most of us have learnt confidence; I think people with lived experience, our confidence is usually whittled down due to services and fighting for our rights, being supermen and superwomen and constantly being on that grind. In working in a coproduced way you're building confidence, you're building meaning and purpose for people's lives. Doing something such as this, I feel as though my voice matters, that I'm able to be more confident, that I'm able to talk about this really well and understand where it's going. I think more than anything it's making a difference to my life and how I see the world, and to understand that there are some genuinely nice people out there and people that want to help. People that are not just doing it to have their name on a document and I think that's the most important thing, that we understand that coproduction does take time. In this case it's taken a lot of investment and that's priceless. I think we've done it in such a way; and you'll notice I'm saying 'we' not just me, we've all contributed in some such way to make this project be fantastic. Moving forward after we've finished this I hope we can all stay in touch. I'm feeling more valued and more heard and I think this is such a great way of working. I know Fiona mentioned that we did have issues in the beginning trying to build boundaries, but I think that was the best way of working, because were flying the plane whilst building it. We're learning, and I think in a lot of ways it's changed all of us for the better.

KS – I think it's really important for people to know in a lived experience role, it's obvious but I think it needs saying... nobody professionally can give your perspective, or dimension, or experience of what you do. So it is invaluable in that sense. Someone sitting behind a desk, with the best will in the world professionally just can't comment really on lived experience. People should recognise how valuable it is to bring forward to help shape services and make their voice count.

It's about the value really of what people can offer, and that's so varied depending on the person. And that's why the crux rests with the person to have the awareness of what's available for them to be able to contribute; how they can share. It's really important for people to understand how crucial their experience is.

Karen Stanners
Lived Experience Researcher

Dr Abbie Woodhouse
Specialist Clinical Psychologist, Health and Justice, Secure Outreach and Transitions Team – Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

Dr Fiona Wood
Clinical Psychologist, Learning Disabilities Community Treatment Team- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

The intermediary role

Francesca Castellano & Robert Ian Thomas

THE SCENE is a crown court in one of England's biggest cities. The complainant, a young woman who alleges sexual assault. The defence barrister, also a woman, has made no headway in trying to cast doubt on the complainant's account. She tries one last throw of the dice. 'I put it to you that everything you have told this court is a complete and utter fabrication'. The complainant thinks for a moment, nods, and says, 'ok then'. Following an intervention by the intermediary, the question is put again as 'have you told the truth today?' The answer this time is 'yes, everything I have said is true'. However, the jury had already heard her first answer, which contradicted the second and may have introduced an element of doubt into their minds, putting at risk the credibility of her account and leading to the possibility of a wrong verdict.

This, in a nutshell, demonstrates the importance of making sure that the vulnerable – complainants, witnesses, defendants – understand what they are being asked in court, clearly and unambiguously. Though this is a particularly vivid example, it is by no means untypical. It neatly encapsulates the challenges faced by vulnerable people (VPs) who may well have had no experience of the unique complexities of the court system, let alone the type of language and linguistic structures used by barristers. So, two issues arise from this scenario: the challenge of the language itself and effect that answers can have on the court. Let's take language first.

If the complainant had not understood the word 'fabrication', it is clear that her best option would have been to state this and the question could have been rephrased before it was answered. However, she may have thought she had understood it, which is at the heart of the argument for advocates reducing their questions to writing and discussing them with an intermediary prior to asking them in court, so that the effect of any potential ambiguities can be mitigated. Then again, even if the complainant had not understood the word, it is entirely possible that she would not have wanted to admit this in front of a room full of strangers, at least some of whom were much better educated and of a higher social status. As Alan Bennett said, 'it's embarrassment that keeps us in our place.' Clients will often say that what they fear most in a court appearance is not being convicted but being made to look stupid in public.

This brings us on to the second point: the effect that answers can have in a court room. There is a performative aspect to court that many new to the system will struggle to understand, whether through inexperience or learning difficulties. Everyone needs guidance in how they are presenting themselves and the impact their words can have on judgement. For the vulnerable, the need is all the greater.

Intermediaries work in the justice system to assist the vulnerable. Clearly defined in the Youth Justice and Criminal Evidence Act 1999 (YJCEA)[1], vulnerability is not so easily

[1] The JYCEA defines vulnerability as All child witnesses under 18 Any witness whose quality of evidence is likely to be diminished because they: are suffering from a mental disorder (as defined by section 1(2) of the Mental Health Act 1983 and amended into a single definition by section 1(2) of the Mental Health Act 2007; have a significant impairment of intelligence and social functioning; or have a physical disability or are suffering from a physical disorder.

pinned down in practice. A defendant with high functioning autism may appear to all intents and purposes to have no difficulties with communication, but in a case, the problems for one such juvenile standing trial for murder lay in communication's grey areas. He struggled to interpret tone, idiomatic language, nuance, implication, sarcasm, all frequent devices used by barristers in court, unconsciously or not. Whilst there is debate around the extent to which non-verbal communication plays in conversation, there is no doubt that missing the key ability to 'read' these areas would significantly impoverish understanding.

Intermediaries work across crown, magistrates', family and youth courts as well as in tribunals. Intermediaries also meet with psychologists, probation officers, solicitors, and barristers. There are different types of intermediary but essentially they all perform the same role which is to facilitate communication between a vulnerable person and legal professionals. Registered intermediaries (RIs) perform this for the prosecution, where an intermediary may also have advised the police on how to frame their questions. Court appointed intermediaries (CAIs) will assist defendants in criminal trials and those in family courts. RIs can also act as CAIs with the appropriate training.

The process of intermediary work starts with a referral. First, the intermediary sits down (or Zooms) with the client and runs through a series of tests to assess and establish the client's communicative abilities. There are particular risks associated with remote assessments. A number of intermediaries have observed that remote assessments can lead to disinhibition in clients which makes the process less reliable. The second step is the report. This crucial document gives a brief overview of the assessment, includes relevant details about the client and makes recommendations regarding the assistance they might need, if any. Whilst intermediaries often must produce a report solely based on their assessment, they can sometimes access background information such as psychologists' reports, school reports, statements of educational needs, exam results and so on. In this way, an intermediary can draw upon established knowledge and combine with their own observations from the assessment to provide a robust understanding of their client.

An RI's report will be seen by the solicitors, barristers, and judge. A CAI's report is delivered directly to the judge via the solicitor. Judges then decide whether to appoint an intermediary and, if so, whether the intermediary is to be appointed for the whole trial or for evidence only for the defendant. In the latter case the intermediary will assist only when the client is giving evidence. In the former then the client will be assisted throughout the trial. RI's normally assist only whilst a witness or complainant is giving evidence.

The process is one thing, but the softer skills of establishing rapport with the client at an early stage is absolutely key to its success. Appearing in court in any capacity can be a uniquely stressful experience and very often the intermediary will be the person in court who has the best relationship with the client. Besides explaining proceedings and ensuring the client is asked questions they understand, intermediaries are responsible for emotional regulation. Clients, whoever they are, are much more likely to understand what is said to them and to be able to express themselves clearly when they are calm. This can be achieved in several ways.

If an intermediary judges that their client is vulnerable, their report will include a request for special measures. The most common of these is the appointment of an intermediary in court, but measures can include the use of a live link room, with the vulnerable person giving evidence from a room separate to the court; video recording of evidence, known as section 28; and the use of screens around the witness box, so that the vulnerable person can only be seen by the barristers, judge and jury, thus avoiding the additional anxiety of the defendant being able to see the complainant. These are at the discretion of the judge. A well-known example of a special measure

involved allowing an autistic witness to take a toy lion's tail – a comfort object used by the witness in their everyday life – into the witness box to hold when giving evidence. Heightened anxiety is a characteristic emotional state of many people with autism, and the provision of a comfort object can ensure that they are calm enough to give their best evidence.

Whether or not special measures are effective lies in rapport the intermediary has formed with the witness/defendant and there is no 'one size fits all' solution. A comfort object could be a photograph of a loved one to remind a vulnerable person who they are tolerating the stress of giving evidence for. A tangible aid, such as a koosh ball, can engage psychomotor skills of a VP with attention deficit hyperactivity disorder, enabling them to focus on the volume of information they are being asked to attend to. In a crown court case of familial historic sexual abuse, the complainant (with learning difficulties and post-traumatic stress disorder) had, for two days, frozen at the point of being questioned about the alleged offences. In exploring why she had only brought the case against her father after such as long period, it was the intermediary who discovered that it was the recent birth of her child that had spurred her to do so. On the third day, she gave evidence whilst stroking her child's toy, imbued in lavender oil, on her lap. It is this unquantifiable soft skill that can often make the difference to a vulnerable person being able to endure the pressures of court.

A good intermediary needs analytical skills, an ability to communicate clearly and empathy. One other important quality is often overlooked: the courage to be assertive. Whilst intermediaries are not members of the legal profession, they can be called upon to give advice on how best to manage the vulnerable person's path through the trial. At times, as in the first example, they intervene while a barrister is in the full flow of cross examination, which is understandably unpopular. Life experience, acquired through a pre-intermediary career, is invaluable.

The Authors

Francesca Castellano, BA Hons., MSc., MBPsS changed careers by taking a Masters in forensic psychology whilst working in the film industry for companies such as Sony, Warner Bros, and Miramax. Whilst studying she worked as a Victim Support worker and an Appropriate Adult in and around London before going on to work as an intermediary. She specialises in working in criminal cases in Crown Courts across the United Kingdom with defendants and witnesses over six years old with impaired communication, including Mild/Moderate learning difficulties, Autistic Spectrum Disorder, substance abuse problems, Attention Deficit Hyperactive Disorder, Obsessive Compulsive Disorder, Oppositional Defiance Disorder, anxiety, and depression. Francesca is bilingual in Italian and speaks fluent French. A trustee of the charity Intermediaries for Justice, she is married with two children.
IntermediaryFC@gmail.com

Robert Ian Thomas M.A., MSc., N.P.Q.H. is an independent intermediary assisting vulnerable clients in Crown, Magistrates, Youth and Family Courts. A Welsh speaker, based in South Wales he works mainly in courts in London and the Midlands. His first career was in English teaching working in schools in the North of England, South Wales, Singapore and the Midlands. The last nine years of his career were as an Assistant Principal at a secondary school in Dudley, just outside Birmingham. After taking early retirement he trained as an intermediary and volunteered as a Samaritans Listener for four years fulfilling a number of roles for the charity including in the prisons team and also as postvention advisor. Each of these roles, teacher, manager and Samaritan have proved to be excellent preparation for the intermediary role which requires a facility with language, the ability to speak to a wide range of people in a way they understand and a combination of a thick skin and sensitivity to the needs of others. A Trustee of the charity Intermediaries for Justice he is

married with two children in their twenties. A qualified Rugby Union referee he holds season tickets for Cardiff City and Glamorgan County Cricket Club.
robertthomas7355@gmail.com

Outside the window

As I sit behind my door
With nothing around but walls and floor
The days are long
The nights are short
But life goes on
Of this I've thought

However long there is to wait
The future lies beyond the gate
I hear the signs of life beyond
The gates and fences all around

The things around I hear and see
Songs of the birds, the buzz of the bee
People on horses trotting by
Beautiful colours of the butterfly

I see the people walking dogs
And hear the pound of the ones who jog
The dogs bound around the field with glee
So happy to be alive and free

The pigeon that stops by each day
On my window sill then flies away
He says hello with his cooing sound
Before he leaves homeward bound

Throughout the year sights and sounds alter
And my enjoyment it never does falter
The changes are a joy to see
Autumn colours on every tree

The change of songs the different birds sing
The awakening of the flowers in spring
Summer brings the swallows in flight
While winter arrives with a frosty bite

I love to watch the world still live
And think of all it has to give
I know that when my time does come
I'll embrace the world and join the thrum

I see the planes as they fly high
Or hear the trains as they go by
I dream of where they travel to
The country or the coast with the sea so blue

So don't sit around to moan and mope
Cos the joy of life gives so much hope
Your time will come when you are free
To be anything you dream to be
Embrace the sounds of the things you see
Fill you heart, you hold the key.

Poem written by a resident on PIPE

PIPE: The journey so far

Gus Nico

MY JOURNEY to HMP Frankland P.I.P.E started with four prison officers. The officers came in the morning and took me in to one of the side rooms, stripped me and then asked me to put on one of their Cat A boiler suits. I had been at Broadmoor for 20 years, 24-hour nursing support, psychology sessions, access to the garden all day and showers in the bedroom.

Now I was feeling dizzy, Broadmoor had dosed me up with Diazepam for the journey to HMP Frankland. Unsteadily I got into the Cat A van being doubled cuffed did not help. It took five hours to travel to Frankland and I felt sick. I got into reception and I felt like crap. I wanted to commit suicide right there, I planned it all out in my head and I was ready to put my plan into action. It was then that I noticed all the cameras and I was so frustrated and annoyed. About half an hour later two mental health nurses came to assess how I was feeling. After the assessment they put me on constant watch this involved a CCTV camera being put up in my cell again, I felt very frustrated.

I arrived on the P.I.P.E early evening. A couple of officers greeted me and offered me some chicken then I was given a bag of biscuits, soap, deodorant, a toothbrush and toothpaste. I was very wary of this kindness from prison officers but I remained polite.

I walked into my cell, there was a TV and a kettle. Having a TV was and is helpful to prevent things getting too bad. Then came the thing I feared the most, the cell door locking. I had to isolate for 14 days because of Covid. This period messed with my head badly. I started hearing voices and seeing things more. The flashbacks got worse but ironically it was the prison officers who supported and believed in me. I felt the NHS prison mental health nurses just fobbed me off and refused to give me any effective treatment. I was so confused and angry – how is it that the prison officers were more understanding at this time?

My head was blown to pieces but I kept on thinking 'use your safe place.' I spent a lot of time stuck behind my cell door, but staff made sure I had DVD's, tea packs, TV guides and time to talk if I needed it. Officers regularly started to come to my door and ask if I wanted to come out and do some cleaning, my answer was a resounding yes, yes, yes! Working was a way to briefly get away from my mental health issues which I was very grateful for. With the extra time out of cell I am slowly building my relationships with officers but I often still feel frustrated and annoyed with myself and this can affect others, because they misunderstand who I am angry with. Recently I was given a job as a wing painter, this also has been an opportunity to learn more skills which was kindly pointed out by my keyworker.

The prison service moves slowly so I have had to temper my excitement at being a wing painter and try to be more diplomatic with staff. It is interesting that there is a learning experience in almost everything we do. It is just a case of looking for it. So far with help of officers and other inmates I am learning what it is to be a P.I.P.E resident. When you first come here it is hard to see where the treatment is but the treatment is consolidation of all your strengths and learning to live with all your weaknesses. It is also learning how to deal with the condition that is human nature. Nobody is perfect, this applies to every one of us but it all comes down to one thing, how you deal with the positives and negatives that is P.I.P.E.

Gus Nico

Highly Specialist Forensic Psychologist

Jen Tomlinson

Background

WHAT IS service user involvement? Put simply, service user involvement is the active participation of a person with a lived experience of mental distress in shaping various aspects of their own intervention journey, in addition to contributing to wider organisational provision and policy based on their own knowledge and experience. Integrally linked is the principle of co-production: the way of working where service users and providers work collaboratively to reach a collective outcome. This is a value-driven approach with the underlying principle that those who are affected by a service are in the best position to help create it.

Over the last 25 years, governments around the world have promoted the importance of service user involvement in an effort to improve the quality and effectiveness of health services. Service user involvement has also been promoted by the World Health Organization and several countries have developed legislation strengthening the influence of service users and giving them greater control over the services they receive (Crawford et al., 2002[1]). Consequently, various studies have suggested numerous benefits of service user involvement including improving the information and accessibility of services, the co-ordination of care, and, increased quality of the relationships between clinicians and those receiving treatment (May et al., 2009[2]; Tehseen, 2013[3]).

Since 1999, NICE (National Institute for Clinical Excellence) has involved patients, service users, carers, and the public including voluntary, charitable, and, community organisations into its work and specifically the production of clear guidance and quality standards on various social care topics. The underlying philosophy of service user involvement is that it adds value to the discussions that inform the resulting NICE guidance which promote good health, illness prevention, and importantly the care that individuals should receive. The NICE's commitment to service user involvement dictates that:

1. all NICE advisory committees and working groups should have at least two lay members (patients, service users, carers or members of the public); and
2. all guidance is available in language and formats suitable for the patients, service users, carers and the public.

In adopting this approach, all guidelines produced are believed to have a greater focus and relevance for the people most

[1] Crawford, M.J, Rutter, D., Manley, C. et al. (2002). Systematic review of involving patients in the planning and development of health bare. *British Medical Journal, 325,* (7375), 1263.

[2] May, C., Montori, V., Mair, F. (2009). We Need Minimally Disruptive Medicine. *British Medical Journal, 339,* (7719):485–487.

[3] Tehseen, N. (2013). Service user involvement, authority and the 'expert-by-experience' in mental health. *Journal of Political Power, 6*(1), 49–68.

directly affected by the identified recommendations (NICE, 2021[4]; Department of Health 2012[5]).

The Primrose Service

The Primrose Service is a non-residential, prison-based, specialist treatment service for a maximum of 12 adult recipients with complex personality. Located in HMP Low Newton, the Primrose Service is: co-commissioned by both the National Health Service (NHS) and Her Majesty's Prison and Probation Service (HMPPS); part of the national Offender Personality Disorder (OPD) pathway; and, is reserved for recipients considered to pose a high risk of harm to themselves and/or others and in need of a high intensity assessment and treatment pathway.

The aim of the Primrose Service is 'to provide a service in a safe and supportive environment, allowing a journey of recovery and self-discovery, identifying links between personality difficulties and risk in an individualised way'.

This aim can be broken down in to three core components:

- to provide a safe and supportive environment for the women who use the service;
- to encourage a journey of recovery and self-identity; and
- to identify links between personality difficulties and risk.

In order to achieve the aforementioned aims, all aspects of the Primrose Service from the assessment through to formal treatment and the complimentary treatment regime are underpinned and guided by various theoretical models:

- Trauma Informed Care (Tees Esk and Wear Valleys NHS Foundation Trust);
- The Chime Recovery Model (Leamy et al., 2011[6])
- The Enabling Environments standards (Royal College of Psychiatry, 2013[7])
- Integrated Model for the Treatment of Personality Disorder (Livesley 2006, 2016[8])
- The Good lives Model (GLM) by (Ward 2002[9])

Trauma informed care

Women imprisoned in England and Wales represent approximately five per cent of the overall prison population (October 2020[10]). An increasing body of evidence suggests most women in prisons have experienced trauma that has had lasting impacts.

Trauma is defined as the response to a deeply distressing or disturbing event

[4] National Institute of Clinical Excellance: www.nice.org.uk/about/nice-communities/nice-and-the-public/public-involvement/public-involvement-programme/patient-public-involvement-policy

[5] Health and Social Care Act (Department of Health, 2012)

[6] Leamy, M., Bird, V., Le Boutillier, C. et al. (2011). Conceptual framework for personal recovery in mental health: Systemic review and narrative synthesis. *British Journal of Psychiatry, 199*(6): 445–452.

[7] Royal College of Psychiatry (2013): http://www.rcpsych.ac.uk/improving-care

[8] Livesley, W.J (2001). *Handbook of Personality Disorders: Theory, Research, and, Treatment.* New York: Guilford Press.

[9] Ward, T. & Brown, M. (2004). The Good Lives Model and conceptual issues in offender rehabilitation. *Psychology, Crime, and, Law, 10*(3), 243–257.

[10] Statistics supplied by www.gov.uk/government/statistics/prison-population-figures-2020

that overwhelms an individual's ability to cope causing feelings of helplessness, and, a diminished sense of self and perceived ability to feel a full range of emotions and experiences. Responses to a traumatic event vary significantly among people and as such adds to the complexity of being a trauma survivor: some individuals will experience multiple symptoms for a contained period of time (ASD)[11], whilst others will go on to experience symptoms for a prolonged period (PTSD)[12].

Trauma-informed care acknowledges that the experiences trauma survivors have in the criminal justice system can inadvertently add new trauma (revictimise) and deepen the impact of existing trauma, rather than lead an individual to positive change in their lives (The Crime Report, 2020) [13]. As such, a trauma-informed approach prioritises attending to all aspects of the treatment provision (including specialist staff training) to give individuals a chance to understand the impact of trauma on their lives, heal, and learn to thrive despite past experiences.

Service user involvement in Trauma Informed Care within Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

As part of the trauma-informed care approach within TEWV, all staff must complete training which focuses on the key principles of trauma-informed care. Subsequently, all teams are required to develop a trauma-informed action plan which is designed to progress all services from being trauma-aware to becoming trauma-informed and ultimately trauma-embedded in its applied practices. Integral to this, and in accordance with NICE guidance, is service user involvement and the acceptance that experts by experience are in the best position to help, advise and guide service development and provision including staff training.

As part of the Primrose Service's trauma-informed action plan, in February 2021 service users accessing the Primrose Service were approached for consultation in preparation for revising the staff training package on trauma informed care and compassion focussed working. The consultation was a staged process spanning seven weeks. The different stages included:

1. An information letter providing details about the Trust's trauma-informed strategy, the context for revising the existing staff training package, details of the timescales involved for the consultation process, and, an overview of the potential role for service users to have as part of the consultation process.
2. For those that agreed to take part in the consultation process, an invitation to an initial meeting to familiarise with the contents of the existing training package was arranged which allowed for the gathering of initial thoughts from service users about the content, and, agree the areas requiring revision.
3. Dissemination of letters to participating service users detailing the specific pieces of work that they have agreed to input on and the deadlines for these.
4. A series of subsequent focus group forums to discuss and agree proposed revisions.
5. An invitation to a second meeting with the service users to collate and finalise the revisions ready for submission to the

[11] Acute Stress Disorder – the experience of post trauma symptoms for a contained period of time, usually a few weeks.

[12] Post Traumatic Stress Disorder – when symptoms last more than a month and severely affect a person's ability to function.

[13] https://thecrimereport.org/2020/10/08/the-trauma-of-women-in-prison

trauma lead of the Trust.
6. A final outcome letter sent to all service users advising of the Trust's acknowledgement for the work completed.

Summarily, collaboration with service users highlighted numerous areas to consider for revision. From the preferred language to be used by staff, which included alternatives for the word trauma, through to suggested inclusions within the training to aid staff in their ability to work effectively and safely with trauma survivors and those for whom the lasting impacts of their experiences continue to manifest in daily presentations: all suggestions were generated by the experts by experience within the service.

Reflections on service user involvement and co-production

Research into service user involvement describes repeated difficulties in translating service user empowerment in an applied way (Omeni et al., 2014[14]), with environmental aspects having the unintended effect of revictimising individuals in our care by virtue of the oftentimes prescriptive aspects of the institution in which someone lives or accesses. Framing empowerment as the process of becoming stronger and more confident, especially in developing a sense of innate value, one could argue that service user involvement and co-production is at the core of providing a solution to bridging the gap between what we know we should do when working with others and actually finding successful ways in which to do this.

The various stages of co-production in this instance afforded a respectful, non-judgmental environment in which service-user contributions were at the fore. Co-production afforded the opportunity for the development and strengthening of therapeutic relationships. Those involved reported feeling encouraged and subsequently felt able to discuss their thoughts and feelings about the existing training package and its shortcomings. Open review of the contents demonstrated two important principles: fallibility and equality, both of which are essential in promoting empowerment. In this way, the process of co-production adhered to the health care definition of empowerment which stipulates that patient independence may be optimised by helping patients to assert control (Gibson, 1991[15]).

The process of service user involvement and co-production in this instance seemed to have unforeseen empowering benefits for one service user in particular. Aside from the suggested revisions for the staff training package, the conversations engendered private reflection for the service user, who subsequently produced a poem about their own trauma experiences to be included in the staff training package to illustrate their daily experience as a trauma survivor. The poem, untitled, is included here:

You pull me in, you spun me around,
You're in my head, you make no sound.
You make me weak and feel isolated,
I can't talk about it, I might be hated.
I can't breathe sometimes, I know you're there,
Why won't you go, why don't you care?
Did I go wrong? Why did this happen?
I look back at my life, I can see there's a pattern.
You holed into me, like you want me to know,
The flashbacks, the nightmares, the images you show.
Hopefully one day I'll leave you behind,
You'll be out of my body and out of my mind.

[14] Omeni, E., Barnes, M., MacDonald, D. et al. (2014). Service user involvement: Impact and participation: A survey of service users and staff perspective. *BMC Health Service Research, 14*, 491. https://doi.org/10.1186/s12913-014-0491-7

[15] Gibson, C.H. (1991). A Concept Analysis of Empowerment. *Journal of Advanced Nursing, 16*(3), 354–361.

For this service user, the collaborative approach enabled them to represent themselves and their experiences in a responsible, self-determined, and personally meaningful way, acting on their own authority and overcoming some elements associated with the sense of powerlessness that was present during and subsequent to their traumatic experiences.

If co-production helps to shape services with the intention of better tailoring to the needs of the individuals who access them, and simultaneously creates an environment for personal reflection and change as part of the process, the priority for all service providers ought to be in identifying how to embed a culture of co-production: providing services that deliver what is needed and increasingly the likelihood that individuals remain engaged with them as opposed to remaining in them.

Jen Tomlinson
Highly Specialist Forensic Psychologist

Poem written by a resident on Primrose (Personality Disorder Service) about her experience of the service

In three short years,
My whole life has changed,
Through learning and therapies,
Carefully arranged.

A three month assessment to start,
All about you,
You think small things won't matter,
Primrose knows they do.

Digging up past traumas,
It really is tough,
I can't remember how many times,
I've stormed out in a huff!

For ages I resisted,
Refused to be candid,
My whole attitudes changed now,
I'm so glad that it did.

I'm more transparent with staff,
Learned how to talk about me,
Everyone agrees the changes,
Are easy to see.

I won't pretend it's been easy,
Plenty of bumps along the way,
But with the skills I'm learning,
I'm getting stronger every day.

It's not all hard work,
We play games and have fun,
Though there's usually an argument,
Over who should've won!

The staff are so supportive,
They really care that you progress,
Seeing the change in yourself,
Is worth the tough process.

I used to question,
Is Primrose for me?
But I've finally bought into it,
It only took till year three!

The staff don't give up on you,
What's best for you, they know,
If you're offered Primrose
I say: you should go!

They don't have miracle cures,
Or a magic wand to wave,
But the real you, lost in crime and self-punishment,
That's who they'll save

Collaborative care planning in a high security hospital: A conversation about getting inclusive practice off the ground

Estelle Moore & Pod Young

Introduction

WE PRESENT a shortened version of a conversation about a ten-year journey to create and utilise collaborative care plan guidance (see Appendix) to support progress from a high security setting to transfer to a medium secure, and eventually to community living. Many other contributors made it possible for Pod (then the service user) and Estelle (a qualified psychologist, still) to work towards Pod's transfer and discharge from high security. The emergence of Pod's ideas about increasing collaboration, and how to generalise this for others in forensic settings, are set out below:

Pod asked Estelle 'Can you talk about what staff think recovery is in forensic settings?'

'Over a decade ago, from the perspectives of 'patient' and 'staff member', we had the opportunity to engage in a number 'recovery-oriented' projects that were being supported through various means (including good practice initiatives and Commissioning for Quality and Innovation (CQUIN) funding). In the late 1990s, recovery was both something of a buzz-word that introduced hope, control and opportunity as key principles of care. It was also a very important movement for services towards holding patients in mind in a different way – not as passive, vulnerable or (over-)reactive individuals to/for whom things must be 'done', but as people who have often had major life adversities, yet despite this, can engage in a meaningful way in their journey towards greater independence, mental stability and well-being. Text books such as *Secure Recovery* (Drennan & Aldred, 2012) offered a new dialogue about a range of ways that recovery fosters inclusion even in spaces where many other indicators (locked doors, keys, etc) send a message of exclusion, albeit at times a necessary one where actions put others at high risk of harm. Services have since moved to a more 'Trauma-informed' position, which encourages everyone to think about what is happening to people right now, what has happened to people in their past, and how to organise aspects of care delivery so as to minimise (repetition of) harm' (Procter et al., 2017).

Estelle asked Pod for his thoughts on this:

'When I heard about recovery, inclusion sounded like the way forwards, but it was really tricky to actually put into action for everyone. Patients seeking out staff for support or chairing meetings about themselves and their needs was an alien concept at first. All the stereotypes about patients being 'too ill' or 'too risky', meant that change in the direction of inclusion was often avoided. Some staff did not trust patients to play their part. It seemed like it did not occur to some staff to ever ask the patient – especially if they were frightened of them'.

Pod and Estelle agreed that:

We took away a lot of learning about being sensible too – all voices in a system have a right to be heard including staff whose role is to contain and minimise violence in forensic settings. People often feel uncertain about ideas that seem too different or ill-considered. When there have been people harmed in the past, everyone is more alerted

to the possibility of this happening again in the future, and this changes how open the 'system' (made up of staff and patients and external bodies) can be to practices that challenge the status quo.

Estelle asked Pod: 'How did you start to get your collaborative care plan noticed'?

'I started small. I got the backing of my primary nurse and my associate nurse to discuss how I could let them know that I was having a good day, a not so good day and/or was heading for seclusion; seems such a simple thing now but I had had a lot of experience of feeling that staff were not interested in what I was feeling in the past; that they treated me as if my mental state was always the same (paranoid). I felt like they were not really interested in why I was paranoid. Once I had a good team, I got the staff to read my notes about my side of the care plan (what I was feeling and thinking), and we talked it over. I think this balanced things up a bit. I can be really persistent, and I know I bugged people at times, but it was worth it to get the key messages across'.

Estelle invited Pod to talk about the barriers he had encountered

'It is really difficult to have the confidence to ask questions when you think that other people don't really see you, that they just remember the last time you lost your temper or threatened some kind of harm. You have to be willing to ask for help, and you have to be prepared to make allowances for how staff respond, when they mean to be helpful but actually reinforce your dependency or dismiss your capabilities. You get so sensitised to noise, and people talking outside your door; to expecting bad news all time, and feeling frustrating by waiting, always waiting for staff, when you are in seclusion. This all makes it harder to adjust when people tell you, you are better, and you are ready to move forwards. I did not always feel ready inside, and you can think: If I am not feeling ready and these guys don't realise it, something bad is likely to happen.

I spent a long time staring at concrete walls, thinking 'how the hell did I get here?' and struggling to believe in myself. That's partly why I like the structure of a care plan: it gives staff a focus to talk about and it shares the problem-solving for an issue which makes it easier to address. I used to want to punch people who did not understand me: I know now that is a trigger for me that I cannot afford to act on. I would not do that now. I realise now that there may be a lot of reasons someone is not on your wavelength and you cannot hold it against them. It is frustrating though, when people who are not listening have power over you and decide your future in the way they assess your behaviour'.

Estelle asked: 'what would you recommend to others in a similar position, Pod?'

'I would say, don't give up. Get up every day with a structure and a purpose as this will help you rebuild your life. Get good staff to back you. They are more likely to do this if you pull your weight, give and take. Remember no two people are the same – what works for one patient may not work for others. But what I learned about myself has been useful, and I am still learning. When you have been in dark and endlessly lonely places, you really value not being behind a door and work hard to do everything within your power to avoid going backwards. Sometimes it still gets too much for me. This happened not so long ago, and I forgot what I would definitely recommend to others: reach out and talk before things build up and hit a wall that gets on top of you'.

Does the literature concur?

It has been widely recognised that a great way to improve the treatment and management of the conditions for those with long-term health needs, is to include the person at the centre, the 'patient', in decision-making as much as possible (Coulter et al., 2013). The same advisory team note that the 'call for a more person-centred, better co-ordinated approach to managing care for people with

long-term conditions has been embraced by numerous advisory bodies, advocacy groups, governments and international agencies' (page 3), and care planning is at the heart of the collaborative process.

Whilst there are many examples of inclusive practice today, why does it often feel more difficult, more 'patchy', to embed throughout forensic services? Historically, being diagnosed with an 'at risk' (especially if risky to others) mental state has set limits on access to conversations about what might help. In her review of collaborative risk assessment approaches in psychiatric practice, Markham (2020) concludes that risk management relies on responsivity in the organisation's culture, which in turn requires an emphasis and skill-set in relational safety and 'epistemic regard for patient self-insight and testimony'. A Norwegian team (Selvin et al., 2021) have set out the adaptations that create a 'health promoting climate' in forensic care settings. These include good communication, professional responsibility-taking and encouragement of patient autonomy (based on a capacity assessment). All this must be achieved without adding risks to the care process. A Dutch team (van den Brink et al., 2015) have shown that forensic out-patients are more than capable of completing risk instruments from their own perspective, and that including their self-assessment improved the prediction of re-offending.

Development of a tool kit to support learning on all frontiers has been advocated by other groups (See Hall & Duperouzel, 2011) to keep such collaboration on track. Troquette and colleagues (2013) studied shared decision-making in care-planning in the Netherlands via a cluster randomised controlled trial, the first of its kind. They found that prevention of recidivism was not reached through embedded risk assessment and shared decision-making, but did find that case managers valued using the intervention with staff and found that this approach to be associated with increased patient satisfaction and quality of life.

Ten year follow up?

Fast forwarding a decade, we could argue anecdotally that collaboration is more commonplace in forensic settings now than it was previously. However, the demonstration of 'remarkable' outcomes in this field of practice are few and far between, in part because there are so many influential factors at play. In the past when we have not attended so much to the impact of past adversity, nor to the critical importance of mutual trust between service users and care teams, (facilitated by staff who can retain an empathic and positive outlook), service systems directly set constraints on choice and empowerment. This could explain the muted evidence for the useful impact of psychological interventions on clinical outcomes (see Cartwright et al., 2021). Drawing on his own experience, over to Pod for the last word: 'I remember years of different types of therapy, some helped a bit. But learning about Trauma-Informed Care has helped me to move on a lot better. Naming the difficult things of the past and sharing this with others is not impossible any more, I am able to engage with, and develop, the care I receive, and it means that I have been able to move forwards in my life'.

Estelle Moore & Pod Young

References

Coulter, A., Roberts, S. & Dixon, A. (2013). *Delivering better services for people with long-term conditions. Building the house of care.* The Kings Fund.

Hall, S. & Duperouzel, H. (2011). 'We know about our risks, so we should be asked.' A tool to support service user involvement in the risk assessment process in forensic services for people with intellectual disabilities. *Journal of Learning Disabilities and Offending Behaviour.*

Drennan, G. & Aldred, D. (Eds). *Secure recovery: Approaches to recovery in forensic mental health settings.* London: Routledge

Langan J. (2008). Involving mental health service users considered to pose a risk to other people in risk assessment. *Journal of Mental Health, 17,* 471–481.

Markham S. (2020). Collaborative risk assessment in secure and forensic mental health settings in the UK. *General Psychiatry, 33.* e100291. doi:10.1136/gpsych-2020-100291.

Procter N., Ayling B., Croft L. et al. (2017). *Trauma-informed approaches in mental health: A practical resource for health professionals.* University of South Australia, SA Health, Adelaide

Selvin, M., Almqvist, K., Kjellin, L. & Schroder, A. (2021). Patient participation in forensic psychiatric care: Mental health professionals's perspective. *International Journal of Mental Health Nursing, 30,* 461–468.

van den Brink, R.H., Troquete, N.A., Beintema, H. et al. (2015). Risk assessment by client and case manager for shared decision making in outpatient forensic psychiatry. *BMC psychiatry, 15*(1), 1–10.

Appendix: The Collaborative Care Plan (abridged version)

Text: Collaborative Care Planning in Forensic Settings

Introduction

The concept of the evolving care plan is that the care plan changes as the patient's mental health changes – for better or worse. This has treatment benefits for hospitals because they can see how the treatment works (or not!) and it can then help in adapting treatment so patients get the best possible care.

If you held up a care plan at the start of treatment and at the end, they would be very different. This is because throughout treatment, symptoms and traits are helped and they become less of an issue so the content of the care plan becomes current and 'more up to speed' with the patient's needs, symptoms, traits and problems.

As time goes by the patient may require a different type of assistance for each level of support in each care plan. This has benefit in risk management, both to self and others as it keeps you up to date with the patient's current mental health risks- identifying high risk behaviour as early as possible can potentially save lives.

Having this care plan available, as well as consistent one-to-one sessions with the care team is an effective and efficient communication tool for all who may read it, including doctors, nurses and teams from other units and hospitals. It has the advantage of being a current and accurate account of the patient's needs. It is also a valuable assessment tool as we can see the types of problems we need to support for and whether those directives meet the criteria for a unit of lesser security.

This is advantageous for patients as it can help them to see how their needs have changed over a period of time. This could help them in their recovery and show their potential for change.

There are benefits for staff to assess and reassess the type of care and support they are

giving to their patients – what has been effective, what helps. This is also a tool for staff to monitor their own performance which is of great benefit to their understanding of how they are treating issues of mental health. The patients and staff are working together to explore what support helps over a period of time. If the problem is not responding to the support provided then this is revealed in the evolving care plan as a lack of evolution. This can be identified sooner as an issue of importance or priority. This care plan helps staff evolve in to a more supportive mental health treatment provider.

The evolving care plan is helpful when a patient relapses because it has been established what has worked previously for the patient, making recovery more likely after the application of previous care plans and treatment goals.

The care plan could impact on treatment and recovery in mental health services because seeing evidence of an effective care plan, through trial and error is a step towards understanding and treating mental disorder.

The benefits of the Care Plan

As a risk management tool

Patients are in control of their care, therefore if someone feels in distress they can choose the right support without an incident report filled in because the treatment and support chosen is a type of advanced directive and is seen as positive rather than destructive.

If a patient is aggressive it could be suggested that being in control of their support could prevent violence and restraint. The staff can use the specific care plan to know how to treat the patient when they present in this way.

As an audit tool

The care plan is fluid and changes regularly. However, if a patient has remained on a higher level of support for a long time, this is visible on the hierarchy of support pyramid. Questions can be raised; is the current treatment working? Are these types of directives working for the patient?

As a communication tool

It is easy for the patient to engage in this care plan because all they need to say is 1,2, or 3 and this will convey to staff how they are and how best to treat them. This is especially useful when in crisis.

As a tool for signalling needs for support

Staff can see at a glance who is in greater need of support. Say, for example, 90 per cent of patients on the ward are fine when the staff can focus their energies on those 10 per cent who really need the help. Providing staff stick to the plans and can see how to be with patients and how to treat them, the care plan is doing its job.

As a recovery tool

The care plans are tailored for patient's individual needs which also changes over time as the patient gets better. It is about trial and error but providing care plans are all up-to-date there is no reason why patients can't receive cutting edge treatment to assist in their recovery.

As an empowerment tool

This whole project is about giving patients that control in their care that they lack in their freedom. Patients can lead their recovery in collaboration with staff and set achievable goals.

By completing these care plans this is a positive step to recovery and taking control of our lives.

How to use the Recovery Care Plan

Trauma Informed Care and perspectives on Admission, transfer and discharge from mental health secure services

Zoe Johnson-Marsh & Lucy

FOR THOSE females who have to enter secure services it is not unfamiliar that their life narrative includes trauma or multiple traumas. Admission to services, transition and discharge can also be challenging and lead to levels of distress that can be traumatic, which has led to the increasing importance of Trauma informed practice; so as to limit re-traumatisation and provide psychological safety and resilience (Butler et al., 2011; Sweeney et al., 2018).

Working with service providers, service users and staff provides the opportunity to improve service users and staff experience, as well as improving the environment. Admission, transfers and discharge are the focus of this article, which has been co-produced with one female service user, named Lucy. Lucy wished to begin with a poem written by her to express her relative overall experience.

'Poem for admission & discharge'

Being admitted to a place like these
Doesn't come with much pleasure or ease
It's such a very scary place to be
Wondering when you will ever be free.
All the new staff, all the new peers
Who have been there for over some years
And you come in as a new fresh face
Being admitted to a new hospital can leave you in a scary place
Your journey through your time in services
Serves so many positive purposes
It can help you get better in your mental health
Even if you feel bad in yourself
Being stuck in places that we are
It's really hard to come so far
It's like being locked in a cage
Especially when you are stuck in services from such a young age
Now being discharged is just as bad
Because you are used to all of the support that you had
And when you feel like you are being let go
It's more scary than you will ever know
Even moving onto somewhere else
Can have a detrimental effect in your mental health
Moving on away from safety, can leave you feeling a little pasty
Having a laugh and being you,
At the end of the day that's all you can do
So don't be scared to move on, you have to focus on number 1
Focus on why you will be going, you will smash it without even knowing.

Lucy explained her experience of admission, transfer and discharge to accompany the poem. She began by saying that her experience of admission and discharge was a 'scary' one. She described how there was a 'honeymoon period', which was a label both her and clinical staff applied. This referred to the early stages of admission when a service user is becoming familiar with their surroundings and may well not present in the same way as they would in the weeks following. On admission, Lucy explained she would take time to assess the staff and peers around her, and was concerned how they may interact with her, as this would provide her with an idea as to how her admission may progress. She spoke about how service users can observe the staff and consider the most effective ways to achieve what they wanted, whether this was to gain access to risk items

or be provided with greater allowances. She explained in turn this would then help to improve the experience of the admission.

Lucy said it could also be a scary experience to be sectioned with others who are on a forensic section in comparison to those who are on mental health section only (i.e. Section 3). She explained that you could be hospitalised with 'someone who has murdered someone', whom would provide details of their offences, and have stated that they would 'do it again'. This further added to the primary experience of feeling as though she had been locked in a 'prison' when coming into secure service from the community, where 'your rights are taken… the doors are locked… you don't know when you will leave'. She spoke about being taken from family and the lack of dignity that can be experienced, when being observed. She explained how initially she would shower and bath in her clothes, as she felt ashamed. When moving between several placements she described it as if she were being 'experimented on', and when her personal effects did not arrive at the receiving hospital she could feel as though this was being done purposefully (when unwell). Lucy mentioned that transfer could be ill timed, such as when her mother died and being moved two weeks later; when she had not had time to process the news fully, and new staff did not have an awareness of the relationship she had with her mother, and would not be able to provide the level of support she required. Conversely, Lucy said admission could be positive, as it also provided the 'next step to recovery', and transfer could be the opportunity to achieve the 'next step' of 'getting out'.

As previously mentioned, Lucy stated that discharge could be scary, but said hospitalisation was a 'journey' and discharge was a continuation of this. Going back to the community where there may be '…all sorts of bad people' (which was reference to her vulnerability of previous traumatising experiences) and being 'scared of getting hurt' was a concern. As well as the 'fear of the unknown'. Lucy spoke about the recognition of the need to look after herself in the community, which presently was not a requirement of her due to staff intervention, which could also be worrying.

Lucy provided recommendations as to how services could improve admission and discharge procedures. She suggested welcome packs with information about the hospital, including the 'rules' should be given, along with complimentary toiletries and some clothing, as service users may not have such items on arrival. Advice should be provided, and support staff offered on a one-to-one observational basis for a specified period by the service user, to support them in their new placement if needed. With regards to discharge, Lucy said information about potential hospitals would be helpful (as with admission) and the ability to research them independently via the internet would be good. Preparation and prior knowledge of transfer (approximately two weeks in advance at least) was felt to be beneficial, not only for herself, but family members also. Lucy also mentioned that knowing the procedures for leave and what therapeutic services were available ('if they'll be able to do psychology') would reduce the concerns of leaving for a new service.

Lucy's narrative amplifies the already reported concerns (e.g. Harris & Fallot, 2001) regarding the impact of hospital procedures, and the necessity to ensure the implementation of trauma informed care. Fallot & Harris (2011) offer five principles to guide trauma informed practice which includes safety, trustworthiness, choice, collaboration and empowerment. Lucy's recommendations for more effective admission and transitions touches on all of these principles. Stating about the need for choice and control in requesting observations for example; that can also offer a sense of safety; as well as to be empowered in researching hospital choices and collaboration regarding decisions made. There are processes that can be implemented within secure hospitals in progressing towards the delivery of trauma informed care. This includes training

regarding trauma and trauma informed practice for staff and service users; Trauma screening for all service users and application of the principles to all hospital procedures, as well as working on embedding this practice within hospital culture. It is hoped Lucy's co-production of this article helps to signify the need for all services to work on implementing these practices and aspire to full trauma informed care.

Zoe Johnson-Marsh & Lucy

References

Butler, L., Critelli, F. & Rinfrette, E. (2011). Trauma Informed Care and Mental Health. *Direction in Psychiatry, 31,* 197–210.

Fallot, R. & Harris, M. (2011). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. www.annafoundation.org/CCTICSELFASSPP.pdf. Published April, 2009. Accessed July 17, 2011.

Harris, M. & Fallot, R. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. In M. Harris & R. Fallot (Eds). *Using Trauma Theory to Design Service Systems.* 3–22. San Francisco, CA: Jossey-Bass.

Sweeney, A., Filson, B., Kennedy, A. et al. (2018). A Paradigm shift: Relationships in trauma informed mental health services. *BJPsychAdv, 24*(5), 319–333.

serco

Bringing service to life

"It's just not for me." How prisoners with lower cognitive functioning and sexual convictions make sense of their custodial experience: A rejection of identity

Sian Murphy – Forensic Psychologist (Serco)
Natalie Leech – Head of Custodial Psychological Services (Serco)

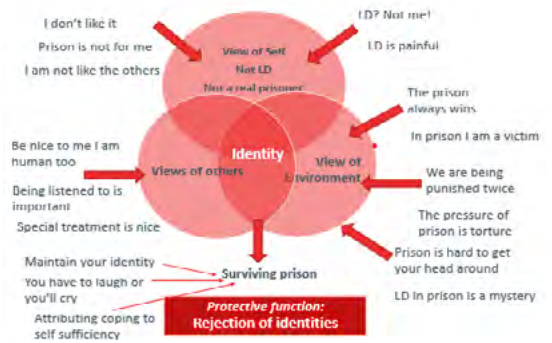
Introduction/Background: Prisoners with learning disabilities are overrepresented in the prison population. (e.g., Hayes et al, 2007; Loucks, 2007). As well as being overrepresented, much of the literature points to this population being disadvantaged (e.g., Murphy, et al., 2017; Jones and Talbot, 2010). Until recently, there was relatively little literature that made any mention of the lived experience of the individual.

Aims: Prisoners with lower cognitive functioning and sexual convictions are rarely asked about their experience of prison. This paper aims to develop understanding using an Interpretative Phenomenological Analysis (IPA) approach.

Method: Semi-structured interviews were conducted with four prisoners in one prison. The interviews were transcribed, analysed and interpreted using IPA.

Conclusion: Identity is a common thread across the themes identified. It is hypothesised that rejecting prisoner, sex offender and learning disability identities could play an important protective function for prisoners in this study. Addressing the needs of offenders with learning disabilities and sexual convictions presents challenges for establishments, due to the unique experience of this group. Recognising the nature of this experience and taking account of the role of identity is essential. Including the prisoner voice is a powerful way to achieve truly meaningful outcomes.

Results:



References available upon request

Contact: Sian.murphy@serco.com

HM Prison & Probation Service

NEUROPTIMAL Advanced Brain Training Systems

Delivering Neurofeedback in a High Secure Trauma Service

NHS Cambridgeshire and Peterborough NHS Foundation Trust

Dr Sarah Hicks, The Fens OPD Service HMP Whitemoor

Objective

To review the introduction of neurofeedback (NFB) in a high secure prison trauma service and explore the learning for possible wellbeing applications for patients and staff.

Background

NFB has been found to reduce trauma symptoms, anxiety, depression, and impulsivity; and to improve sleep, cognitive performance, mood, concentration, and attention (Panisch and Hai 2018, van der Kolk *et al.* 2016, van Outsem 2011, Askovic *et al.* 2017, Hammond 2005). NFB has also been found to enable engagement in psychological therapies previous inaccessible (Askovic *et al.* 2017). NeurOptimal® NFB is a type of brain training that enables brain reorganisation resulting in improved functioning and wellbeing (Zengar Institiute Inc. 2021).

Who

- 8 patients (adult male offenders)
- 17 clinical staff (adult females and males)
- Conducted in the Fens OPD Service
- Located in HMP Whitemoor; a high security prison

What

- NeurOptimal® 3 (Zengar Institute Inc., 2018)
- Advanced brain training utilising Dynamical Neurofeedback® algorithms – computer software to monitor electrical activity in the brain via sensors and provide audio feedback

How

- 5-20 NFB sessions
- 33-minute NFB session
- NFB sessions run once or twice weekly
- Delivered by trained administrator
- Conducted 1:1 in interview rooms

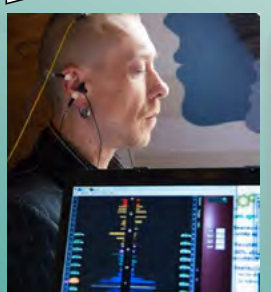
Findings

Barriers

- Mistrust, fear & paranoia
- Unknown intervention & mis-information
- Resources: cost, time, staff, & regime
- Negative attitudes (ind. & institution)
- Mixed uptake and consistency

Positives

- Improved wellbeing
- Improved sleep
- Improved concentration
- Reduced anger



Conclusion

We learnt the importance of providing awareness and exposure when introducing an innovative intervention, to combat the barriers highlighted. There were many logistical challenges faced in delivering a technology-based intervention in a high security setting and we found the need for dedicated resources essential for consistency of delivery. The difficulty of fluctuating motivation and engagement was also problematic and required significant flexibility to enable delivery. Overall, there were positive outcomes despite the challenges and NFB is being integrated into our treatment for patients and being utilised for staff wellbeing, particularly focusing on covid recovery.

Firesetter Typologies and Crime Scene Behaviours

1. Introduction

- Only 7% of arson results in a conviction[1], therefore *undetected* firesetters and their crime scene behaviours are poorly researched.
- Typologies based on motivation and personal traits can be subjective; and focus on sub–groups such as children.

Aims:

a) Identify common firesetting crime scene behaviours.
b) Establish types of firesetting behaviours using crime scene behaviours.
c) Compare firesetter typologies identified in this data set with those already established in research.

2. Method

- Between 2016 to 2018, WMFRS collected crime scene behaviour data from 9,541 deliberate fires (Table 1).
- MDS analysis identified common firesetter behaviour and clusters of crime scene behaviours.

Crime Scene Behaviour Variables
Weekday/weekend
Time of Day/Daylight
Month/Season
Residential
Business
Civic Building
School/Educational institution
Car/Vehicle
Hospital
Miscellaneous, Uninhabited or Derelict buildings or items

Table 1

3. Results

- Three types identified (A, B and C), from crime scene behaviour of both *detected* and *undetected* firesetters.
- Common firesetting behaviours – Miscellaneous/uninhabited/derelict, daylight and weekday (Figure 1).

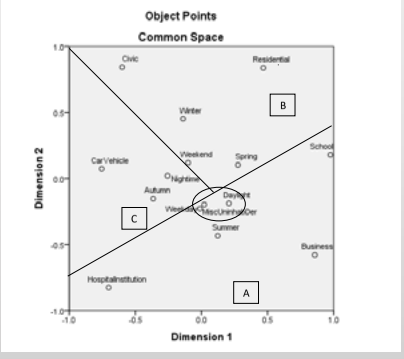


Figure 1

4. Conclusion & Recommendations

- Analysis yields 3 types based upon *all* deliberate firesetters. These types share commonalities with previous research on types.
- Further research required on personality traits, socio–economic traits etc., for *both* detected *and* undetected firesetters.
- Application of knowledge of common crime scene behaviours for investigative and interventions purposes.

[1] Department for Communities and Local Government, 2018

Dr Vicki Parker
victoria.parker5@nhs.net

serco

Bringing service to life

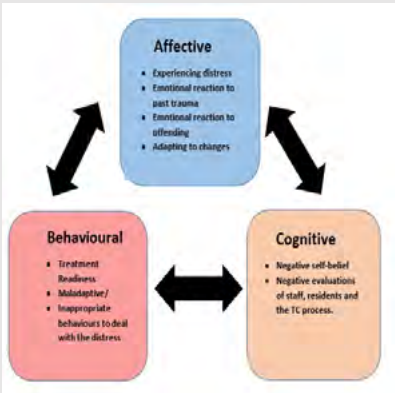
The Development of Theory For The Non-completion of Prison Based Democratic Therapeutic Communities: Residents' Perspectives

Ellen Green (Forensic Psychologist in Training); Jennifer Steans (Forensic Psychologist)

Introduction/Background: Existing research into treatment drop out has highlighted that an individual has to be ready to engage in treatment. Previous research suggested that non-completion of risk focused interventions is associated with higher rates of recidivism (Day, Casey, Ward, Howells, & Vess, 2010; McMurran & Theodosi, 2007; Polaschek, 2012). There is limited research into attrition in Democratic Therapeutic Communities (DTC).

Aims: This study aimed to explore what factors are impacting on individuals becoming 'non-completers' of the DTC.

Method: The study was qualitative in nature; 6 participants were interviewed individually regarding their experience of the TC following theoretical sampling. These individuals had either withdrawn or been deselected. Grounded Theory was used to identify categories which was then factored into a theoretical model of why individuals withdraw or become deselected from the TC.



Results: Through coding of interview transcripts and the development of a theoretical model, three main categories (affective, behavioural and cognitive factors) were conceptualised from the ten initial categories which impact on DTC 'Non-Completion'.

It is hypothesised that there is an interplay between these categories which impacts on the likelihood of non-completion.

Conclusion: The findings of the study suggested that residents would benefit from being taught some coping skills prior to their engagement in core therapy on the DTC. This study highlights that participants who do not have the coping skills to manage the distress they experience in therapy are less likely to complete. A replication of this study is encouraged to explore the experience of those who 'complete' the TC intervention.

Contact: ellen11uk@aol.com/ natalie.leech@serco.com

References available upon request

serco

Bringing service to life

The Impact of Perceived Dangerousness on Prison Staff Burnout

Ellen Green (Forensic Psychologist in Training); Kathryn Marsh (Forensic Psychologist)

Introduction/Background: Within previous studies prison staff have been found to have higher levels of burnout in comparison to the general population (Keinan & Maslach-Pines, 2007). The term burnout has been defined as emotional and/or physical exhaustion, lower job productivity and over-depersonalisation (Perlman & Hartman, 1982). The impact of burnout has been linked to a variety of negative consequences including low job satisfaction (Borritz et al., 2006), decreased work performance (Shaufeli & Peeters, 2000) and increased staff turnover (Carlson & Thomas, 2006). Due to the complex and challenging environment of prisons, danger has been found to cause stress in staff (Lambert, Hogan & Barton, 2002; Hartley et al., 2013). However, limited research has been carried out using UK prison staff samples.

Aims: The study aimed to extend existing research by examining the impact of prison staff's perceived dangerousness on the three dimensions of burnout: Exhaustion, Cynicism and Professional Efficacy.

Method: The study adopted a quantitative approach where initial purposive sampling took place in 2018 and questionnaires were given to staff in a UK adult male private prison. The existing data was used within the current study involving 139 participants. Measures included the Perceived Dangerousness Scale (Cullen et al., 1985) examining the extent to which participant's viewed their workplace as dangerous. Maslach's Burnout Inventory - General Survey (MBI-GS: Maslach, Jackson, & Leiter, 1996) was used to measure the three different dimensions of staff burnout.

Results: Following relevant assumption testing, a simple regression analysis was employed which indicated no statistically significant impact of perceived dangerousness on all three elements of staff burnout: Exhaustion, Cynicism and Professional Efficacy. The findings of the study suggested that despite the dangerousness associated with working in a prison, staff perception of this did not predict burnout.

Conclusion: The statistically non-significant findings of this study suggest there are current best practices within the prison system which help to mitigate the impact of perceived dangerousness on staff experiences of burnout. This may include but is not exhaustive to; the shift towards rehabilitative culture, physical safety (body warn cameras), staff supervision, reflective practice, staff training and specialist units such as the Social Responsibility Unit which all help minimise anti-social behaviour and institutional violence. Future qualitative research could explore further variables that are not included in the present study which could include exploring types of support offered to staff and available training within different establishments.

Contact: ellen11uk@aol.com / Kathryn.marsh@serco.com

References available upon request

"Send Nudes"

An exploration of sexting behaviour, self-esteem, theory of mind and revenge-porn proclivity.

Dannii Jarvis & Dr Simon Duff
Dannii.jarvis@nottingham.ac.uk

Background Information

Sexting under the age of 18 in the UK is illegal and constitutes to distribution of child pornography.
Studies have identified that both sexting and revenge porn (RP) are a growing issue in online victimisation and grooming.
Low Self-Esteem (SE) and Theory of Mind (ToM) deficits have been associated with perpetrators of sexual offences, particularly those who offend against children.
There is also growing evidence to suggest that those with Low SE are at risk of harmful sexual behaviours.

Aims

- To address the paucity in research into adult sexting
- To explore the sexting behaviour of adults aged 18+
- To examine the relationship between sexting, SE, RPP and ToM.
- (Additional study will compare the sexting experiences of younger adults [18-25] and older adults [26+])

Hypothesis

- Sexting = increased risk of RP
- Low SE = greater likelihood of engaging in RP
- Poorer ToM = greater likelihood of engaging in RP
- The extremities of SE (low/High) = greater engagement in sexting behaviours.

The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA

Methodology

Participants (Ps) were asked to complete an online study, answering questions about their sexting behaviours and completing the below measures:

- Revenge Porn Proclivity Scale (Pina et al., 2017)
- Adult Theory of Mind task (Baron-Cohen et al., 2001)
- Self-Esteem Scale (Rosenberg, 1965)

Participants:

N=211, aged 18-89, *Md* =26 (*IQR*: 22,32)
White British(41.7%), Other (36%), Asian (14.7%), Mixed (4.7%), Black (2.8%)

Preliminary sexting results:

- 50.7% of Ps have been shown a sext that someone else received
- 44.7% of Ps received their first sext before the age of 18 (24.8% before the age of 16).
- 35.5% of Ps sent a sext before the age of 18 (14.9% were sent before the age of 16)
- 59.3% of Ps reported receiving an unsolicited sext.
- The age at which Ps sent their first sext varied from 11-50 [N=141, *M*=19 (SD=6.1)

Please contact the author for key references

Paper #115

BUCKINGHAMSHIRE NEW UNIVERSITY EST. 1891

Current Attitudes to Punishment and Rehabilitation of Offenders in the UK: New Insights in an Age of Terror

Background

Given the rise in terror-related instances dominating news headlines in recent times (Westminster Bridge, Manchester Arena, London Bridge/Borough Market, Finsbury Park, Streatham), harsher punishment fads seem to be resurfacing in the UK, with the government in crisis over how to curb public panic surrounding terror, and the sentencing of offenders.

Despite this, little contemporary research has focused on surveying attitudes towards punishment, specifically for terror-related crimes in the UK. Such attitudes are of importance as they have been drawn upon to inform policy which, in turn, informs changes (and funding) to the prison system and rehabilitation approaches (Jacobson, 2005).

Viral social media campaigns highlight further the public's power to mould criminal justice policy, whether in favour of punitive legislation* injudiciously passed by politicians in response to public outcry over publicised (albeit typically rare) criminal events (Ahlin et al., 2017; Bergseth & Bouffard, 2013; Frost 2010), or to force equality, rehabilitation and fair justice.

Past Research

- Punishment motives: Retribution, Utilitarian (Deterrence and Incapacitation) & Rehabilitation (Courtwright & Mackay, 2004).
- Fear of crime increases punitiveness (Frost, 2010); on an 'individual' level from personal/vicarious experience (Gross & Aday, 2003), and a 'meso' level from social disorder (Broken Windows Theory; Kelling & Wilson, 1982).
- Right-wing authoritarianism predicts peoples worry about social threats & punitive support (Gerber & Jackson, 2016).
- Fear of terrorism specifically, increases support for anti-terrorism policy (Huddy, Feldman, Taber, & Lahav, 2005).
- But, there's a lack of unanimity about what 'fear' measures ("worry" of future risk, for self or others; Nellis, 2012).

Aims

To collect data nationally on current public attitudes towards criminal punishment, as well as gauge the degree of support for new harsher sentences, recent legislative changes and early release modifications for terror related offences.

Method

Participants

- *N* = 406 (132 male; 270 female; 4 other)
- Aged 18-74 years (*M* = 35 yrs, *SD* = 12.62)
- Victim/Witness of terror: 5.4% (self) & 14.6% (family/friend)

Design & Materials

Predictor Variables

- Demographics (gender, age, political affiliation, occupation)
- Fear (worry) of Terror Victimisation (self/family/friend), 2Q, and Perceived Future Risk of Terror Victimisation (self/family/friend), 10Q, 10-point Likert Scales (Nellis, 2012).
- Past witness/victim in terror event (self/family/friend), 2Q, yes/no (Bitton & Salawi, 2019).

Criterion Variables

- Measured by Kugler and colleagues' (2013) 14-item Punitiveness Scale (*Cronbach's alpha* = .85) (subscales: *Retribution, Rehabilitation, Deterrence & Incapacitation*)
- 4Q regarding agreement with proposed government changes to *Counter Terrorism Sentencing Bill** (10-point Likert Scale) and one open-ended question to expand on reasoning behind agreement (or not) with harsher sentencing.

Procedure

All above scales/Q's were presented in an online survey, utilising a snowballing technique to encapsulate the widest cross section of those over 18, and eligible to vote in the UK (i.e. jury eligible). Debrief and support contacts were provided after.

References

Ahlin, E. M., Gibbs, J. C., Kavanaugh, P. R., & Lee, J. (2017). Support for restorative justice in a sample of US university students. *International Journal of Offender Therapy and Comparative Criminology, 61* (2) 229-245.

Bergseth, K., & Bouffard, J. (2013). Examining the effectiveness of a restorative justice program for various types of juvenile offenders. *International Journal of Offender Therapy and Comparative Criminology, 57*, 1054-1075.

Bitton, M., & Slawi, T. (2019). Do Jews and Arabs differ in their fear of terrorism and crime? *Journal of Interpersonal Violence, 34* (9), 4041-4060.

Courtright, K. E., & Mackey, D. A. (2004). Job desirability among criminal justice majors: Exploring relationships between personal characteristics and occupational attractiveness. *Journal of Criminal Justice Education, 15*(2), 311-326.

Frost, N.A. (2010). Beyond public opinion polls: Punitive public sentiment & criminal justice policy. *Sociology Compass, 4*(3), 156-168.

Gross, K., & Aday, S. (2003). The scary world in your living room and neighborhood: Using local broadcast news, neighborhood crime rates, and personal experience to test agenda setting and cultivation. *Journal of Communication, 53*(3), 411-426.

Huddy, L., Feldman, S., Taber, C., & Lahav, G. (2005). Threat, anxiety, and support of anti-terrorism policies. *American Journal of Political Science, 49*(3), 593-608.

Jacobson, M. (2005). Downsizing prisons: How to reduce crime and end mass incarceration. NYU Press.

Wilson, J. Q., & Kelling, G. L. (1982). Broken windows. *Atlantic Monthly, 249*(3), 29-38.

Kugler, M. B., Funk, F., Bilsky, J., & Goldwater, M. (2013). Differences in punitiveness across three cultures: A test of American exceptionalism in justice attitudes. *Journal of Criminal Law & Criminology, 103*, 1071-1114.

Nellis, A. M., & Savage, J. (2012). Does watching the news affect fear of terrorism? The importance of media exposure on terrorism fear. *Crime & Delinquency, 58*(5), 748-768.

Results

- Preliminary correlations informed predictors to include in a series of multiple regression models for each criterion.

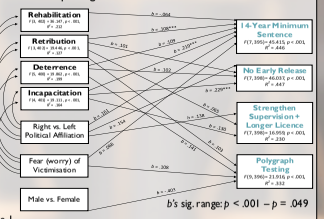


Figure 1.
Path diagram of significant predictors for 4 motivations of punishment, and 4 proposed 'harsher' changes to Counter Terrorism Sentencing Bill. *** $p < .001$

- The open-ended Q revealed motivations for harsher punishment are more complex than Kugler et al.'s (2013) sub-scales suggest:

A - Reasoning behind support for longer sentencing may be due to allowing, in turn, more time for rehabilitation.
B - Rehabilitation support is further fueled by terror offenders potentially being victims of coercion/grooming.
C - Rehabilitation and Incapacitation motivations are underlined by a "nothing works" attitude.
D - Underlying reasons for Retributive motivations relate to offence seriousness factors (pre-planning, impact, victim no.)

Conclusion

The study found substantial support for previously identified motivations that account for variance in punitiveness, and harsher sentencing. With further analysis, findings have the potential to highlight to policymakers, and relevant agencies, the public's punitive attitudes, and in turn their support for approaches to punishment, rehabilitation and new terror legislations.

A – *"…a longer sentence is required to shed beliefs/ideology that drove them to commit crimes."*

B – *"A lot of people who commit terror offences are victims themselves sin one way or another… in the UK (they) are often the victims of intense grooming."*

C – *"…they will continue to pose a threat no matter how long a sentence they receive.)*

D – *"Intent to cause so much death, destruction, chaos & fear is a strong factor in my belief (in) harsher sentences… (this) is increased if a terror offence involving killing is committed."*

Machan. C claire_machan
E: Claire.Machan@Bucks.ac.uk

O'Keeffe, C. ciaranokeeffe
E: Ciaran. Okeeffe@Bucks.ac.uk

***Counter Terrorism Sentencing Bill proposed changes:**

a) Introduce tougher sentences for the most serious terrorist offenders and a 14-year minimum for the worst terrorist offenders.

b) Remove the possibility of any early release from custody for serious dangerous terrorist offenders who receive an Extended Determinate Sentence (EDS).

c) Introduce measures to strengthen licence supervision for terrorist offenders, with longer periods on licence following release.

d) Introduce Polygraph testing for terrorist offenders on licence.

Um, T. (2016). *The Rehabilitation Paradox* [Online Image]. The New Yorker.

Buckinghamshire New University
School of Health & Social Sciences
High Wycombe Campus
Queen Alexandra Road
High Wycombe
Buckinghamshire HP11 2JZ
https://www.bucks.ac.uk/

@BNUPsychology

Research funded under SPF small grant from: UKRI Research England

University of Nottingham
UK | CHINA | MALAYSIA

The Female Additional Manual (FAM): Systematic review & meta-analysis of the predictive validity of HCR-20 & FAM for female-perpetrated violence

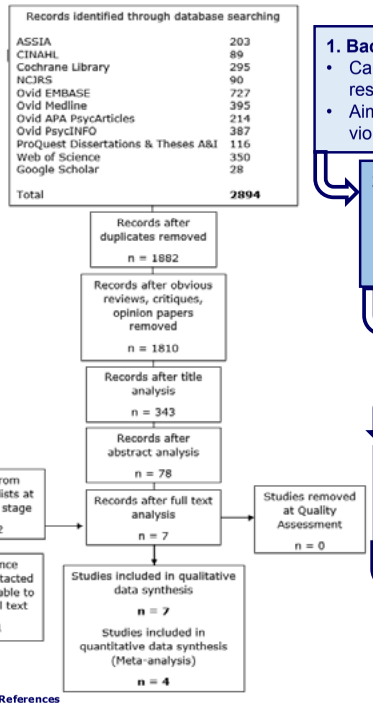
Aggie Milner & Kevin Browne, University of Nottingham

1. Background & Objectives

- Calls for gender-sensitive risk assessment; FAM development started 2007; limited research to date - mixed results.
- Aim: to evaluate all research exploring the validity of HCR-20 & FAM for predicting violence within female forensic population.

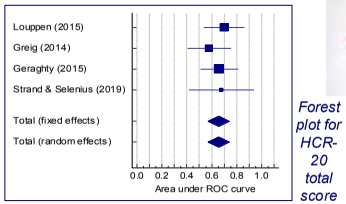
2. Method & Eligibility Criteria

- Protocol followed PRISMA-P guidelines (Shamseer et al., 2015).
- *Population*: adult females (18 years and above)
- *Exposure*: HCR-20 (any version) **AND** FAM risk assessment tools.
- *Outcome*: any violence (e.g., recidivism, recorded incidents, self-report).

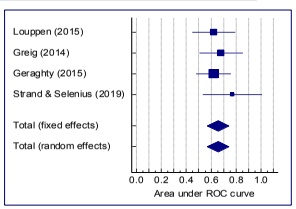


3. Results

- Two meta-analyses: 4x studies with similar methodology and reported HCR-20 & FAM, and HCR-20 alone.
- All HCR-20 Version 2, 12-month follow-up period, inpatient violence.
- Rice & Harris (2005) suggest following effect sizes: AUC = 0.56-0.63 (Low); AUC = 0.64-0.70 (Moderate); AUC = 0.71-1.00 (High).



Forest plot for HCR-20 total score



Forest plot for HCR-20 + FAM total score

	N	Total N	AUC	95% CI	z	p	Q	Significance level	I^2 (%)
HCR-20 FAM	4	142	0.645	0.568 to 0.740	14.924	$p<0.001$	1.37	$p = 0.71$	0.00
HCR-20	4	142	0.645	0.566 to 0.742	14.566	$p<0.001$	1.04	$p = 0.79$	0.00

4. Conclusions

- Firstly, both the HCR-20 with and without the FAM suggested a moderate effect size for the tool's ability to accurately predict inpatient violence by women.
- Secondly, the FAM does not appear to add any value to the HCR-20 when assessing risk of future violence by women.

5. Future Research

- Research is needed beyond predictive validity of the tool.
- Utility of FAM in clinical practice?
- Does it improve collaborative risk assessment & formulation, better informing risk management and treatment?

Selected References

- Geraghty, K. A. (2015) *Assessing Risk in Female Offenders*. Foren.Psy.D thesis, University of Birmingham.
- De Vogel, V., De Vries Robbé, M., Van Kalmthout, W., & Place, C. (2014). *Female Additional Manual (FAM). Additional guidelines to the HCR-20^{V3} for assessing risk for violence in women*. Utrecht: Van der Hoeven Stichting, Netherlands.
- Greig, D. G. (2014). Gender-sensitive violence risk assessment: A preliminary investigation into the predictive accuracy and clinical utility of the Female Additional Manual (Doctoral dissertation, Arts & Social Sciences: Department of Psychology).
- Louppen, M. (2015). 'De kracht van de FAM: Een studie naar risicotaxatie bij vrouwelijke forensisch psychiatrische patienten. [The power of the FAM. A study into risk assessment with female forensic psychiatric patients.]' Utrecht, Netherlands: Van der Hoeven Kliniek, Universiteit Utrecht.
- Rice M. E., & Harris G. T. (2005). Comparing effect sizes in follow-up studies: ROC area, Cohen's D, and R. Law and Human Behaviour. *Law and Human Behaviour, 29*, 615-620.
- Shamseer, L., Moher, D., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Stewart, L. A. (2015). Preferred reporting items for systematic review an meta-analysis protocols (PRISMA-P): elaboration and explanation. BMJ, 349.
- Strand, S. J., & Selenius, H. (2019). Assessing risk for inpatient physical violence in a female forensic psychiatric sample–comparing HCR-20v2 with the female additional manual to the HCR-20v2. *Nordic journal of psychiatry*, *73*(4-5), 248-256.

Information Box:

Hackett, Holmes, and Branigan (2016) define HSB as "sexual behaviour expressed by children or young people under the age of 18 (referred to here as children) that is developmentally inappropriate, may be harmful towards another child or self, and/or abusive towards another child or self, young person, or adult" (Hackett et al, 2016, p 12).

We Must Talk About Harmful Sexual Behaviour in Children: Impact of Psychological Consultations on Professionals.

Authors: Andrea Pailing and Dr Karine Greenacre

Objective

- Research has informed understanding of children who display Harmful Sexual Behaviour (HSB) and why the behaviour manifests.
- Research suggests more can be learned
- about how to foster a formulation led approach, and how to equip a workforce working with children displaying HSB.
- **We explored the impact of psychological consultations on professionals working with children who display HSB**.

Method

- Nine professionals were recruited using Random purposeful sampling. All had received a consultation from a local HSB service.
- Participants engaged in face to face semi-structured interviews using a specifically designed schedule.
- All interviews were audio recorded, transcribed, and coded with use of a second coder.

Data Analysis

- Analysis used Braun and Clarke's (2006) stages of Thematic Analysis (TA).
- Semantic codes were used. The data was analysed with no pre-conceived assumptions; an inductive approach to TA was followed.
- A total of four themes emerged relevant to the research question, consistent with the internal homogeneity and external heterogeneity dual criteria when identifying themes (Patton, 1990).

"I remember looking at this case going, this is a sex offender in the making"

"They calmed me down, helped me look beyond the behaviour"

Figure 1.
Thematic Map Using Semantic Coding.

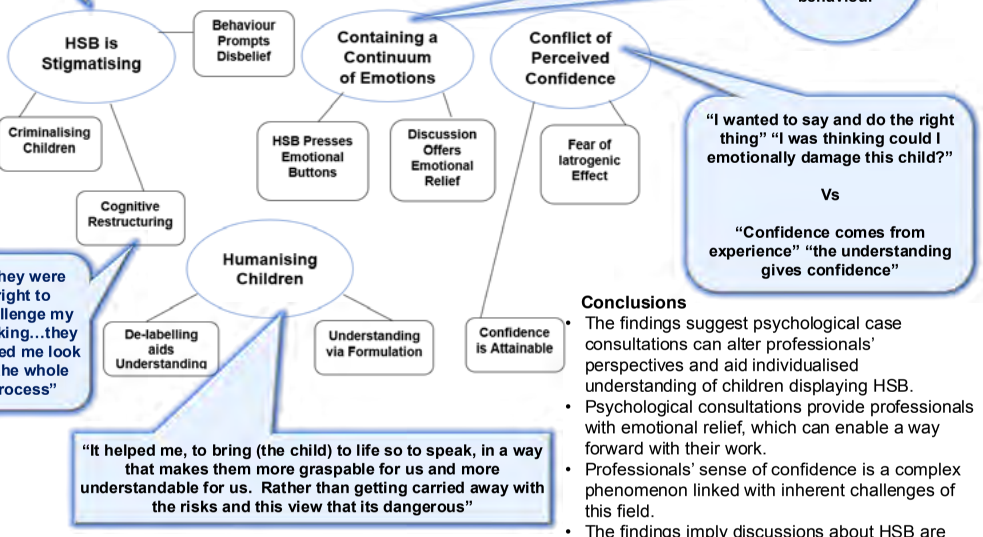
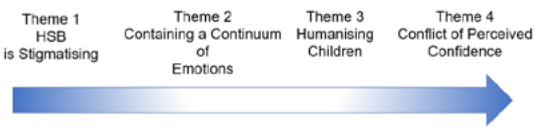


Figure 2.
Participants Narratives Identified Themes Across the Consultation Process



Conclusions

- The findings suggest psychological case consultations can alter professionals' perspectives and aid individualised understanding of children displaying HSB.
- Psychological consultations provide professionals with emotional relief, which can enable a way forward with their work.
- Professionals' sense of confidence is a complex phenomenon linked with inherent challenges of this field.
- The findings imply discussions about HSB are imperative to reduce stigma, aid understanding and enable the workforce.

References:
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.
- Hackett, S., Holmes, D., & Branigan, P. (2016). *Harmful sexual behaviour framework: An evidence-informed operational framework for children and young people displaying harmful sexual behaviour.* London: National Society for the Prevention of Cruelty to Children. p 12.
- Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Acknowledgements: special thanks to the local HSB team and partnering agency to Norfolk and Suffolk NHS Foundation Trust.

Book Reviews

Cerys Miles

IN THIS EDITION we bring you three book reviews from our members. First, Geraldine Akerman shares her reflections on *Working Effectively with Personality Disorder. Contemporary and critical approaches to clinical and organizational practice* (edited by Ramsden et al.). Geraldine takes us through the book's main sections, considering its application of the *Power Threat Meaning Framework* to encourage us to think differently. We then have a review of *Forensic Psychology: Fact and Fiction* (by Thomas Davis) thoughtfully presented by Richard Crisp. Richard highlights the standout features of the book and considers who might particularly benefit from reading it. Our final review by Cheryl Odell is of *Desistance from Crime: New advances in theory and research* (by Michael Rocque). Cheryl helpfully reflects on the engaging features of the book, considering its value in informing the work she undertakes in her professional role.

Dr Cerys Miles
Book Review Editor, *Forensic Update*

Working Effectively with 'Personality Disorder'. Contemporary and critical approaches to clinical and organizational practice **(2020; Luminate) By Jo Ramsden, Sharon Prince & Julia Blazdell**
Reviewed by Geraldine Akerman

This fascinating volume applies the Power Threat Meaning Framework (PTMF) to organisations and practice. It challenges several assumptions, such as that working with those who have faced emotional distress leads to services themselves and those who work in them becoming disordered. It contends that the term 'intervention' can be used in too narrow a form, and how services aim to alleviate individual intra-psychic problems but failed to ascertain which 'interventions' 'cure' people. Highlighting the pathologising of behaviour, that is itself a response to a situation, the book discusses the legitimacy of trying to 'treat' people and expect them to 'recover' from a socially constructed 'illness'. Refreshingly, the authors acknowledge that these ideas are not new, but rather they are collected through years of experience.

Chapter one presents personal experiences of being labelled as having a 'personality disorder' and the authors generously share their experiences, thoughts and feelings about this. The following chapter by Benefield and Haigh explains how disrupted relationships can impact on individuals, leading them to be excluded and marginalised. They highlight how diagnosis can be the key to accessing services or to further exclusion and how services evolved in NHS England over many years to the use of Improving Access to Psychological Therapies (IAPT) services. They explain how the principles of Enabling Environments values and standards are dovetailed with those for Therapeutic Communities, (TCs) Psychologically Informed Environments (PIEs), and Psychologically Informed Planned Environments (PIPEs), but problems may arise due to the lack of a coordinated policy with central government, which can lead to conflict and competing service provision. They conclude by highlighting the need for professional leadership, training and education across public services.

As the chapters unfold, Pilgrim reports on the politics of diagnosis of personality disorder from the perspective of a critical realist, highlighting the importance of considering what risk the patient's actions pose rather than a particular diagnosis. Later chapters, authored by Prince and Ellis, discuss the development of personal meaning and narratives and how

advances in thinking have highlighted that diagnosis of Borderline Personality Disorder pathologises women for their response to gender oppression and abuse, mentioning power imbalances, and linking to the PTMF as a means of de-medicalising misery (Rapley et al., 2011). Barrett considers the need to be 'good enough', describing individual development from a psychoanalytic viewpoint; how having insufficient, absent, or inconsistent containment at early stages, can hinder the ability to mentalise experiences and manage anxieties. She considers how prisons can have competing perspectives; the wish for rehabilitation against the requirement to punish. Jong discusses how public services can be risk averse and highlights the need to design services which provide containment, by having a shared purpose, clear principles, and role structures.

Part 2 starts with Ramsden writing poignantly about the need for fair and equitable service access and how difficult that can be to achieve. She charts the progress since the 'No Longer a Diagnosis of Exclusion' (NIMHE, 2003) paper, presenting a depressing summary of how things have not changed greatly, despite a proliferation of services. This is largely due to people not fitting within prescriptive criteria of inclusion, a familiar problem for many practitioners. Assessing so-called 'personality disorder' remains problematic. She posits a great question, 'can we provide the services we need?' rather than 'can you access the services we provide?' The assessment then is of the service rather than the individual and gives useful advice as to how to maximise accessibility to services by engaging with the client responsively to their needs. They make links to the PTMF with the drive to view mental health symptoms as intelligible response to their circumstances. She suggests that specialist personality difficulty services understand symptoms better than generic mental health services, and that taking a trauma-informed approach is vital.

Later, the importance of partnership working is discussed, including co-production with those accessing the services. Hirons and Sutherland remind the readers that only two decades ago personality disorder would be seen as untreatable with pessimistic treatment outcomes being the norm. In the interim services have developed even though many are still struggling to access these services. In exploring the evidence, they opine there is reason for optimism, which is encouraging. They suggest that service user engagement is the goal rather than a manualised approach and why co-production is vital to re-assign power, responsibility and resources. She unpacks common difficulties and how they can be overcome. Following this theme Harvey and Tuohy emphasise the importance of a relational focus in partnership working and the need for collective and containing leadership. McMurran goes on to explain why services should collaborate with researchers and be aware of possible adverse outcomes, while seeking to be objective, working collaboratively with other units to share best practice. Her wisdom is, as always, much appreciated.

In the penultimate chapter Ramsden reiterates how important it is to contain teams and work through tensions which are inevitable in organisations. The final chapter sees Gordon encouraging critical reflection and to mentalise the impact on all who are involved in joint working. Gordon describes how important it is to review learning opportunities and evolve.

I would recommend this book to anyone working with those who have personalities which mean they find it difficult to relate to others. This can be staff and those seeking help. It is in-depth and straightforward, and as it is written by practitioners the use of examples helps illustrate points being made.

Geraldine Akerman
Principal Psychologist at HMP Grendon and Chair of the DFP Committee

References

National Institute for Mental Health in England (2003). *Breaking the cycle of rejection: The Personality Disorder Framework*. Leeds: NIMHE

Rapley, M., Moncrieff, J., Dillon, J. (2011). *De-Medicalising Misery: Psychiatry, Psychology and the Human Condition*. London: Palgrave Macmillan.

Forensic Psychology: Fact and Fiction
(2021, Red Globe Press)
By Thomas Davis
Reviewed by Richard Crisp

Dr Thomas Davis is a Professor of Psychology at Nichols College, Massachusetts, with experience and research interests in cognitive psychology, namely the field of memory, which is evident from the number of engaging features in the book designed to enhance learning. It is clear from the style, features and layout of the book that it is designed for students and instructors of forensic psychology. The book illustrates well the wide-ranging field of forensic psychology, with references to the different settings the field pertains to, including the courts, the law, the police, and the prison service. The book is heavily based on presenting theory and applying this to practice.

Two features in this book stood out to me, setting this book aside from a typical textbook you might buy when studying. First, as the title suggests, the book offers a novel approach emphasising 'fiction versus fact' to develop learning by challenging misconceptions around key topics of forensic psychology within it. I found this entertaining and insightful, with each comparison between the fictitious bias and the actual fact. Second, with the use of a 'critical thinking and application questions' section after each topic, Dr Davis offers thought provoking questions and analysis of the topic covered. This feature, coupled with the online resources available via the book, leaves the reader internalising the material and with further questions to explore. Whilst the book provides a detailed overview of a range of relevant topics, it acknowledges you might want to read in more depth about certain areas and positively, signposts you to do this. For example, a handy feature of the book is the 'names to know' segment of each chapter which provide key names in that field, which would be incredibly helpful for students.

I would have benefitted from having this book when I was completing my undergraduate and postgraduate studies in forensic psychology as it comprehensively provides an overview of key areas. The book is written in a manner that would be easy to understand for students new to forensic psychology and strengthens your knowledge as you read on around that topic. Some areas covered in the book include: what is forensic psychology, detecting deception, juries, offender profiling and assessing fitness to stand trial. Each of these topics though less relevant to my role, remain interests of mine and it was useful to gain up to date knowledge in these areas.

Dr Davis' interests in forensic psychology are evident in the tone of his writing style and approach to the topics covered. Particularly, his fields of expertise of memory and interviewing techniques are applied in depth to the criminal justice system and are the focus for the second part of the book covering the interviewing of vulnerable people, children, eyewitnesses and suspects. Whilst reading these chapters I found myself making links to my role in interviewing people who have offended and vulnerable people, thinking about ethics and how to improve my practice but provided with some understanding and empathy for the experiences of those being interviewed. Therefore, whilst the book is clearly aimed at students and instructors as an audience, I would argue that practitioners in the field, particularly like myself, forensic psychologists in training, would find this a thought provoking read.

As a practitioner within the criminal justice system, the fourth part of the book 'applying psychology to forensic techniques' was particularly helpful to think about with regards to applying theory to practice. The book covered the effects of solitary confinement and isolation within custody and as I read this I was reminded how particularly relevant this is at present in the prison service where Covid-19 pandemic restrictions are still in place and possibly many prisoners could be experiencing these struggles, and I pondered what could be done to mitigate whilst these restrictions remain.

What I enjoyed most from reading the book was the focus on the developing contemporary topics in forensic psychology. I was surprised to find whole sections of the book on intimate partner violence, victim blaming, terrorism and cyberstalking for example, each providing up to date theory in these areas. I have long pursued reading and started conducting research into stalking, and from reading this book I started to understand the extent to which cyberstalking is different from offline stalking. This widened my interest and left me curious to learn more about cyberstalking.

Richard Crisp MBPsS
Forensic Psychologist in Training at HMP Dovegate

***Desistance from Crime: New advances in theory and research* (2017, Springer)**
By Michael Rocque
Reviewed by Cheryl Odell

Desistance from Crime provides a comprehensive overview of desistance theory and research, from its inception to current day. I found the book to be logically structured, with each chapter building upon the last. Rocque starts by introducing the concept of desistance and how this was historically identified as a field of study. Significant consideration is given to how desistance is defined; decades of research have highlighted that there is no one definition of desistance, and research outcomes vary depending on the researcher's perspective and whether they consider desistance to be the total termination of offending, or a more gradual decrease in frequency. There is examination and discussion of a large number of longitudinal studies of desistance, and then the subsequent theories of desistance purported by different researchers.

The chapter that particularly stood out to me was Chapter 6, where the author provided an integrated conceptualisation of maturation and the links of the component parts to desistance. Before this chapter, the theories were seemingly very diverse and none by themselves seemed to hold the 'answer' to why some people desist from offending, or explain the variations in age of desisting. Roque suggests that desistance is a product of adult maturation, and that there are five domains that contribute to this: psychosocial maturation (e.g. independence and aggression control), civic/communal maturation (e.g. being a 'good citizen', voting and paying taxes), adult social role maturation (e.g. adult relationships, employment, having children), identity maturation (e.g. changes in views of self and attitudes towards deviance) and neurocognitive maturation (e.g. the brain structure changes that continue from adolescence into mid-20s, improvement in executive function and intelligence). A holistic view is taken, with the assertion that attaining just a couple of these domains may not be sufficient for desistance to occur.

For me, this provided something of a 'light bulb moment', as before the integrated theory was presented it seemed that early theories focused on desistance and maturation as primarily a product of aging, with people generally ceasing to offend in early adulthood. I found myself repeatedly asking 'but what about the men we have in the Long Term and High Secure Estate, who have continued to offend later into adulthood?' My question was answered within this chapter with explanation of how there are factors which can delay maturation in those that persistently offend, such as contact with the Criminal Justice System, which impedes normal opportunities for normal adult socialisation, puts individuals in the company of deviant peers and has been shown in some studies to increase impulsivity.

The final chapter focuses on how desistance theory can and should be utilised within correctional policy. Tony Ward's Good Lives Model is cited as one way of bringing desistance theory into the work that we do, in

terms of helping people to consider how they want things to be and how they can achieve their primary good through more pro-social means. Roque states ' GLM helps practitioners recognise that they should not only be helping prevent outcomes, but also helping to create outcomes' , which I felt was a helpful reminder of the scope of our work as forensic psychologists.

Overall, I found the book to be engaging, as rather than providing a dry description of research and theory, Rocque begins his early chapters with case studies and real-life examples of offenders' lives and how they came to desist from further offending. The example of 11 year-old John Wesley Elkins who violently murdered his parents in 1889, then left prison in 1902 and achieved an education, found employment and got married is particularly interesting, and demonstrative of the impact of age and brain maturity on desistance. I would recommend this book for anyone working in the field who feels they would benefit from a clear and comprehensive overview of desistance research, and a coherent integrated model.

Cheryl Odell
Chartered and Registered Forensic Psychologist at HMP Full Sutton

Forensic Update

The professional peer reviewed publication
of the Division of Forensic Psychology

Guidelines for Contributors

We welcome contributions in various formats including: reviews, research (completed or in progress) and commentaries on any aspect of forensic psychology or related fields. However, this will be somewhat dependent on the amount of material the Editorial Team receives. Articles will be edited by the Editorial Team. *Forensic Update* is published quarterly in January, April, July and October. Copy should be with the editors at least three months prior to proposed publication date. The editors cannot guarantee that a submission will appear in the following issue after it has been accepted. Please contact the editors if you would like to discuss ideas for papers or guidance for submissions.

Audience: Please write your article at a level suitable for an intelligent reader with a basic knowledge of forensic psychology. Try to avoid assuming detailed specialist knowledge. Keep statistics to a minimum.

Psychologists in Training: Trainees need to ensure that their supervisor is aware of their interest in submitting material to *Forensic Update*. The work needs to have been supervised before it is submitted. The Editors would also advise that material be co-authored and countersigned.

Style: We aim to publish articles that are accessible, and therefore would encourage you to write in a lively and easily readable style.

Length: Articles should ideally be between 1500 and 2000 words. Shorter or longer articles may be published subject to discussion with the Editors as we don't want to impinge on a paper's quality by being too fussy about the word limits.

References: These should be kept to a minimum wherever possible and should be presented in the following format:

> Milgram, S. (1974). *Obedience to authority.* New York: Harper & Row.
>
> Kennerley, H. (1996). Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology, 35,* 3325–3340.

Footnote: At the end of your article, please include your name and where you work, contact details and word count. For example, Ann Other is with the Nowhere Institute ann.other@hmps.uk. 2515 words.

Copyright: Copyright for published material rests with the British Psychological Society unless specifically stated otherwise. As the Society is a party to the Copyright Licensing Agency (CLA) agreement, articles published in *Forensic Update* may be copied by libraries and other organisations under the terms of their own CLA licences (www.cla.co.uk). Permission must be obtained from the British Psychological Society for any other use beyond fair dealing authorised by copyright legislation. For further information about copyright and obtaining permissions, go to www.bps.org.uk/permissions or e-mail permissions@bps.org.uk. Authors will be required to complete a copyright form before their article goes to press.

Presentation: It is essential that authors proofread their work for grammatical or spelling errors and send a final copy without tracked changes. It can take significantly longer to review articles if this is not carried out thoroughly. Tables or figures should be attached as separate Word or Excel files. Authors need to be mindful that this publication is in black-and-white, so please do not send us anything in colour.

Further guidance on presentation can be obtained from the *Style Guide* published by the British Psychological Society. It can be downloaded free of charge from the Society's website.

the british
psychological society
division of forensic psychology

St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel 0116 254 9568 Fax 0116 227 0787 E-mail info@bps.org.uk
www.bps.org.uk

ISSN 2050-7348