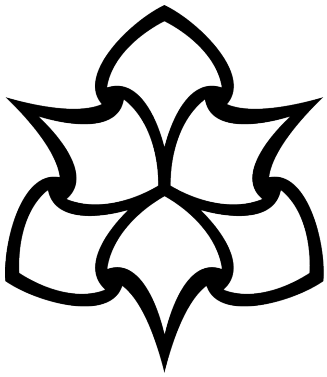

Sheffield Hallam University | Hallam Centre for Community Justice

Literature Review

Therapeutic Environments/Communities and Vulnerable Prisoners in relation to the Care, Support and Integration (CSI) Unit

Kevin Wong, Dan Ellingworth & Linda Meadows

Hallam Centre for Community Justice
Sheffield Hallam University

August 2013

Contents

1. Introduction and approach

This literature review forms part of the evaluation of the Care Support and Integration (CSI) Unit commissioned by Mount Eden Correctional Facility (MECF).

As reported by Fitton-Higgins (2013)[1], Serco's experience of custodial management in other jurisdictions has demonstrated that providing a therapeutic, safe, structured, busy and purposeful environment to vulnerable prisoners can minimize incidents of self-harm. It can also contribute to increasing prisoners' self-esteem, motivation, and engagement in the prison regime.

The CSI unit was developed on this basis with the aim of assessing and supporting prisoners within a therapeutic environment, but with the ultimate aim of safely facilitating their integration into the mainstream prison.

The key criterion for prisoners to be referred to the CSI unit is vulnerability in the mainstream prison, which can be caused by the following factors (Fitton-Higgins, 2013):

- mental illness;
- history of self-harming behaviours in relation to stressors;
- poor coping ability in the prison setting;
- change in social situation (e.g. loss of a loved one through death or termination of a relationship);
- health related problems that are difficult to manage in the mainstream prison;
- detoxing from drugs;
- physical and intellectual disability.

While a history of self-harm is a factor for referral to the CSI unit, prisoners actively at risk of self-harm, are cared for in the at-risk unit (ARU).

The overall aim of this literature review is to provide an analysis of the approach which underpins the CSI unit, focusing on 'therapeutic environments', led by a clear ethos, psychological paradigm and related staff development, rather than specific programmes and interventions.

1.1. Research questions

The review aims to answer the following research questions:

- Definitional Questions:
    - How have the terms 'vulnerable prisoners' and 'therapeutic environments' been used in the policy and research literature?
    - Are there distinctive characteristics of therapeutic environment operating in a criminal justice context?
- Associated characteristics:
    - Which groups of offenders are more likely to be deemed as 'vulnerable'?
    - Which are more likely to have received the service of a therapeutic environment?
    - What evidence is there that indigenous people receive a different level of service from therapeutic environments across the world?

[1] Fitton-Higgins, E. (2013) Business Case: Mount Eden Corrections Facility, Care, Support and Integration (CSI) unit.

- Principles and content of therapeutic environments:
    - What are the different guiding principles of therapeutic environments in the criminal justice system?
    - What are the key features of the delivery of therapeutic environments in the criminal justice system across the world?
    - What interventions are employed within therapeutic environments in a criminal justice context?
    - What are the characteristics of staff delivering the therapeutic environment, and what training is provided?
    - Do therapeutic environments in a custodial setting differ from those observed in a community setting?
    - How are the special needs of prisoners addressed in the design and delivery of therapeutic environments?
    - To what extent does the New Zealand context differ from other parts of the world?
- Evaluative assessment and what works:
    - What outcomes are explicitly targeted by therapeutic environments?
    - What evidence exists in the evaluation research literature of impact on these outcomes?
    - What examples of good practice can be identified in relation to working with vulnerable prisoners in therapeutic communities?

The review was undertaken as outlined below in 1.2 and 1.3.

1.2. Database Searching

The literature review focused on two central concepts underpinning the theoretical basis of the CSI Unit, namely:

- vulnerable prisoners
- therapeutic environments/communities

The approach involved searching for each of these concepts independently, and then combining these together to produce a more focussed review.

The search terms used were:

- vulnerable prisoners:
    - 'vulnerable' OR 'at risk' OR 'at-risk' OR 'mental health*'AND
    - 'prison*' [2] OR 'offend*' OR 'crim*' OR 'judicial' OR 'justi*'
- therapeutic environment:
    - 'therap*' OR 'psych*' AND
    - 'environment' OR 'community' OR 'setting' OR 'wing' OR 'intervention' AND
    - 'prison*' [3] OR 'offend*' OR 'crim*' OR 'judicial' OR 'justi*'.

[2] The asterisk is a wildcard, representing any number of further characters. Prison* will therefore include the words "prison", "prisons", "prisoner", "prisoners" etc.
[3] The asterisk is a wildcard, representing any number of further characters. Prison* will therefore include the words "prison", "prisons", "prisoner", "prisoners" etc.

Further general internet searches were also undertaken using combinations of the search terms above.

The search results (bibliographic citation and abstracts) were downloaded and exported to an Excel spreadsheet.

1.3. Relevance and quality assessment

An initial review of the titles and abstracts was undertaken to determine the items' likely relevance to the research questions. Studies which seemed on initial review to be relevant to the research questions were retrieved and reviewed against quality criteria to establish their applicability, credibility, rigour and robustness, for example: the design, sample sizes, methodology and analysis.

Where the research team identified documents which were perceived to be of value but which did not meet all the quality criteria, these were further assessed for inclusion by a second researcher and/or the project manager.

This resulted in a total of 57 documents which were then included in this review.

All relevant literature which 'passed' the quality standard described above was summarised and categorised according to the research questions to which they related. These summaries then formed the basis of the final literature review report.

2. Main Findings

The findings have been set out broadly in relation to the research themes detailed in Section 1.

2.1. Defining vulnerable prisoners

There appear to be few standard definitions of a 'vulnerable' prisoner. In some jurisdictions, including Northern Ireland, Scotland and England and Wales, all persons in lawful custody are regarded as being a 'vulnerable group' due to their incarceration (Criminal Justice Inspection Northern Ireland, 2009). This is also acknowledged by the United Nations (UN) Office on Drugs and Crime, taking an overview of prison regimes across the world (United Nations, 2010).

However, some general definitions of vulnerable prisoners exist, most commonly where they are defined by the problem/issue to which they are deemed vulnerable. Noting that certain groups are particularly vulnerable in prison and need additional care and protection, the United Nations Handbook for Prison Leaders identifies six 'particularly vulnerable' categories of prisoner: women prisoners; life and long-term prisoners; mentally ill prisoners; prisoners under a death sentence; elderly prisoners; and foreign prisoners (United Nations, 2010). In addition, the handbook also recognises that prisoners with HIV/AIDS are considered a vulnerable group in many prisons across the world.

These vulnerable groups and the issues identified in the UN handbook are reflected in the findings of the New Zealand National Health Committee report (2007). This report also identifies that prisoners are likely to have an 'imported vulnerability' due to social exclusion and an unhealthy pre-prison context, i.e. they are likely to be members of an ethnic minority, have limited education and a history of instability, unemployment or underemployment, substandard diet and housing conditions, and inferior medical access. In addition, common ailments are likely to include: co-morbid mental health and substance abuse/addiction problems; higher rates of disease; cognitive, behavioural and emotional problems; and self-harming or suicidal behaviour.

Vulnerable prisoners have also been defined by the admission criteria of those who are housed in a Vulnerable Persons Unit (VPU). As illustrated by Hawkins (1991), these include those with:

- a proven inability to adjust or be safe in the general prison population;
- a history of self-mutilation;
- a past history of mental illness or treatment in a psychiatric setting;
- a history of being persistently bullied in prison;
- a history of persistently getting into debt in prison;
- evidence of poor personal hygiene; and
- no history of serious institutional violence and had not been housed under Rule 43 (segregation for disciplinary problems within the past 28 days)

More recently guidance on identifying vulnerable prisoners has focused on those at risk of bullying, suicide and self-harm (UK Ministry of Justice, 2014). The Prison Youth Vulnerability Scale developed by the New Zealand Department of Corrections (Tie & Waugh, 2001) is based on assessing: vulnerability to victimisation; vulnerability to suicide/self-harm; and well-being.

The most detailed literature for vulnerable prisoners has developed in relation to suicide. This is unsurprising given that in western nations (US, UK, Australia) suicide is the leading cause of death in prison (Fazel & Benning 2006; Kariminia et al., 2007). A particular focus of this literature has been

on typologising prison suicide/attempted suicide as a means of informing suicide prevention initiatives (Rivlin, Ferris, Marzano, Fazel & Hawton 2013). A table summarising this is reproduced in Appendix 1.

The New Zealand Suicide Prevention Strategy 2006-2016 acknowledges that institutional settings such as prison provide contextual factors which may contribute to suicide (Ministry of Health, 2006). It highlights the importance of promoting mental health and well-being policies and practices in prison and other settings and an over-arching principle of being responsive to the needs of the Maori population.

2.2. Therapeutic environments/communities in prison

Three distinct themes have emerged from the literature search on therapeutic environments and/or communities in prison. These are:

- Therapeutic communities in prison - therapeutic environments/programmes which are designed to treat a particular condition such as drug misuse or mental illness;
- Therapeutic/social climate of prisons - assessing the extent to which prisons provide an environment in which therapeutic progress is supported and encouraged;
- Therapeutic impact of the physical prison environment.

The first two themes adhere closely to the main focus of this literature review i.e. 'therapeutic environments', led by a clear ethos, psychological paradigm and related staff development. The findings on therapeutic communities are detailed in sections 2.3 to 2.5. The findings on therapeutic/social climate of prisons is contained in section 2.6

The last theme, the therapeutic impact of the physical prison environment does not meet the review criteria of psychological paradigm and staff development, however, the literature suggests that the physical environment may have an impact on the well-being of staff and prisoners. This suggests that the design of the CSI unit with its access to an outside space may be important, therefore the key literature on this has been summarised in section 2.7.

2.3. Therapeutic communities

A commonly used definition of a therapeutic community (TC) is that provided by Roberts (1997, p.4), who describes a TC as "a consciously-designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent. In the therapeutic community the community is the primary therapeutic instrument." Some of the literature also suggests that self-definition is one of the criteria for defining a TC.

Therapeutic communities (TCs) in prison are regarded as falling into two types (Rawlings, 1998; Kennard, 2004):

- *democratic TCs* - these are generally found in the UK and Europe and have generally focused on prisoners with mental illness, whilst a recent prison-based democratic TC has been established to work with prisoners with learning disabilities (Morrisey, Taylor, Bennett, 2012)
- *hierarchical* (alternatively referred to as *'concept-based')* TCs - which are more widely used, are mainly found in the US and focus on prisoners with drugs misuse.

Treatment in both types of TCs (in a custodial and non-custodial setting) tends to last between six and twelve months (Lees, Manning & Rawlings, 2004), however, other studies indicate that this could be shorter and longer for hierarchical TCs (Lipton, Pearson, Cleland & Yee 2002).

Differences between the two forms of TC are reflected in the type of literature that is devoted to them. Systematic data collection, statistical analysis and the use of control groups are more common in studies of hierarchical TCs, while qualitative descriptive methods were more common in studies of democratic TCs (Nieminen & Isohanni 1997).[4]

The two forms of TC in prison are derived from two distinct models. Democratic TCs are based on the model developed by Maxwell Jones at the Henderson Hospital in the UK (Rapoport, 1960). Hierarchical TCs are based on the model developed by Chuck Dederich at Synanon in California (Yablonsky, 1965). They regard themselves as TCs, but do not always qualify this with the term 'concept-based' or 'hierarchical'.

In their systematic international review of TCs, focused primarily on democratic TCs, Lee, Manning and Rawlings (1999) noted that some of the key researchers in the field of TCs[5] have proposed a theoretical integration of the two models based on the following arguments:

> "(a) both types are basically democratic or peer driven, albeit with strong constraints, (b) that concept-based therapeutic communities are widening their client target and becoming very professionalised, and (c) that they are really addressing different stages of a single maturational cycle - concept-based therapeutic communities designed for early containment and behavioural change, and democratic therapeutic communities designed for later intra-psychic reconstruction." (Lees at al., 1999, p.23)

While this theoretical integration has been proposed, the literature suggests that in practice, the two models have generally been implemented as discrete models.

2.4. Democratic therapeutic communities in prison

Principles

Four core statements which map out the themes or 'common ground' for democratic TCs as a treatment modality (but which allow for variation) are provided by Kennard (2004). These are summarised as:

- *Resource pooling* - The self-conscious pooling of the total resources of the institution, staff, patients and relatives in furthering treatment (Jones, 1968);
- *Living-learning* - Everything that happens between members of the community (staff and residents) as part of living and working together (even crises) is viewed as a learning opportunity;
- *Permissiveness* - Regarded as the most important of the four principles identified by Rapoport (1960).[6] This involves members of the community (staff and residents) tolerating from one another a wide degree of behaviour that may appear to be distressing or deviant by normal standards;

[4] Based on a review of 223 TC articles published between 1987 and 1992
[5] Maxwell Jones (1979, 1984), De Leon (1983; also Rubel et al., 1982; Sugarman, 1984),
[6] The other three principles are: communalism - tight knit relationships, shared facilities and use of first names; democratisation - residents and staff share decision making; reality confrontation - residents should be continually confronted with interpretations of their behaviour as seen by others. (Rapoport, 1960, pp 54-64)

- *Culture of enquiry* - A basic culture among staff of adopting an "honest enquiry into difficulty" (Rapoport, 1960), involving a conscious effort to identify and challenge dogmatic assertions and/or accepted wisdoms.

According to Kennard the mechanism of change within democratic TCs can be described as providing:

> "a wide range of life-like situations in which the difficulties a member has experienced in their relations with others outside are re-experienced and re-enacted, with regular opportunities—in groups, community meetings, everyday relationships and, in some communities, individual psychotherapy—to examine and learn from these difficulties. The daily life of the therapeutic community provides opportunities to try out new learning about ways of dealing with difficulties." (Kennard, 2004, p.296)

Prison Service democratic TCs provide an open living-learning environment for prisoners and staff. Prisoners and staff teams are empowered to make their own decisions, although they can expect to be questioned by the whole community on any matter e.g. a decision not to go to work, request for release on temporary license, a decision to transfer a prisoner, or a decision to change the daily timetable.

Modifying democratic therapeutic communities for prisons

TCs in prison have been modified to meet prison requirements of security and control, with therapeutic timetables arranged around prison timetables of work, association, eating and lock-up. Some TC prisons, which are independent of mainstream prisons, most notably, HMP Grendon in the UK and some of the German Social Therapeutic Institutions,[7] have been able to modify prison timetables and regulations slightly to accommodate therapeutic activities. Small therapeutic community units inside mainstream prisons have been unable to do this.

As noted by Lees et al. (1999), the location of a TC within a secure environment poses problems for the therapeutic integrity of the TC regime, in terms of a conflict between control and democracy. The way in which this can be overcome is illustrated by the regime at HMP Grendon, as reported by Kennard (2004). This includes:

- making significant decision-making available, from allocating members to community jobs such as cooking and gardening, to voting a member out of therapy for a serious rule violation;
- allowing prisoners to behave as they 'normally' behave rather than as model prisoners, so creating the possibility of “offence paralleling” behaviour, which can provide the material for group therapy;
- allowing prisoners to act as auxiliary therapists for one another, giving feedback on the impact of each other's attitudes and behaviour and confronting one another on the basis of their own experience and self-knowledge - considered valuable in cutting through rationalisations or denials of the offence and its consequences.

[7] According to Coignerai-Weber (1979) the first social-therapeutic institution opened in 1970 at an adult correctional facility with a capacity for 30 clients. Those eligible for treatment had to be aged between 25 and 30 years, of average intelligence, serving up to three years and had to be willing to be treated and fulfil social selection criteria. The methods employed included: individual therapy; therapy in small groups, therapy in large groups, daily contacts with fellow offenders at the treatment facility; contacts with ordinary inmates at work; outside contacts with family and friends; and therapy for released prisoners or prisoners on temporary leave at a centre outside the prison.

Kennard and Roberts (1983, p.58) have identified that one of the main positive effects of running a prison TC has been breaking down the traditional roles which prisoners and officers create for themselves and each other, as encapsulated in the terms 'cons' and 'screws'. Prisoners are also able to give up the need to impress their peers.

Service context

Secure therapeutic communities are located mainly within prison and correctional services. Of these, only HMP Grendon (category B, medium secure) in Buckinghamshire, UK, is an entirely therapeutic community prison. Other UK TCs comprise small units inside larger mainstream prisons. These include: Max Glatt in Wormwood Scrubs; the lifers' TC unit in Gartree (category B), young offenders TCs in Glen Parva, Feltham and Aylesbury (Cullen & Miller, 2010); Blundeston (category C) and Send (a closed women's prison) (Stevens 2010) . As noted by Lees et al. (2004), some German Social Therapeutic Institutions have been established in separate secure premises outside prisons and the Slovenian prison system is largely based on a therapeutic community model. In addition some secure psychiatric hospitals in the UK also house therapeutic communities for forensic patients (Lees et al., 2004). HMP Dovegate (Category B) located in Staffordshire in the UK, houses the most recent democratic TC to be established in the UK. The newly built private prison opened in 2001 and is currently run by Serco. It contains a 200-inmate, purpose built TC unit attached to a conventional prison, which in total holds 1060 inmates. A detailed account of the features of HMP Dovegate as a democratic TC including staff roles within the unit and the training provided is contained in Appendix 2.

Auditing democratic therapeutic communities

A regular audit[8] of twelve democratic TCs, across five prisons in the UK[9] has been conducted since the mid-2000s by the Community of Communities comprised of: the Association of Therapeutic Communities; the Royal College of Psychiatrists; the Prison Service; and the College Centre for Quality Improvement.

The integrated audit is intended to evaluate compliance with the Democratic TC Core Model, accredited by the Correctional Services Advice and Accreditation Panel (CSAAP) and to facilitate quality improvement through membership of the Community of Communities' Quality Improvement Network (The Community of Communities, 2012).

Assessment is based on a scoring system with the results reported as (The Community of Communities, 2012):

- an overall performance score, recommendations and areas of achievement;
- scores for each of four areas: institutional support; treatment management and integrity; continuity and resettlement; and quality of delivery; and
- a comparison of the performance of the prison-based TCs with adult TCs which are part of the Community of Communities' audit process.

2.5. Hierarchical (concept) therapeutic communities

As noted earlier hierarchical (concept) TCs focus on drug users.

[8] What commenced as an annual audit has changed to a biennial audit.
[9] These are: Dovegate, Grendon, Gartree, Blundeston and Send.

Principles and features

The key principles and features which underpin a hierarchical TC, based on the systematic review by Lipton, Pearson, Cleland and Yee (2002) are:

- the purposive use of the community as the main way of facilitating social and psychological change in individuals, blending confrontation and support (De Leon, 1995);
- a community comprised of residents (with drugs problems), professional staff and recovering drug users serving as staff;
- work is used as an organising therapeutic activity community which means that residents are involved in all aspects of the operation of the community;
- hierarchical organisation - staff and resident roles are aligned in a clear chain of command with new residents assigned to work teams with the lowest status but with the potential to move up the hierarchy if they demonstrate increased competency and emotional growth; and
- "acting 'as if'" - new residents are required to make believe that they accept the values and conditions of TCs until the community values and conduct become internalised.

In relation to drugs misuse hierarchical TCs operate on the following basis:

- drug misuse is seen as a disorder of the whole person, therefore the person is the treatment problem not the drug;
- drug misuse is regarded as a symptom of immaturity with the drug user being unable to postpone gratification, tolerate frustration and develop healthy relationships;

Case studies which illustrate the features and phasing of treatment within hierarchical TCs are contained in Appendix 3.

Differences between hierarchical therapeutic communities in prisons and in the community

Lipton, Pearson, Cleland and Yee (2002) identified the following differences between hierarchical TCs in prison and community:

- TCs in prison are more constrained by rules and policies especially in relation to security;
- The range of programme autonomy, clinical creativity and independence of action is wider in the community than in prison TCs;
- Prison TCs have fewer persons recovering from drugs misuse as staff compared to community TCs, therefore there are fewer role models for prisoners to identify with;
- Mixed gender groups are rarely found in prison TCs limiting the opportunities for each gender to develop positive working and social relationships with the other;
- Prison TCs have fewer work-based opportunities to develop leadership and responsibilities of employees;
- In the community, breaking a rule, such as theft could be used as a learning opportunity, in prison this is likely to be regarded negatively and result in punishment;
- In prison, staff would be compelled to report such an offence which may impact negatively on the programme. In the community, the offence would be used in a group meeting between staff and residents and consequences could be discussed and assigned;
- Prison TCs have a limited range of rewards and incentives; and

- Prison TCs have lower drop-out rates than community-based TCs - 50 per cent in a year compared to 70 to 90 per cent.

2.6. Evaluative assessment of therapeutic communities and what works

Mental health and functioning

A systematic review of research evidence into the effectiveness of TCs was undertaken by Lee, Manning and Rawlings (1999, 2004).

The review noted that democratic TCs were aimed at a range of mental illnesses in which substance abuse, if present, was considered a symptom rather than the core issue. As opposed to hierarchal TCs which were targeted exclusively at substance (generally drug) misusers. Although the focus of the review was on democratic TCs, both types of TCs were covered by the review. Offenders covered by the review included:

- 'Subnormal' male psychopaths (mainly adolescent offenders);
- Mentally ill offenders;
- Prison inmates who had been released for between seven weeks and four years;
- Male (adolescent) delinquent inpatients aged 13-25 with relatively low IQs;
- Forensic patients (psychotic offenders, some prisoners and people with socially accentuated psychiatric disorders) in Slovenia; and
- Persistent male offenders.

Outcomes that were assessed by studies contained in the review were:

- Ability to form satisfactory personal relationships;
- Psychology (basic personal traits and attitudes);
- Levels of: aggression, disturbance, self-esteem, symptom reduction; being on medication at discharge; suicide attempts;
- Being transferred to an acute ward;
- Finishing treatment;
- Alienation, purpose in life, hostility, criminality, internal control;
- Number of assaults and serious incidents;
- Amount of prison violence (riots, serious assaults, suicides, escape attempts);
- Reconviction, recidivism;
- Employment record post discharge;
- Clinical well-being post-discharge;
- Hospital readmission;
- Interaction (COPES scale);
- Changes in core personality disorder symptoms;
- Global functioning, social adjustment, independence, coping with everyday life;
- Satisfaction with employment and social-leisure activities; and
- Drug and alcohol problems.

The meta-analysis of effectiveness was focused on mental health and functioning. This was based on data from 29 published studies which included a control group, of which 8 studies involved randomised control trials. Lees et al. (1999) found that:

- TCs produced positive change in people's mental health and functioning;
- there was 'accumulating evidence' of the effectiveness and suitability of TCs in treating personality disorder, particularly severe personality disorder;
- there was evidence of the efficacy of TCs (modified for prison security needs) in managing difficult prisoners and significantly reducing serious prison discipline incidents after admission, including fire setting, violence, self- harm and absconding;
- there was evidence that the longer a person remains in treatment, the better the outcome. Very short stay residents did particularly badly.

The single evaluation that Morrissey et al conducted on a TC for men with intellectual disability and personality disorder was based on small intervention group of 11 individuals. The TC group showed comparatively less pathology over time and in relation to the comparison group. Change was more likely for clinical scales that measure internalising problems, than for externalising problems. There was a strong trend towards reduction in seclusion hours of the TC group over time with significant differences between groups being observed at six and twelve months. The mean number of violent incidents did not reduce over time.

Recidivism

In their meta-analysis of the effectiveness of TCs on recidivism, Lipton et al. (2002) primarily focussed on hierarchical therapeutic communities although they also included what they referred to as milieu TCs. The principles and features of milieu TCs (as described) appeared to align to those of democratic TCs and German social therapy.[10] The findings were drawn from the results of 42 studies of adults which were restricted to those which compared an experimental group with a 'no treatment' group or 'treatment as usual' group.

Recidivism was measured either by re-arrest or re-incarceration. The meta-analysis found that hierarchical therapeutic communities and milieu therapeutic communities were associated with a moderate effect on recidivism outcomes. The evidence on just hierarchical TCs and German social therapy showed that they worked better than their 'treatment as usual' comparison groups.

Lipton et al. (2002) also found that the results of short term custodial hierarchical TC programmes (90 days) compared with longer term hierarchical custodial TC programmes (six months or more) were negligible. However, they suggested this may be due to the continuation of TC in the community for the short custodial programmes following release from custody. The length of a TC intervention should therefore be measured from the onset in the prison, through the transition to a community-based TC and finally to discharge.

Another review which examined seven studies of prison based hierarchical TCs (Smith, Gates, Foxcroft, 2006) found that only two of the studies showed reductions in recividism (based on re-incarceration) in the 12 months following release from custody. One these studies compared TC with no treatment, the other compared TC with other mental health programmes.

[1010] Milieu therapy has been defined as: provision of a psychologically safe environment in which every-day events, relationships and interactions are used with therapeutic intent. This can be based on different approaches and models of therapy. Accessed at: http://www.therapeuticcommunities.org/what-is-a-tc-mainmenu-94/45 (August 2014)

Belongingness and responsible agency

Pearce and Pickard (2012) have suggested that two specific factors in combination contribute to the effectiveness of TCs: the sense of belongingness and the capacity for responsible agency. They suggest that a sense of belongingness is correlated with improved self-esteem and overall well-being and that the capacity for responsible agency is central to behavioural change. TCs are generally applied to fields where positive outcome requires both personal growth and behavioural change. The way in which TCs are configured enable them to place demands of growth and change of their members because the sense of belongingness engendered by TC methods protects against the risks engendered by this demand.

2.7. Social/therapeutic climate of prisons

A recent focus of research has been on the *social* and/or *therapeutic climate* of prisons in relation to rehabilitation. This has been underpinned by the view that rehabilitation programmes can and do bring about significant reductions in crime and reduce the direct and indirect costs associated with victimisation and incarceration (Andrews & Bonta, 2010; Drake, Aos & Miller, 2009). However, the environmental and interpersonal context in which rehabilitation programmes are offered, i.e. the social/therapeutic climate of prisons can affect programme delivery (Shefer, 2010) and the effectiveness of treatment (Blagden & Thorne, 2013).

Day, Casey, Vess and Huisy (2012) have noted that despite the appeal (and face validity) of notions of an institutional milieu or social climate, defining and operationalising this has been difficult. They suggest that this is due to the concepts of *culture* and *climate* being used interchangeably. Aiming to clarify the differences, they suggest that culture can best be understood in terms of relational structures that help to define and restrict the permissible range of behaviours in social situations, such that social order can be maintained. Climate refers to the perceptions of an organisation at an operational level about its ability to be open to change and to support new ideas. They conclude that organisational climate may be easier to assess and change than culture.

Schalast, Redies, Collins, Stacey and Howells (2008) have devised the Essen Climate Evaluation Schema (EssenCES) to assess social climate in a forensic setting. The schema assesses three elements:

- therapeutic hold - the extent to which the climate is supportive of therapy and therapeutic change;
- patients' cohesion and mutual support - whether the mutual support typically viewed as characteristic of therapeutic communities is present; and
- experienced safety - i.e. tension and the perceived threat of aggression and violence.

A prison version of the scale was used to examine the social climate of fourteen units in five prisons in Germany, of which six were described as social therapeutic treatment units (Schalast & Groenewald 2009). The study found that prisoners and staff reported greater support (therapeutic hold) and safety (experienced safety) in the therapeutic units than in the general units. Staff reported more cohesion (cohesion and mutual support) in the therapeutic units. Prisoners perceived slightly more cohesion in the general prison units than the therapeutic units.

Day et al. (2012) used the EssenCES measure to establish whether meaningful differences could be observed between two Australian prisons, one which strove to provide a therapeutic climate in which prisoners were expected to engage in rehabilitation programmes and the other offering a mainstream service with a much more restricted range of programmes. The results suggested that when staff and prisoner views were considered together, the social climate of the rehabilitation prison was rated as safer, more supportive and more therapeutic than the mainstream prison.

However, the staff responses were more clear-cut than the prisoner responses. Day et al. (2012) suggest that social climates characterised by high levels of social cohesion, mutual support and safety are likely to be successful in rehabilitating offenders.

Blagden and Thorne (2013) have suggested that the social climate of prisons can be considered within the context of the current dominant model of offender rehabilitation, i.e. the 'risk, need and responsivity' model. The responsivity of the correctional climate may play a role in desistance from crime. They suggest that it is important for prisons to consider this given that imprisonment itself may actually be criminogenic (Cid, 2009). Blagden and Thorne (2013) also suggest that a prison's rehabilitative climate can be understood as the prison's social climate coupled with the prison's culture, philosophy and fitness for purpose in relation to reducing reoffending. Blagden and Thorne (2013) used quantitative (the EssenCES measure) and qualitative (interviews with prisoners and staff) evidence to assess the therapeutic environment at HMP Whatton, a prison which holds adult male sex offenders. They concluded that the prison was a 'prison of change', with this embedded in its very purpose. This was manifested in participants believing in change and believing change was possible in themselves and others. Prisoners wanted to change, wanted to show that they had changed and staff were keen to recognise and reinforce this change.

In a similar vein, Smith and Schweitzer (2012) have suggested that it is possible to use the Correctional Programme Assessment Inventory (CPAI) to design a therapeutic prison to deliver effective rehabilitative interventions. They report that items within the CPAI have been incorporated into the accreditation standards of correctional services in the UK, jurisdictions in the US and the Correctional Service of Canada. The dimensions of the inventory are organised around two themes:

- Capacity of the prison to deliver rehabilitative interventions including:
    - organisational factors;
    - programme implementation/maintenance;
    - management/staff characteristics;
    - inter-agency communication; and
    - evaluation.
- The content of services, which includes:
    - client risk/need practices;
    - programme characteristics; and
    - core correctional practices.

Further details about these factors are detailed in Appendix 4.

2.8. Therapeutic impact of the physical prison environment

Lindemuth (2007) reviewed several studies conducted within the US correctional facilities which suggest that the physical environment of the prison itself can have a positive therapeutic impact on the physical well-being of prisoners. Features include: views from the cells (exterior or interior); the cell's relative privacy, and noise level within the cell; and naturalistic elements visible from the cell (Moore, 1981, and West, 1986). Hiller (2001) found that gardens within correctional facilities can help reduce stress among inmates and staff by providing more complex, visually engaging views within the prison landscape. Further, individuals interacting with garden plants for prolonged periods of time, whether through active gardening or quiet contemplation, may have the opportunity to experience significant, long-term emotional and psychological changes.

2.9. Indigenous peoples and therapeutic environments

The search found few articles in relation to indigenous peoples and therapeutic environments.

The evaluation of Mona House Residential TC for alcohol treatment in New Zealand (based on initial cohort sample of 18 men) noted that there was increasing agreement on developing effective services for Māori based on holistic and integrative Māori perspectives (Adamson, Deering, O-Hinerangi, Huriwai, Noller, 2010). In particular, given the high proportion of Māori with offending and substance-related issues. The evaluation found that there was a strong endorsment for the programme having a postive impact on the four cornerstones of health as operationalised by Hua Oranga - wairua, hinengaro, tinana and whānau. There were improvements in mental health functioning for men interviewed more than once.

Grant (2014) provides an account of responses in Australia to the Royal Commission into Aboriginal Deaths in police and prison custody in 1991. Queensland developed an alternative to traditional custody for Aboriginal prisoners, establishing 'therapeutic environments' in or adjacent to Aboriginal communities. These were based on a philosophy of assisting Aboriginal people in healing, recovery and rehabilitation and supporting individuals to become independent and responsible underpinned by the design and development of each centre.

Other developments have included:

- Cultural centres and spaces within prisons to enable Aboriginal prisoners to fulfil cultural obligations for example Darwin Correctional Centre organised the construction of a bough shelter for prisoners to participate in sorry camps to allow prisoners to gather and grieve. However, Grant noted that while this may have acknowledged the cultural needs of Aboriginal prisoners, this was a poor substitute for participating in a funeral had potential repercussions for prisoners on their release, even if they were not permitted or unable to attend.
- Prison accommodation to meet Aboriginal domiciliary and socio-spatial needs - Grant (2013) reported that evidence based research found that Aboriginal prisoners required prison accommodation that allowed them to stay connected to country, maintain relationships with family and kin, to live within a specified social group and to meet their privacy, health and safety needs. While Indigenous prisoners may prefer to have communal living spaces, it was vitally important the individuals have private space.

A small qualitative study of TC was undertaken by Brookes, Glynn and Wilson (2012 in relation to men who identified themselves as 'black' from the UK, Africa and the Caribbean. This found that elements of the TC regime at HMP Grendon may not be culturally appropriate, appealing or marketed to black prisoners. The study suggested that this may be compounded by the social stigma attached to black men's mental health, combined with their overrepresentation within the criminal justice and mental health systems.

2.10. Good practice

As noted in the introduction the overarching aim of the CSI unit is to assess and support prisoners within a therapeutic environment, with the ultimate aim of safely facilitating their integration back into the mainstream prison.

The prisoners housed in the unit are likely to be vulnerable because of one or more of the following factors:

- mental illness;

- history of self-harming behaviours in relation to stressors;
- poor coping ability in the prison setting;
- change in social situation (e.g. loss of a loved one through death or termination of a relationship);
- health related problems that are difficult to manage in the mainstream prison;
- detoxing from drugs;
- physical and intellectual disability.

The examples of good practice contained in this section, are drawn primarily from the literature around the social and therapeutic climate of prisons, as these appear to have the greatest applicability to the operation of the CSI unit and the whole of MECF.

The learning from democratic TCs and hierarchical TCs is perhaps of less relevance because of:

- the duration of these interventions - typically between between six and twelve months (Lees, Manning & Rawlings, 2004). The majority of prisoners are in MECF for considerably shorter periods of time. For example only a third of discharged prisoners from MECF form part of the Out of Custody Index (OCI) cohort, i.e. are in custody for more than 42 days (Hall, 2013), i.e. around one and a half months; and
- the level of change required to implement these interventions - for example (as noted in 2.4) the implementation of democratic TCs requires a relaxation/modification of prison practice around security and control.

The two areas of good practice drawn from the research around social/therapeutic climate of prisons focus on: assessing the impact of the unit; and on ways in which its operation could be improved.

Assessing and monitoring impact

The three key elements of the Essen Climate Evaluation Schema (EssenCES) devised by Schalast et al (2008) could be incorporated into an assessment of the effectiveness of the CSI unit - something which could be undertaken by residents and staff of the unit on an ongoing basis. As detailed in 2.7, the three elements are:

- therapeutic hold - the extent to which the climate is supportive of therapy and therapeutic change;
- patients' cohesion and mutual support - whether the mutual support typically viewed as characteristic of therapeutic communities is present; and
- experienced safety - i.e. tension and the perceived threat of aggression and violence.

These could provide additional outcomes to those detailed by Fitton (2013).

Operationalising a social/therapeutic climate

Implementing the elements of the Correctional Programme Assessment Inventory (CPAI) as proposed by Smith and Schweitzer (2012) would provide a way of enhancing the therapeutic impact of the CSI unit.

A number of the elements of the inventory (detailed in Appendix 4) may already be operationalised in the CSI unit. Assessing the operation of the unit against the inventory dimensions would provide a way of any gaps in provision and optimising the way in which the unit is currently working.

Some of the key operational dimensions that are particularly worth noting are listed under the two broad themes of the CPAI:

- capacity of the institution:
    - having a moderate decentralisation of the bureaucratic structure of the prison to allow flexible responses to problems;
    - the attitude, qualifications and experience of correctional officers - as noted by Smith and Schweitzer (2012) they are an often overlooked valuable resource, particularly as prisoners spend the vast majority of their time with these frontline staff. Their qualifications and experience are therefore are as important as those of clinical staff. At a most basic level they need to be committed to human service and endorse the notion that offenders can change
    - have formal links with other providers - given the short stay of most MECF prisoners, it may be particularly critical for case coordinators to have good liaison with external providers, who may be able to continue the support for prisoners when they return to the community.
- content of services - the following have been designated as core correctional practices:
    - corrections staff serving as an anti-criminal model for offenders by engaging in pro-social behaviours and reinforcing inmates when they do the same;
    - using high-level reinforcement to encourage pro-social behaviours as well as effective disapproval such as: immediate statements of approval and support for what an offender has said or done; and elaboration of the reasons why this behaviour is desirable;
    - effective use of authority to guide the offender towards compliance, i.e. focusing their message on the behaviour exhibited not on the person performing it;
    - corrections staff being trained in cognitive restructuring, i.e. being able to teach offenders how to generate descriptions of problematic situations, identify risky thinking and practice more pro-social alternatives; and
    - corrections staff developing a therapeutic alliance between staff and offenders by staff being: open, warm, exhibiting respectful communication, being non-judgmental, empathic, flexible, enthusiastic and engaging.

References

Adamson, S., Deering, D., O-Hinerangi, M., Huriwai, Noller, G. (2010) An evaluation of the Moana House Residential Therapeutic Community, Alcohol Advisory Council New Zealand

Andrews, D.A. and Bonta, J. (2010) Rehabilitating criminal justice policy and practice. P*sychology, Public Policy and Law*, 16, 39-55.

Blagden, N., Thorne, K. (2013) HMP Whatton - A prison of change? Prison Service Journal, Issue 208 pp 3 - 9

Brookes, M., Glynn, M., Wilson, D. (2012) Black men, therapeutic communities and HMP Grendon, Therapeutic communities: The International Journal of Therapeutic Communities. Vol. 33 Issue 1, pp 16-26

Cid, J. (2009) Is imprisonment criminogenic? A comparative study of recidivism rates between prison and suspended prison sanctions. *European Journal of Criminology*, 91, 425-447.

Coignerai-Weber, C. (1979) Ten years of social therapy in the Tegel (West Germany) corrections facility,Monatsschrift Fuer Kriminologie und Strafrechsreform Volume: 62 Issue 6 pp 338 - 347

Criminal Justice Inspection Northern Ireland (2009) Vulnerable prisoners: An inspection of the treatment of vulnerable prisoners by the Northern Ireland Prison Service, Criminal Justice Inspection Northern Ireland

Cullen, E. and Miller, A. (2010) Dovegate Therapeutic Community: Bid, birth, growth and survival, in Richard Shuker and Elizabeth Sullivan (eds) *Grendon and the Emergence of Forensic Therapeutic Communities: Developments in Research and Practice*, Sussex, Wiley.

Day, A., Casey, S., Vess, J., Huisy, G. (2012) Assessing the therapeutic climate of prisons, Criminal Justice and Behaviour 2012 39: 156

De Leon, G. (1983). The next therapeutic community: autocracy and other notes toward integrating old and new therapeutic communities. *International Journal of Therapeutic Communities*, 4(4), 249-261.

Drake, E. K., Aos, S. and Miller, M. G. (2009) Evidence-based policy options to reduce crime and criminal justice costs: Implications in Washington state. *Victims and offenders*, 4, 170-196.

Fazel, S. and Benning, R. (2006) Natural deaths in male prisoners: a 20-year mortality study *European Journal of Public Health,* pp 441-4

Fitton-Higgins, E. (2013) Business Case: Mount Eden Corrections Facility, Care, Support and Integration (CSI) unit. Serco New Zealand

Grant, E. (2014) Approaches to the design and provision of prison based accommodation and facilities for Australian Indigenous Prisoners after the Royal Commission into Aboriginal deaths in custody, Australian Indigenous Law Review 17(1) pp 47-55

Hall, S. (2013) Key Performance Indicator - Final agreement, Serco New Zealand

Hawkins, P. (1991) Special regimes: HMP (Her Majesty's Prison) Littlehey "A" Wing, in Simon Boddis (ed) *Prison Service Psychology Conference: Conference proceedings*, 234-237.

Hiller, L. (2001) Gardening Effort: Project alters prison climate. *Las Vegas Review-Journal*, September 17.

Jones, M. (1968) *Social Psychiatry in Practice.* Harmondsworth, Penguin Books.

Jones, M. (1979) Therapeutic communities, old and new. *American Journal of Drug and Alcohol Abuse*, 6(2), 137-149.

Jones M. (1984) Why Two Therapeutic Communities. *Journal of Psychoactive Drugs*, 16(1), 23-26.

Kariminia A; Law MG; Butler TG; Corben SP; Levy MH; Kaldor JM; Grant L, 2007, ' Factors associated with mortality in a cohort of Australian prisoners', *European Journal of Epidemiology*, vol. 22, no. 7, pp. 417 - 428

Kennard, D. (2004) The therapeutic community as an available treatment modality across different settings*. Psychiatric Quarterly*, 75(3) 295-307.

Kennard, D. and Roberts, J. (1983) *An Introduction to Therapeutic Communities*, International Library of Group Psychotherapy and Group Process, London, Routledge and Kegan Paul.

Lees, J., Manning, N. and Rawlings, B., (1999) *Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders,* NHS Centre for Reviews and Dissemination, University of York.

Lees, J., Manning, N. and Rawlings, B., (2004) A culture of enquiry - research evidence and the therapeutic communit*. Psychiatric Quarterly*, 75(3),

Lindemuth, A. (2007) Designing Therapeutic Environments for Inmates and Prison Staff in the United States: Precedents and Contemporary Applications*. Journal of Mediterranean Ecology*, 8, 87-97.

Lipton, D. S., Falkin, G. P. and Wexler, H. K. (1992) Correctional Drug Abuse Treatment in the United States: An Overview, in Carl G. Leukefeld and Frank M. Tims (eds) *Drug Abuse Treatment in Prisons and Jails*, pp 8-30

Lipton, D. S., Pearson, F. S., Cleland, C. M. and Yee, D. (2002) The effects of therapeutic communities and milieu therapy on recidivism: meta-analytic findings from the correctional drug abuse treatment effectiveness (CDATE) study, in J. McGuire (ed) *Offender rehabilitation and treatment: effective programmes and policies to reduce re-offending*, 39–77. Chichester, UK: Wiley.

Ministry of Health (New Zealand) (2006) *New Zealand Suicide Prevention Strategy 2006-2016,* Ministry of Health, New Zealand.

Ministry of Justice (UK) (2014) 4. Vulnerable Prisoners, Prison Life, Ministry of Justice. Available at https://www.gov.uk/life-in-prison/vulnerable-prisoners. Accessed August 2014.

Main, T. (1983) The concept of the therapeutic community: Variations and vicissitudes, in M. Pines (ed) *The Evolution of Group Analysis*, London, Routledge and Kegan Paul.

Moore, Ernest O. (1981) A Prison Environment's Effect on Health Care Service Demands. *Environmental Systems,* 11, 17-34.

Morrisey, C., Taylor, J., Bennett, C. (2012) Evaluation of a therapeutic community intervention for men with intellectual disability and personality disorder, Journal of Leaning Disabilities and Offending Behaviour, Vol 3 Issue 1, pp 52-60

National Health Committee (New Zealand) (2007) *Review of research on the effects of imprisonment on the health of inmates and their families,* National Health Committee.

Nieminen, P. and Isohanni, M. (1997) The use of bibliometric data in evaluating research on therapeutic community for addictions and psychiatry. *Substance Use and Misuse*, 32(5), 555-570.

Pearce, S. and Packard, H. (2012) How therapeutic communities work: Specific factors related to positive outcome, *International Journal of Social Psychiatry*

Rapoport, R.N. (1960) *Community as Doctor: New Perspectives on a Therapeutic Community*, London, Tavistock Publications.

Rawlings, B. (1998) *Research on therapeutic communities in prison: A review of the literature Produced for the prison service*. Accessed at: http://www.dldocs.stir.ac.uk/documents/rawlings.pdf. August 2014

Rivlin, A., Ferris, R., Marzano, L., Fazel, S. & Hawton, K. (2013). A typology of male prisoners making near-lethal suicide attempts. Crisis. doi:10.1027/0227-5910/a000205

Roberts, J. (1997) How to Recognise a Therapeutic Community, *Prison Service Journal*, 111, 4-7.

Rubel, J. G., Baker, K. G., Bratten, T. E., Hartwig-Thomson, L. and Smirnoff, A. M. (1982) The role of structure in the professional model and the self-help concept of the therapeutic community: different strokes for different folks, *International Journal of Therapeutic Communities*, 3(4), 218-232.

Schalast, N. and Groenewald, I. (2009) Drogen–Sucht–Kriminalität [Drugs, addiction, criminality]. In H. Haller & J. M. Jehle (eds), *Forum* , 329-352. Mönchengladbach, Germany: Forum Verlag Godesberg.

Schalast, N., Redies, M., Collins, M., Stacey, J. and Howells, K. (2008) EssenCES: A short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health,* 18, 49-58.

Shefer, G. (2010) *Doing rehabilitation in the contemporary prison: The case of One-Wing Therapeutic Communities* (Unpublished PhD thesis), Cambridge University, Cambridge, UK.

Smith, L. A., Gates, S. and Foxcroft, D. (2006) Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews,* 2006, Issue 1.

Smith, P. and Schweitzer M. (2012) The therapeutic prison. *Journal of contemporary criminal justice*, 28(7), pp 7- 22.

Spiegler, M. D., & Guevremont, D. C. (2010). *Contemporary behavior therapy* (5th ed.). Belmont,CA: Wadsworth.

Stevens, A. (2010) *Introducing forensic democratic communities,* in Richard Shuker and Elizabeth Sullivan (eds) *Grendon and the Emergence of Forensic Therapeutic Communities: Developments in Research and Practice*, Sussex, Wiley.

Sugarman, B. (1984) Towards a new, common model of the therapeutic community: Structural components, learning processes and outcomes. *International Journal of Therapeutic Communities*, 5(2), 77-98.

The Community of Communities (2012) *Democratic communities in prison, National audit report 2011/12,* The Community of Communities, Royal College of Psychiatrists Centre for Quality Improvement, London.

Tie, D. and Waugh, E. (2001) *Prison Youth Vulnerability Scale Administration and Technical Manual,* Department of Corrections, New Zealand.

United Nations Office on Drugs and Crime (2010) *Handbook for prison leaders: A basic training tool and curriculum for prison managers based on international standards and norms,* Criminal Justice Handbook Series, United Nations, New York.

Yablonsky, L. (1965) *The Tunnel Back,* MacMillan, New York.

Yalom, L. D. (1995) The Theory and Practice of Group Psychotherapy (4th edn). New York: Basic Books

West, Marcia J. (1986) *Landscape Views and Stress Response in the Prison Environment*, Landscape Architecture, University of Washington, Seattle.

Appendix 1: Typology of prison suicide/attempted suicide

Table A.1 Summary of typologies of prisoners dying by suicide or attempting suicide developed in a range of studies reproduced from Rivlin et al. (2010).

Author	Country	Typology of prison suicide/attempted suicide	Primary study methods used
Danto (1973)	US	1. Disgraced serious offender 2. Persistent but isolated recidivist 3. "Manipulative" suicide attempter	Psychological autopsy, analysis of prison files
Hatty and Walker (1986)	Australia	1. Previously suicidal, violent offender, remanded in custody 2. Prisoner unfit to plead or facing indefinite prospect of a Governor's Pleasure sentence, transferred to unfamiliar surroundings on a disciplinary measure 3. Young offender with history of convictions for property offences, with no job and no family for support	Analysis of prison files
Dooley (1990)	UK	1. Prison situation 2. Outside pressures 3. Guilt for offence 4. Mental disorder	Analysis of prison files
Liebling (1992)	UK	1. The psychiatrically ill 2. The serious offender facing a life sentence 3. Unpredictable young offender sentenced or facing charges for acquisitive offences and showing similar characteristics to the general prison population	Interviews with suicide attempters broadly defined
Lester and Danto (1993)	US	Based on Durkheim: 1. Egoistic 2. Fatalistic	Literature review
Liebling (1995)	UK	1. Poor copers 2. Long-sentence prisoners 3. Psychiatrically ill	Interviews with suicide attempters broadly defined
The present study	England and Wales	1. Prisoner unable to cope 2. Psychotic prisoner 3. Instrumental motive 4. "Unexpected" attempt 5. Prisoner withdrawing from drugs	Interviews with prisoners making near-lethal suicide attempts

Appendix 2: Case study of a democratic therapeutic community

The set-up and development of the TC unit within HMP Dovegate provides a way of illustrating:

- the features of a democratic TC unit within a custodial setting;
- the staff roles within such a unit; and
- the training provided.

Configuration of the TC unit

The 200 bed TC unit comprises four communities (wings), an assessment unit and a high intensity programme unit (HM Prison Service, 2005). Facilities such as gym, health care, stores, works, kitchen and the offender behaviour unit are shared with the main prison.

Each of the forty bed wings has a community therapist, a counsellor, or a trained psychologist and eight other members of staff; with the latter, prison officers, who act as both a "standard security officer" and as a therapist.

As reported by Cullen and Miller (2010), the primary theoretical underpinning for the TC was based on a professional orientation of cognitive-behavioural therapy and the group psycho-therapeutic work of Yalom (1995). This was a departure from traditional psycho-dynamic therapy and the version of this developed at HMP Grendon.

Staff training

The unit gained accreditation with the Correctional Services Accreditation Panel early in 2004 which meant that the TC, developed at the institution, was a recognised method for addressing Offending Behaviour.

The following is drawn from the detailed account of the establishment and development of the unit provided by Cullen and Miller (2010), Cullen was the lead forensic psychology consultant involved in setting up the TC from the bidding stage onwards.

The original training programme developed by Cullen and Woodward[11] for the wing therapists, managers and counsellors comprised the following:

Week one

- A history of democratic TC referencing the work of Maxwell Jones and the four principles of democratic TC identified by Rapoport (1960);
- The unique Dovegate TC staff model with the five primary roles of:
    - PCO (prison officer);
    - the SMART (Social Milieu and Reintegration Therapist) role, detailed below;
    - the group facilitator role;
    - the processor/team support role; and

[11] Woodward was the therapist in charge of the TC at HMP Gartree and had been a wing therapist at HMP Grendon.

    - the recorder/data collector;
- Basic group facilitator skills;
- The philosophy and principles of TCs; and
- The Yalom group factors of universality and altruism.

Week two

- Interpersonal learning and attachment theory;
- Stack Sullivan's self-dynamism;
- Consensual validation and the corrective emotional experience with the five components of:
    - a strong expression of emotion involving risk in expressing, and directed towards another person;
    - a group that is supportive enough to permit risk taking based on the above;
    - reality testing, enabling the individual to examine an incident or emotion through the assistance of the group;
    - recognition of how the feeling and behaviour may be inappropriate, negative or unhealthy; and
    - facilitation of the individual's capacity to interact with the group more deeply and honestly.

The remainder of the training involved learning about 'jail craft' and also provided staff with an opportunity to explore their "being through the life story work of the experiential group, complete with the tears that the universality of human experience brings."

Basic therapy and group meetings

The therapy sessions and group meetings on the therapy wings at HMP Dovegate were structured in the following way (Cullen and Miller 2010):

- Each day commenced with a business meeting chaired by staff to review "happenings for the day" and to listen to individual requests, complaints and comments;

- Each community (wing) had a community meeting chaired by a resident on a Monday and Friday to review agenda items, these included: a resident's behaviour to staff responses to their behaviour;

- Individual communities held staff meetings and staff sensitivity group meetings after each community meeting; and

- Small group meetings on Tuesday, Wednesday and Thursday facilitated by staff, with feedback meetings between staff and residents following each small group meeting and process meetings for staff following this.

Collateral therapies

Additional therapies were also delivered in addition to the core therapy. These were limited by cost but initially included:

- Reasoning and rehabilitation (a correctional services panel accredited programme);

- Sex Offender Treatment Programme (SOTP), also accredited;
- Psychodrama and art therapy.

The team at HMP Dovegate also developed additional collateral programmes, the Reintegration Programme and the ASET[12] accredited NVQ Level 2 programme *Understanding and managing anger*.

[12] Accreditation Syndicate for Education and Training

Appendix 3: Case studies of hierarchical therapeutic communities

An example of a prison-based hierarchical TC is provided by Lipton, Falkin and Wexler (1992): the Stay'n Out programme was a modified classical hierarchical TC that began in July 1977. Programme capacity (at the time of the research) was 120 inmates. Residents lived in two housing units segregated from the rest of the prison population. They had contact with prisoners in the general population only when away from the TC unit, for example at the cafeteria, infirmary and library. The staff were primarily comprised of ex drug users with TC experience who served as role models. Residents were responsible for maintaining the programme unit, undertaking jobs such as cleaning the latrine, to enforcing house rules for proper conduct. A major reward for good conduct was promotion to a higher job level with increasing responsibilities and status. Misconduct was viewed as an opportunity for a 'learning experience' to develop - or often to learn for the first time - appropriate ways to relate to others. Group activities included encounters (therapy), seminars (education), and special groups to deal with unit management problems. Individual counselling and referrals to community TCs were also provided.

As noted by Lipton et al. (2002), a hierarchical TC often provides additional services including: family treatment, vocational training, medical and mental health services.

The phased approach to the involvement of residents in a modified hierarchical TC (which involved work release) is illustrated by Lockwood (1992). This included:

- Phase 1 - 2 week orientation, involving induction into TC, assessment and evaluation.
- Phase 2 - 8 weeks emphasising involvement in TC including morning meetings, community jobs, group therapy, individual counselling, confrontation and nurturing.
- Phase 3 - 5 weeks of role modelling and supervision of other clients with assistance from staff.
- Phase 4 - 2 week transition from TC to outside community involving, resume preparation; interview skills and job seeking and
- Phase 5 - remaining at the facility obtaining and maintaining employment for 7 weeks period and finding housing.

Appendix 4: The dimensions of therapeutic prison

Capacity of the institution

Smith and Schweitzer (2012) suggest that the following factors contribute to the capacity of the institution to effectively implement rehabilitative interventions.

Organisational factors

Therapeutic prisons should:

- have three key documents: a mandate; clearly articulated goals that are shared among key administrators and frontline staff; a documented code of ethics;
- have a history of adopting new initiatives and the capacity to make modifications within a reasonable period of time;
- have a moderate decentralisation of the bureaucratic structure of the prison to allow flexible responses to problems;
- be characterised by organisational harmony, i.e. little task or emotional-personal conflict at the interdepartmental, staff and/or management levels;
- have low staff turnover.

Programme implementation/maintenance

Therapeutic prisons should:

- be initiated at a time when it is not confronted with significant policy changes, marked changes in the demographics or needs of clients and staff turnover;
- have empirically documented the need for its programmes and services; and
- implement interventions based on credible scientific evidence.

Management/staff characteristics

Key features of management and staff characteristics include:

- the education and experience of the programme director;
- the engagement of the programme director with staff at all levels through training, supervision and programme delivery;
- the qualifications and experience of frontline staff including both clinical positions and security positions. Smith and Schweitzer contend that correctional officers are an often overlooked valuable resource, particularly as prisoners spend the vast majority of their time with these frontline staff.

In addition, the therapeutic prison should use structured mechanisms to evaluate the personal qualities of job candidates. At a most basic level these are being committed to human service and endorsing the notion that offenders can change.

Inter-agency communication

The therapeutic prison should:

- have formal links with other agencies to ensure services are available to meet the diverse needs of offenders; and
- ensure that case managers regularly communicate with providers to co-ordinate provision for offenders and where appropriate advocate on behalf of offenders.

Evaluation

The therapeutic prison should ensure that:

- offenders' treatment progress is regularly monitored;
- periodic, objective standardised assessments of prisoner target behaviours are made;
- offender re-arrest, reconviction and/or re-incarceration data is collected to allow for comparisons to be made between those who have received treatment and a risk-controlled comparison group; and
- there is internal or external capacity for ongoing assessment/evaluation of topics related to service delivery.

Content of services

Smith and Schweitzer (2012) also suggest that following domains (related to the content of services) are relevant to the design of a therapeutic prison.

Client risk/need practices

These include:

- establishing clear admissions and exclusionary criteria to define who should receive the intervention;
- a standardised assessment of offender risk and need factors to make placement decisions and develop case management plans; and
- assessing offenders to identify key factors that may affect their responsivity to treatment in order that the style or mode of delivery can be adjusted to remove potential barriers to treatment.

Programme characteristics

At a basic level the therapeutic prison should:

- target criminogenic needs or the dynamic risk factors linked to criminal behaviour;
- employ a combination of treatment strategies to target the individualised criminogenic needs of offenders using evidence-based strategies;
- have a range of appropriate reinforcers, at a minimum: tangible reinforcers; token reinforcers; social reinforcers and activities (Speigler & Guevremont, 2010); and a protocol for administering them.

Core correctional practices

Core correctional practices refer to the skills and competencies that professionals should exhibit whenever they interact with offenders rather than the skills required for the delivery of a specific programme or technique (Andrews & Bonta, 2010). These are:

- corrections staff serving as an anti-criminal model for offenders by engaging in pro-social behaviours and reinforcing inmates when they do the same;
- using high-level reinforcement to encourage pro-social behaviours as well as effective disapproval such as: immediate statements of approval and support for what an offender has said or done; and elaboration of the reasons why this behaviour is desirable;
- effective use of authority to guide the offender towards compliance, i.e. focusing their message on the behaviour exhibited not on the person performing it;
- structured learning procedures for skill building Goldstein (1986) - the main components of this are:
    - define the skill to be learned by describing it in concrete steps;
    - model or demonstrate the skill for the offender;
    - have the offender practice the new skill by role playing with corrective feedback;
    - using homework assignments to extend learning opportunities;
    - have the offender practice the skill in increasingly difficult situations with feedback;
- corrections staff being trained in cognitive restructuring, i.e. being able to teach offenders how to generate descriptions of problematic situations, identify risky thinking and practice more pro-social alternatives; and
- corrections staff developing a therapeutic alliance between staff and offenders by staff being: open, warm, exhibiting respectful communication, being non-judgmental, empathic, flexible, enthusiastic and engaging.