Submitted: 03 August, 2023 Accepted: 17 October, 2023 Published: 30 January, 2024 DOI:10.22514/jomh.2024.016

RAPID REPORT

JOMH Journal of Men's Health

Healing trauma in a traumatising environment with young adult men

Laura E. McMinn[1,*], Geraldine Akerman[1], Eileen Gaffney[2]

[1]Barnet Enfield and Haringey NHS Mental Health Trust, N15 3TH London, UK
[2]HM Prison & Probation Service, SW1H 9AJ London, UK

***Correspondence**
laura.mcminn3@nhs.net
(Laura E. McMinn)

Abstract

In this article, the authors outline the interventions offered by the Offender Personality Disorder (OPD) Pathways Complex Needs Service (PCNS) in a Young Offenders Institute and Category C men's prison for addressing trauma with young adult men within the prison environment and highlight the challenges of trauma-informed practice and interventions within this context. The importance of collaborative work with the young men will be emphasised within the development of clinical formulations and responsive treatment plans. Direct and non-direct trauma therapies offered by the PCNS will be outlined (*e.g.*, Eye Movement Desensitisation and Reprocessing (EMDR) Therapy, sensory approaches). The article will emphasise the importance of adopting a multidisciplinary and system-wide approach to healing trauma, and the crucial role of the PCNS prison officers. The various clinical spaces available for staff to process traumatogenic material will be highlighted as key to maintaining staff wellbeing and resilience. A reflection from a prison officer working in the service will be provided. This article aims to highlight the importance of adopting a holistic and system-wide approach to healing trauma for young men in custody.

Keywords

Trauma-informed practice; Trauma; Young offenders institute; Prison officer; Young offender; Offender personality disorder; OPD

1. Background to the service

The Pathways Complex Needs Service (PCNS) opened in 2014, as part of the national Offender Personality Disorder (OPD) strategy. The PCNS provides holistic treatment for young men at high risk to others who have persistent emotional, behavioural, and psychological difficulties, which may be indicative of emerging personality difficulties. The PCNS is a non-residential therapies service staffed by specially trained prison officers (PO) and clinical staff from the National Health Service. The service model is based on: (i) desistance research which recognises "the individual as the agent of change" and explores "individuals' social contexts, embedded social networks and subjective interpretations as keys to understanding long-term life change" (p.6) [1], and; (ii) the current state of knowledge concerning young adults in prison with emerging personality difficulties, *e.g.*, [2, 3]. Emphasis is placed on the importance of relationships and the role of early attachment disturbance in the development of personality. The service aims to support the young men in building a new, non-offender identity, developing positive social roles, and building a pro-social support network. Those who access the service are expected to work and access education and offending behaviour programmes throughout the week. However, the interventions offered also consider that young people with personality difficulties may struggle to complete and benefit from other accredited interventions. Accordingly, a key service objective is to provide additional support to encourage meaningful engagement with these interventions. All Pathways courses are voluntary, promoting choice and control, and in line with developing autonomy. Considering the Power Threat Meaning Framework [4], all work is undertaken collaboratively.

2. Prisons as traumatising

People who are imprisoned in custodial establishments typically come with experiences of significant abuse and adversity [5]. Ongoing mental health issues, physical trauma, and traumatic head injuries are common in this population [6]. The deprivations and pains of imprisonment are well established in the literature [7–9], however, the experience of trauma and adversity can complicate and be complicated by the stress associated with imprisonment [10]. The environmental factors of prison which may exacerbate trauma include the volume of people, inescapable noise, bright lights, threat of violence, and lack of control over one's routine, to name but a few. As such, it is likely that a prisoner's nervous system exists in a constant state of overwhelm and threat. Historical trauma experience may mean that individuals employ unhelpful or harmful coping strategies to distract from a hyper-aroused state, for example substance misuse or aggression [11, 12],

which further maintains this cycle of trauma. They may struggle to trust and benefit from the very therapeutic services and interventions that, in theory, may help to break this cycle. Prisoners have reported experiences of being consistently let down by statutory services, of professionals coming and going in their lives, and of impersonal and potentially damaging reports being written about them. Individuals who screen-in to OPD services are those with the most complex histories who fit the criteria of high harm, high risk and high vulnerability, and are thought to be the most likely to re-offend [13].

3. A trauma-informed approach in prison

The complexity of presentations observed within the treatment population of the OPD Pathways services necessitates a holistic and Trauma-Informed (TI) approach within its treatment services [14]. Trauma-Informed practice is a strengths-based approach grounded in the understanding of responsiveness to the impact of trauma [15, 16], a commitment to alleviating the impact of trauma and not retraumatising, and adheres to principles of safety, trustworthiness, empowerment, choice, collaboration and cultural consideration [17]. Embodying such principles in practice can be challenging for many services [16] and is particularly difficult for services operating within a custodial establishment. Take, for example, the TI principle of empowerment [17, 18]. Empowerment appears at first a particularly difficult principle to embody within such an environment, as clear and definite power structures are always present. Visibly, this is in the physical structure of the prison, and through the presence of uniformed staff and those carrying keys. There are also invisible power structures at play, such as the fact that prisoners are not in the establishment out of choice, and even those who self-referred to services may still perceive some form of coercion or obligation to engage, *e.g.*, [19]. The PCNS works hard to provide individuals with a sense of empowerment through, for example, specific interventions aimed at developing mastery (*e.g.*, through creative or occupational therapies), through the approach of staff seeking to identify and emphasise the individual's strengths, and through the collaborative approach to formulation and treatment. Choice and control, along with trusting relationships with staff, were identified as key factors which supported young Black, Asian and minority Ethnic men to overcome internal perceptive barriers to engaging with an OPD service within a Young Offenders Institute [20].

The current understanding of trauma is that of a biopsychosocial response to external events, impacting the functioning of the body's physiological threat response system, and mediated by the personal meaning an individual has made of those events [6, 21]. As such, the experience of trauma is highly subjective, and may depend upon the meaning an individual ascribes to such experiences. Therefore, the process of developing a formulation can be a powerful therapeutic tool through which an individual can make sense of their experiences [22, 23]. A key function of OPD services is to develop a comprehensive formulation which links personality features to risk [13], such that this can support the individual in their understanding of themselves and how they can reduce their risk of reoffending. Service users in the PCNS are actively involved in the development of their formulation. The aim is to re-develop the narrative around them, which most often has been a negative, de-personalised, and disempowered story portrayed by historical reports. Within the PCNS, the young man works together with his keyworkers to share his experiences, through words, imagery or performance, through which he can understand his pathway to offending and begin to reveal his pathway to desistance.

Another route the PCNS takes to empower service users is through the forums in which the young men accessing the service are encouraged to feedback into the service. Service users have contributed to the development of new interventions, the revision of assessment paperwork, and have provided input to service operational policies in line with the TI approach. The PCNS has been at the forefront of developing the peer worker initiative across the establishment, coordinating with other departments to develop the processes around the recruitment, training and retention of a peer worker workforce within the establishment. This process has not been without challenge, and it has taken three very dedicated staff members (two clinicians and a PO) to push the initiative forward. The PCNS has recruited and trained a group of five peer workers, whom have each been working with the service for at least one year. One role of the peer workers is to provide formal input into the service, feeding back on policies and processes, and sharing their experiences of the service. Their input is highly valued by the PCNS, and staff book-in time to review aspects of the service in the fortnightly peer worker forum. For example, the peer workers have recently provided feedback on a service-level policy regarding incidents that would typically result in the service user being prevented from accessing the day centre for seven days (*e.g.*, if involved in an incident of violence, if found carrying a weapon, or if found under the influence of illicit substances). The peer workers were shown the policy and a reflective discussion was had regarding their personal experiences of the policy being applied. The discussion generated ideas regarding potential changes to the policy. These ideas and suggestions were then taken to the staff team to consider and review. The policy is currently undergoing further revision and discussions are being had as to whether the policy needs to be split according to the three types of incidents, and how it can be applied on a case-by-case basis rather than according to a rigid dichotomy. The peer workers additionally have a role to play on their respective residential wings (*i.e.*, the blocks or units where their cells are located), providing information about the service to other prisoners, and offering peer support where appropriate. The peer workers receive clinical supervision every six weeks from a named worker (PO or clinician) within the PCNS, as such they are provided with a space to reflect on their experiences as a peer worker and to further develop in their role, whilst the service maintains an oversight of their activities.

4. The relational model

A key area in which the Pathways TI practice is evident is in the effort invested into relationships with service users, with each other as a team, and with the wider establishment. Rela-

tionships are key when it comes to working with traumatised individuals [24], and the PCNS prides itself on the relational approach it takes with service users and the systems around them. The individuals who screen into the service have often experienced various types of traumas, including complex developmental and relational trauma, along with post-traumatic stress disorder, which is often related to their experiences of violence. Young people in custody have often experienced a matrix of multiple, overlapping traumas, losses and stressors [5]. These traumas often begun in critical early life and may have even occurred in-utero, impacting the young person's developmental trajectory in emotional, sensorial and cognitive areas [25]. Trauma does not occur within a vacuum, it is impacted by systemic, relational and contextual factors [26]. As such, the ramifications of traumas most likely exist on a continuum and are shaped by interconnected factors. Neuroscience has shown that interpersonal experiences in essence shape and influence the brain [27], thus the PCNS considers relationships to be a powerful influence over the developmental trajectories of young people. The PCNS therefore considers relationships to be at the epicentre of assessments, formulations, and interventions.

In the PCNS, the young person's keyworkers function as a "second chance secure base" (p.18) [26], supporting them to revise and refine the relationship templates and assumptions they may have developed. As such, the working alliance that the keywork triad, consisting of the young person and their keywork team, has, is a crucial focus for keywork within the service. The working alliance is defined as the degree to which the therapeutic relationship is grounded in collaborative work with a shared purpose [28, 29]. Whilst there exists a plethora of research into the alliance within voluntary therapy contexts, less is known about this alliance within forensic settings [30]. Dominant models of rehabilitation of those in custody emphasise the importance of the working alliance [31]. Within this context, the alliance demonstrates how the responsivity principle [32] is applied, adapting treatment to maximise engagement by the client. Relationships with service users are developed from the foundational belief of redeemability [33], which inspires hope and encourages the keywork team to focus on strengths rather than problematic behaviour. From this stance, PCNS staff consider the question "what happened to you and how did you make sense of this", rather than, "what's wrong with you" [4], acknowledge that hurt people hurt people [34, 35], and so look behind presenting behaviour to understand individual needs and experiences. As such, the approach within the PCNS understands that presenting problems and apparent resistance may be symptoms of difficulties in past relationships.

The pace of PCNS is directed by the service user and responsive to their needs. For example, a young man may be referred for assessment but unable to engage with the assessment at that time, and a period of focus on containment and stability will occur on an outreach basis, before the individual may feel comfortable attending the day centre. This approach is guided by Livesley's phases of treatment for individuals with personality difficulties [36] and, more recently, by the Trauma Recovery Model [33]. Relationships are built through conversation, playing games, and/or socially creative activities such as arts and crafts. The service seeks to develop a community around the service user, whereby they will develop relationships with not only their named keyworkers, but also with other clinicians and POs within the team, for example through socially creative activities led by other staff within the PCNS, or through other therapeutic groups and activities. As such, the PCNS operates as a team around the keywork triad, reflective of a team around the family in community social care settings. For the keywork team, the PCNS functions as a "robust active support system" (p.104) [26], valuing clear communication and shared responsibility. The PCNS team places great emphasis on reflective practice, which is an important process in order to stay mindful of the potential for the splitting and reintegration of therapeutic relationships in forensic contexts [37]. The PCNS places great value on reflective spaces for the team, including at least fortnightly clinical supervision for all staff and a fortnightly reflective practice group. Additionally, operating as a keywork pair (*i.e.*, the PO and clinician) enables a unique reflective space where dynamics can be identified and considered flexibly within and around keywork sessions. The PCNS environment and culture aims to be compassionate, respectful, safe and pervasive. The TI approach recognises that a negative environment can evoke retraumatisation and so all staff work closely to contribute to an atmosphere of safety and containment. Practitioners and POs acknowledge that therapeutic breaches happen and can be repaired, and this can be incredibly reparative for those accessing the service, who have likely experienced major ruptures in past relationships.

Trauma-informed working maintains that the whole establishment needs to take the approach for it to be effective [16]. The PCNS works closely with the wider establishment to spread the TI culture, including wing staff and other departments in conversations about the functions and deeper meanings behind an individual's behaviour, and contextualising behaviour within a framework which acknowledges the potential traumas and adversity the young person may have experienced. The PCNS sits on all cross-department meetings where individuals in custody are discussed, providing a TI understanding of the young person's needs and behaviour, and emphasising the importance of reducing the opportunity for retraumatisation. The PCNS additionally offers a consultation service to the wider establishment in respect to individuals in custody who are not currently on the PCNS caseload or who do not screen-in to the OPD service. This may look like a case formulation session with departments and/or wing staff, whereby the individual's behaviour and needs will be viewed through a TI lens, or the PCNS may direct towards other departments which are more suited to the individual's needs. Another way the TI culture is spread outwards from the PCNS is through the supportive relationships staff build with the wider prison, particularly the staff within the service that make up a significant part of the care team for prison staff and the Prison Officer Association representatives. Through these associations, the PCNS is viewed by the wider establishment as a place to go for support if needed, not just in regard to the individuals in custody, but also for prison staff.

5. Interventions available in the service

The PCNS service is guided by well-evidenced and sequential phases of TI working, that of creating a sense of safeness, followed by facilitating emotional processing, and finally narrative/cognitive sense-making [33, 36]. The service acknowledges that these phases are often non-linear, and that an individual may move backwards and forwards between phases, or indeed may remain in the initial phase for their whole time with the PCNS. Staff working within the PCNS understand that the phases cannot be rushed, providing appropriate scaffolding to support the individual to move steadily through the phases. The psychosocial interventions available in the service are guided by the evidence base in three main areas: (a) factors supporting desistance from offending (*e.g.*, [38]); (b) the psychosocial and physiological impact of developmental and relational trauma (*e.g.*, [25, 26, 39, 40]), and; (c) the link between complex trauma and risk of offending (*e.g.*, [41, 42]).

Due to the multiple and complex traumas they have experienced in their short lives, the young people the PCNS works with represent a heterogeneous group of unique individuals whose developmental age may differ from their cognitive age. These young people may not have experienced a safe relational anchor in their lives and often have invested more energy into their survival, thus have often not mastered age-appropriate competencies such as problem solving or relationship effectiveness. The TI approach in the PCNS seeks to enhance engagement and help those accessing the service to build self-regulation and resilience skills in order to mitigate re-traumatization. The culture of the PCNS emphasises physical, psychological, and emotional safety for all those accessing and working in the service. It creates the opportunity to rebuild a sense of safety, control, and empowerment. Safety, or safeness [43], is crucial for reparative and healing processes to occur. When a young person experiences safeness in the PCNS, they are more able to be in their thinking brain, rather than their survival brain [25] and are therefore more able to work towards adapting their internal working models and scripts about themselves and the world around them [26].

The service provides two levels of intervention: (1) an Outreach Service involving preparatory and motivational work, as well as; (2) a more intensive Intervention Service. Each young adult accessing the service is provided with a keyworker (a PO) and a clinical staff member (either a psychologist, mental health nurse or other allied health professional), who collaborate with the young man together as a keywork pair, as well as providing individual input. Young men accessing the intervention service are provided with an individually tailored therapeutic programme, which includes group and individual interventions targeting personality vulnerabilities and offending behaviour. This includes regular keywork and access to psychological, family/systemic, art, creative, somatic (body-based), and occupational therapies. All interventions are delivered in a TI manner, with consideration given to the order in which they are undertaken, such that the pace is responsive to the individual. The service uses a strengths-based and collaborative approach. Those who access the PCNS are wholly involved in creating documents, paperwork, co-facilitating, and advising as to what is effective with this client group. The interventions fall under a range of domains, including social and creative (*e.g.*, creative writing, art therapy, theatre, dance, music, gardening, podcasting), emotional management, understanding past behaviour, sensory and somatic approaches and daily living skills. As this list highlights, there are a range of therapeutic models applied. Core psychological therapies include Schema Therapy [44], Mentalization-Based Therapy [45], and EMDR therapy [46], the former two are delivered on a group basis but can be adapted for individual work if a young man would struggle to access group work. Within keywork sessions, the concept of risk assessment is explained and considered, with those working in the service developing their understanding of why particular acts indicate risk, and how they can manage this in the future. Structured professional judgement risk assessments, such as the Historical Clinical Risk Management-20, Version 3 (HCR-20^{v3}) [47] and the Spousal Assault Risk Assessment Version 3 (SARA; [48]) are talked through and potential risk scenarios developed in collaboration. Therapeutic models, such as the Good Lives Model (GLM; [49]), are used to guide keywork sessions in order to support an individual to understand their offence cycle and begin to consider more prosocial ways of meeting their needs. Such models may be chosen to compliment work that service users may be completing as part of their sentence plan. For example, the young man may be reflecting on their past and current use of violence in the accredited Offending Behaviour Programme *Kaizen*. Using the GLM in keywork sessions provides a strengths-focused framework to build on learnings from the programme and support the service user to construct their prosocial identity and think about their future. The service model encourages past relationships to be acknowledged, which could include a visit or contact with those previously in the intervention service when they have progressed to another OPD service in prison or in the community.

6. The role of prison officers (PO) in the PCNS

Prison Officers hold an integral role within the service and report feeling a sense of achievement through supporting individuals to progress through their sentence and make effective changes in their lives. Such experiences are commonly reported by POs working in OPD services (*e.g.*, [50]). As POs they aspire to develop meaningful relationships with the young men they are working with, maintaining a compassionate stance whilst upholding and having pride in their role as uniformed staff. Working alongside their clinical colleagues, they invest a great deal into their working alliance with service users. Several meta-analyses have suggested that self-reported working alliance is linked with better self-reported outcomes [51–54] and this finding appears to be robust against other variables such as therapy-adherence or pre-treatment severity [55]. As such, there is clear support for the emphasis on developing strong working alliances with PCNS service users. Through this relational model, the compassion expressed towards the service users and the act of advocating for them in various internal forums (*e.g.*, applications for work and other activities, cross-department meetings), a space is created in which service

users feel safe to experience vulnerability and to work towards positive change.

Staff assaults are not uncommon within the establishment, as POs are often working with highly traumatized individuals within a very rigid, punitive, and often retraumatizing environment [56]. Prisons across the UK have seen an increase in violence, self-harm, and suicide in recent years, which is set against a backdrop of reduced investment and an increasing prison population [57, 58]. Prison Officers are therefore frequently exposed to traumatic material [59, 60] and likely to experience direct or vicarious traumatization [61], leading to an increased risk of developing PTSD, depression, anxiety, and sleep disorders [62, 62–65]. Generally, within custodial environments, there exists a very limited offering of support structures, such as clinical supervision and reflective practice, despite such spaces being identified as helpful by prison staff [66]. Prison Officers within the PCNS receive a high level of clinical supervision and are highly reflective practitioners. Self-reflection is important to mitigate the impact of perceptive biases on the working alliance, to delicately balance seeing the service user beyond their offending behaviour and support them to address the factors which led to this behaviour [37].

Offering keywork and interventions jointly between PO and non-uniformed (clinical) staff is vital in breaking down barriers and improving prisoners' trust with both staff groups. Service users often report being highly wary of clinical staff, as many have had prior challenging and confronting experiences in respect to recorded assessments and reports upon which decisions about their lives and progress have been made. This joined-up approach has the additional benefit of challenging preconceptions that POs only exist for security and discipline, instead highlighting their role in facilitating an atmosphere of safety and containment in a therapeutic context.

The POs in Pathways wear several hats within the establishment, forming a large part of the Care Team (a cross-department team of individuals providing confidential wellbeing support to their colleagues), Prison Negotiators, and Prison Officer Association representatives. As such, they are highly regarded and respected throughout the establishment, providing critical links with staff across the prison through which the TI culture of the service spreads. Recent evidence from the UK has highlighted the case for collaborative TI approaches such as the SECURE STAIRS framework of integrative care [67]. As such, the PCNS make efforts to collaborate with wing staff and other departments to coordinate support around service users.

7. Reflection from a PO in the PCNS

The work is not without its challenges for officers in particular. For instance, to not get worn down by the challenges of doing this type of work in a prison setting and some of the negativity from other areas of the prison. Officers in other areas can hold a negative view and, as can be the case with specialist services, they can be viewed with suspicion and envy (*e.g.*, [50]). The PCNS can be viewed by wing staff as soft, which can be translated to less punitive and more reflective. When criticism and scepticism arise, it is perceived as a challenge to engage in conversation. The prisoners coming into jail can have complex personality difficulties, and this can present a challenge to prison officers on the wings. As a team, we offer support to both prisoners and officers on the wings, offering them time to talk through formulations developed in the service. This way of working has helped develop a mostly positive working relationship with other staff. All PCNS staff have access to supervision and reflective practice, which allows each individual to process potentially traumatic material, and discuss how it may have impacted on each person whilst gaining their supervisor's perspective. This contrasts with staff working on wings who do not have this space. Wing officers often deal with multiple traumatic events during the course of their day and are largely left to deal with the emotional impact on their own. Personal and professional development within the PCNS as an officer is exceptional. There are opportunities for training, supervision, and reflective spaces which are typically not available to prison officers. The specialist training benefits officers professionally and can show prisoners that prison officers can have a therapeutic role and security role which are not mutually exclusive. The management structure within the OPD service is very supportive and allows good working connections through away days and training events that enable the staff team to feel connected to the wider OPD pathway. The service connects with the wider London Partnership of OPD services once per year, funded jointly by the services. This provides opportunities for sharing good practice and resources (such as novel intervention programmes and local policies), for networking to benefit progression pathway planning for people in custody, and for feeling connected to the wider OPD community of service providers.

8. Summary and conclusion

This article described the work undertaken in an OPD service with young adult men in custody. The PCNS seeks to operate within a trauma-informed framework, which is not without its challenges in a custodial and often highly punitive environment. The service uses Livesley's [36] phases of treatment and the Trauma Recovery Model [33] to guide the intervention process, with great focus on establishing a sense of safeness for the young men accessing the service. Collaborative working with the young men is prioritised at every stage of intervention, and there are forums whereby service users can feedback into service development. There is great emphasis on training for staff, and on creating opportunities for reflection and staff support. The PCNS believes staff training on complex trauma and TI approaches are crucial, alongside offering reflective spaces in which to process traumatogenic material, for a TI and relational model in prison to work. Such processes may be costly and time-consuming to establish, however have been reportedly successful in the Youth Justice context [67]. The TI culture of the PCNS is spread through the various cross-department meetings, providing a TI lens through which to view the young people discussed at these meetings. Prison officers in the PCNS play a vital role in the service and are well-regarded throughout the establishment. The PCNS model described here demonstrates how TI practice can be embodied within a custodial environment, and how a TI service can provide holistic and integrative trauma treatments and

TI support to individuals in custody and to the wider custodial establishment. Recognising the mind body connection is imperative and the use of somatic therapies that access trauma remembered at a cellular level to complement the more traditional talking therapy has shown promise within the service. Further research should be completed to evaluate this. Feedback from service users and staff across the prison in respect to the work of the PCNS is largely positive, suggesting that the TI approach works in practice. However, in order that this approach can be pushed forwards across custodial and secure settings, not only in the UK but internationally, empirical research is greatly needed. With TI principles being operationalized into policy (*e.g.*, [17]), now is the time for TI services to empirically evaluate their provision with both qualitative and quantitative methods, not only in regard to reducing trauma symptoms, but also whether such approaches lead to reductions in recidivism.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

AUTHOR CONTRIBUTIONS

LEM and GA—wrote this manuscript. EG—contributed a prison officer's view. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

ACKNOWLEDGMENT

The authors would like to thank Kate Geraghty for her inspiration in writing this article, the authors would also like to thank the Pathways team for their ongoing dedication and work towards trauma-informed practice within the service and in the wider prison.

FUNDING

This research received no external funding.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

[1] Maruna S, Mann R. Reconciling 'desistance' and 'what works'. 2019. Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2019/02/Academic-Insights-Maruna-and-Mann-Feb-19-final.pdf (Accessed: 11 February 2023).

[2] Levenson JS, Grady MD. The influence of childhood trauma on sexual violence and sexual deviance in adulthood. Traumatology. 2016; 22: 94–103.

[3] Taylor J. Compassion focussed working in secure forensic care. Journal of Criminological Research, Policy and Practice. 2017; 3: 287–293.

[4] Johnstone L, Boyle M. The power threat meaning framework: towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Counselling Psychology Review. 2018; 33: 57–59.

[5] Beyond Youth Custody. Trauma and young offenders: a review of the research and practice literature. 2016. Available at: http://www.beyondyouthcustody.net/wp-content/uploads/BYC-Trauma-Young-Offenders-FINAL.pdf (Accessed: 11 February 2023).

[6] Streeck-Fischer A, van der Kolk BA. Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on childhood development. Australian and New Zealand Journal of Psychiatry. 2000; 34: 903–918.

[7] Cohen S, Taylor L. Psychological survival: the experience of long-term imprisonment. 1st edn. Penguin Books Ltd: London. 1972.

[8] Haney C. The psychological effects of imprisonment. In J. Petersilia, K. R. Reitz (eds). The Oxford Handbook of Sentencing and Corrections (pp. 584–605). 1st edn. Oxford University Press: Oxford. 2012.

[9] Ismail N, Forrester A. The state of English prisons and the urgent need for reform. The Lancet Public Health. 2020; 5: e368–e369.

[10] Facer-Irwin E, Karatzias T, Bird A, Blackwood N, MacManus D. PTSD and complex PTSD in sentenced male prisoners in the UK: prevalence, trauma antecedents, and psychiatric comorbidities. Psychological Medicine. 2022; 52: 2794–2804.

[11] HM Prison & Probation Service. Prison drugs strategy. 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf (Accessed: 11 February 2023)

[12] Gov.uk. Violence involving prisoners. 2021. Available at: https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/prison-and-custody-incidents/violence-involving-prisoners/latest#download-the-data (Accessed: 11 February 2023).

[13] NHS England. The offender personality disorder (OPD) pathway: a joint strategy for 2023 to 2028. 2023. Available at: https://www.england.nhs.uk/long-read/the-offender-personality-disorder-pathway/#summary (Accessed: 22 December 2023).

[14] Skett S, Lewis C. Development of the offender personality disorder pathway: a summary of the underpinning evidence. Probation Journal. 2019; 66: 167–180.

[15] Akerman G, Needs A, Bainbridge C. Transforming environments and rehabilitation: a guide for practitioners in forensic settings and criminal justice. 1st edn. Taylor Francis Group: London. 2018.

[16] Levenson JS, Prescott DS, Willis GM. Trauma-informed treatment practices in criminal justice settings. Handbook of Issues in Criminal Justice Reform in the United States. 2022; 30: 483–502.

[17] Office for Health Improvement & Disparities. Guidance: working definition of trauma-informed practice. 2022. Available at: https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice (Accessed: 11 February 2023).

[18] Harris M, Fallot RD. Using trauma theory to design service systems. 1st edn. Jossey-Bass/Wiley: San Francisco. 2001.

[19] Ross MW, Diamond PM, Liebling A, Saylor WG. Measurement of prison social climate. Punishment & Society. 2008; 10: 447–474.

[20] Hunter S, Craig E, Shaw J. "Give it a Try": experiences of black, Asian and minority ethnic young men in a prison-based offender personality disorder service. Journal of Forensic Practice. 2019; 21: 14–26.

[21] Moskowitz A, Heinimaa M, van der Hart O. Defining psychosis, trauma, and dissociation. Psychosis, Trauma and Dissociation. 2018; 1: 7–29.

[22] Gibbs M, Griffiths M, Dilks S. A grounded theory of how service users experience and make use of formulation in therapy for psychosis. Psychosis. 2020; 12: 245–256.

[23] Redhead S, Johnstone L, Nightingale J. Clients' experiences of formulation in cognitive behaviour therapy. Psychology and Psychotherapy: Theory, Research and Practice. 2015; 88: 453–467.

[24] Brown JD, King MA, Wissow LS. The central role of relationships

with trauma-informed integrated care for children and youth. Academic Pediatrics. 2017; 17: S94–S101.
[25] Perry B, Szalavitz M. The boy who was raised as a dog. 3rd edn. Basic Books: NY. 2017.
[26] Treisman K. Working with relational and developmental trauma in children and adolescents. 1st edn. Routledge/Taylor & Francis Group: London. 2017.
[27] Siegel DJ. The developing mind: how relationships and the brain interact to shape who we are. 3rd edn. The Guilford Press: NY. 2020.
[28] Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy. 1979; 16: 252–260.
[29] Baldwin SA, Wampold BE, Imel ZE. Untangling the alliance-outcome correlation: exploring the relative importance of therapist and patient variability in the alliance. Journal of Consulting Clinical Psychology. 2007; 75: 842–852.
[30] Sturm A, de Vogel V, Huibers MJ. Two sides of the working alliance: a qualitative study from the perspective of both probationers and probation officers. European Journal of Probation. 2022; 14: 40–59.
[31] Bourgon G, Guiterrez L. The importance of building good relationships in community corrections: evidence, theory and practice of the therapeutic alliance. In P. Ugwudike & P. Raynor (eds.) What Works in Offender Compliance (pp. 256–275). 1st edn. Palgrave Macmillan: London. 2013.
[32] Andrews DA, Bonta J. Rehabilitating criminal justice policy and practice. Psychology, Public Policy, and Law. 2010; 16: 39–55.
[33] Skuse T, Matthew J. The trauma recovery model: sequencing youth justice interventions for young people with complex needs. Prison Service Journal. 2015; 220: 16–25.
[34] Taylor J, Akerman G. Compassion focused cultures: introducing compassion into a democratic therapeutic community. Abuse: An international Impact Journal. 2022; 3: 24–45.
[35] Taylor J, Hocken K. Hurt people hurt people: using a trauma sensitive and compassion focused approach to support people to understand and manage their criminogenic needs. The Journal of Forensic Practice. 2021; 23: 301–315.
[36] Livesley WJ. Integrated treatment: a conceptual framework for an evidence-based approach to the treatment of personality disorder. Journal of Personality Disorders. 2012; 26: 17–42.
[37] Youssef C. The importance of the therapeutic alliance when working with men who have committed a sexual offence. Journal of Criminal Psychology. 2017; 7: 206–220.
[38] HM Inspectorate of Probation. Desistance: general practice principles. 2020. Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/models-and-principles/desistance/#:~:text=Desistance%20is%20the%20process%20of,some%20false%20stops%20and%20starts (Accessed: 11 February 2023).
[39] Porges SW. The polyvagal theory: neurophysiological foundations of emotions, attachment, communication, and self-regulation. 1st edn. W. W. Norton & Company: London. 2011.
[40] van der Kolk BA. Developmental trauma disorder: toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals. 2005; 35: 401–408.
[41] Duke NN, Pettingell SL, McMorris BJ, Borowsky IW. Adolescent violence perpetration: associations with multiple types of adverse childhood experiences. Pediatrics. 2010; 125: e778–e786.
[42] Fox BH, Perez N, Cass E, Baglivio MT, Epps N. Trauma changes everything: examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. Child Abuse & Neglect. 2015; 46: 163–173.
[43] Gilbert P. The evolved functions of caring connections as a basis for compassion. In P. Gilbert, G. Simos (eds.) Compassion Focused Therapy: Clinical Practice and Applications (pp. 90–121). 1st edn. Routledge: Abingdon. 2020.
[44] Young JE, Klosko JS, Weishaar ME. Schema therapy: a practitioner's guide. 1st edn. Guilford Press: New York. 2003.
[45] Bateman A, Fonagy P. Mentalization based treatment for borderline personality disorder. World Psychiatry. 2010; 9: 11–15.
[46] Shapiro F. Eye movement desensitization and reprocessing (EMDR) therapy: basic principles, protocols, and procedures. 3rd edn. Guilford Press: NY. 2017.
[47] Douglas KS, Hart SD, Webster CD, Belfrage H. HCR-20 Version 3. Mental Health, Law, and Policy Institute, Simon Fraser University. 2013.
[48] Kropp PR, Hart D. SARA-V3: user manual for version 3 of the spousal assault risk assessment guide. Proactive Resolutions. 2015.
[49] Ward T, Fortune C. The good lives model: aligning risk reduction with promoting offenders' personal goals. European Journal of Probation. 2013; 5: 29–46.
[50] Bond N, Gemmell L. Experiences of prison officers on a lifer psychologically informed planned environment. Therapeutic Communities: The International Journal of Therapeutic Communities. 2014; 35: 84–94.
[51] Del Re AC, Flückiger C, Horvath AO, Wampold BE. Examining therapist effects in the alliance-outcome relationship: a multilevel meta-analysis. Journal of Consulting and Clinical Psychology. 2021; 89: 371–378.
[52] Flückiger C, Del Re AC, Wampold BE, Horvath AO. The alliance in adult psychotherapy: a meta-analytic synthesis. Psychotherapy. 2018; 55: 316–340.
[53] Horvath AO, Bedi R. The alliance. In J. C. Norcross (ed.). Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients (pp. 37–70). 1st edn. Oxford University Press: New York. 2002.
[54] Horvath AO, Del Re AC, Flückiger C, Symonds D. Alliance in individual psychotherapy. Psychotherapy. 2011; 48: 9–16.
[55] Flückiger C, Rubel J, Del Re AC, Horvath AO, Wampold BE, Crits-Christoph P, *et al*. The reciprocal relationship between alliance and early treatment symptoms: a two-stage individual participant data meta-analysis. Journal of Consulting and Clinical Psychology. 2020; 88: 829–843.
[56] HM Prison & Probation Service. Understanding prison violence: a rapid evidence assessment. 2018. Available at: https://www.gov.uk/government/publications/understanding-prison-violence-a-rapid-evidence-assessment (Accessed: 11 February 2023).
[57] Ismail N. After a decade of austerity, urgent changes are needed to improve prison services. University of Bristol Policy Report 79. 2022. Available at: https://www.bristol.ac.uk/policybristol/policy-briefings/prison-funding-austerity/ (Accessed: 11 February 2023).
[58] Sturge G. UK prison population statistics. House of Commons Library. 2022. Available at: https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf (Accessed: 11 February 2023).
[59] Bourbonnais R, Jauvin N, Dussault J, Vézina M. Psychosocial work environment, interpersonal violence at work and mental health among correctional officers. International Journal of Law and Psychiatry. 2007; 30: 355–368.
[60] King A, Oliver C. A qualitative study exploring vicarious trauma in prison officers. Prison Service Journal. 2020; 251: 38–45.
[61] Frost L, Scott H. What is known about the secondary traumatization of staff working with offending populations? A review of the literature. Traumatology. 2022; 28: 56–73.
[62] Binley J. The experience of post-traumatic stress disorder in ex-prison officers. Prison Service Journal. 2023; 267: 66–74.
[63] Kinman G, Clements AJ, Hart J. Job demands, resources and mental health in UK prison officers. Occupational Medicine. 2017; 67: 456–460.
[64] Kinman G, Clements AJ. Sickness presenteeism in prison officers: risk factors and implications for wellbeing and productivity. International Journal of Environmental Research and Public Health. 2022; 19: 3389.
[65] Walker EJ, Jackson CA, Egan HH, Tonkin M. Workability and mental wellbeing among therapeutic prison officers. Occupational Medicine. 2015; 65: 549–551.
[66] Dennard S, Tracy DK, Beeney A, Craster L, Bailey F, Baureek A, *et al*. Working in a prison: challenges, rewards, and the impact on mental health and well-being. The Journal of Forensic Practice. 2021; 23: 132–149.
[67] Taylor J, Shostak L, Rogers A, Mitchell P. Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS). Safer Communities. 2018; 17: 193–201.

How to cite this article: Laura E. McMinn, Geraldine Akerman, Eileen Gaffney. Healing trauma in a traumatising environment with young adult men. Journal of Men's Health. 2024; 20(1): 120-126. doi: 10.22514/jomh.2024.016.