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Trauma-Informed Care in Women's Prisons

A CO-PRODUCED RAPID LITERATURE REVIEW

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TICA
Trauma Informed Community of Actions

Summary

Context

Women entering the criminal justice system often have multiple and complex needs, including traumatic histories of abuse and victimisation, mental health difficulties, substance misuse and previous involvement with the care system. Evidence from community-based initiatives suggests that trauma-informed systems are effective and can benefit both staff and trauma survivors.

Aim

This review aimed to identify the evidence for trauma-informed and trauma specific care in female prisons. In addition, the review expands on these findings to explore areas related to trauma-informed care (TIC) and female prisons in the UK more widely.

Methods

A rapid review of the literature was conducted using innovative, co-production methodology to identify research studies and grey literature that investigates or discusses TIC for women in prisons. This review happened in two stages: 1) a rapid review of the current international literature; 2) a lived experience expansion of these findings, using an adapted critical interpretive synthesis approach.

Findings

Experiences of trauma in female prisons were associated with psychiatric diagnoses such as depression, anxiety and PTSD. The most significant paper was a recent meta-analysis of TIC in female prisons. Here, 16 studies were identified that met quality criteria, nine of which focused only on women. TIC significantly improved symptoms associated with PTSD. Although many different models of intervention exist, most are offered in a group format and session lengths vary.

Seven specific areas of further interest relating to TIC in women's prisons were identified. These included: 1) the difference between TIC and trauma-specific approaches; 2) trauma-informed substance misuse 3) debates around 'personality disorder' pathways and the fit with TIC; 4) trauma and physical health; 5) self-harm; 6) specific TIC for vulnerable groups: women with long sentences, foreign national prisoners and mothers in prison; 7) the role of lived experience in TIC.

02

Recommendations

Trauma-informed care (TIC) and trauma specific (TS) interventions should be based in the community.

In-prison support should not be implemented in a way that inadvertently incentivises up-tariffing or increased custodial sentences. No woman should be sent to prison for treatment due to a lack of appropriate community-based TIC.

Apart from some therapeutic communities, the prison environment is not in general conducive to trauma-informed work. Assessments need to be made on an individual prison basis to reflect on the risks and benefits of implementing TIC and the possibility of causing inadvertent harm.

Where TIC is implemented in prisons, this necessitates a holistic approach with buy-in from senior management and officers. It involves a whole prison approach; one-off training is not sufficient.

Some trauma-informed and trauma specific work is required to meet the needs of the small number of women serving IPP or long sentences.

Specific healthcare pathways can be improved by taking a trauma-informed approach. There is evidence of good practice already for a trauma-informed perinatal pathway; this should be implemented.

There needs to be routine screening for traumatic head injury of all women. Trauma specific interventions adapted to meet the needs of these women should be considered.

No woman should be forced to take part in a trauma-based intervention as part of a sentence plan. Consent is of paramount importance.

Traumatised women must not be given or considered to meet the criteria for personality disorder in order to access TIC/TS care.

Consider implementing TIC approaches and interventions that centre the context of distress, rather than individual pathology.

Co-production is key to TIC. This includes people with lived experience leading on designing and delivering training, and co-producing outcome measures to assess whether TIC/TS interventions have been successful.

03 Trauma and Trauma Informed Care

Trauma is a commonplace feature of many peoples' lives and people, who have experienced trauma, often present to public services. This is especially true of mental health services and, as will be shown, those who have been incarcerated in prison.

Trauma has been defined by NHS Scotland (2021) as:

> '....resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.'

Trauma-informed practice/care employs a variety of strategies depending on the preference of the client (Menschner and Maul, 2016). Some strategies have been designed with younger people in mind. For adults, prolonged exposure therapy for veterans with PTSD has been shown to be effective. Trauma-related stress can be reduced using eye movement desensitisation and reprocessing (EMDR), and there is evidence that this can be helpful for survivors that have been raped. There are other 'present focused' therapies that have been shown to be useful which help to build a sense of safety. Younger people can find family therapy of use and trauma-focused CBT has also been shown to be effective. The National Institute for Clinical Effectiveness (NICE) guidelines for post-traumatic stress-disorder (PTSD) recommend the interventions listed above (NICE, 2018).

Trauma can occur once, for example, suffering the violence of rape or it can be a set of continuing events such as the physical/emotional/sexual abuse of a child (Sweeney et al, 2016). Organisations that are trauma-informed aim to prevent re-traumatisation by promoting trust and safety in the manner in which they are structured and organised. A number of principles should underpin trauma-informed practice and these have been outlined in Figure 1 below (Sweeney et al, 2016).

04 Trauma-Informed Practice Principals

1.**Recognition**
Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope

2. Resist re-traumatisation
Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can re-traumatise survivors (and staff). Take steps to eliminate re-traumatisation

3. Cultural, historical and gender contexts
Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships

4. Trustworthiness and transparency
Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal

5. Collaboration and mutuality
Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur

6. Empowerment, choice and control
Adopt strengths-based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment

7. Safety
Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe

8. Survivor partnerships
Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration

9. Pathways to trauma-specific care
Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced

Part 1: Rapid Literature Review

Method

This rapid review of the literature uses innovative, co-production methodology to identify research studies and grey literature that investigates or discusses trauma-informed care (TIC) for women in prisons. Our approach expands on existing rapid literature review methods by drawing on the principles of critical interpretive synthesis (CIS) (Dixon-Wood et al., 2006). This adapted approach had two stages: 1) a researcher conducted a rapid literature review using a structured search strategy with protocol-driven searches across a range of electronic databases; 2) a researcher with lived experience prioritised and focused in more detail on areas of relevance using meta-ethnographical techniques (Noblit & Hare, 1988) to identify literature from adjacent fields not immediately or obviously relevant to the review's structured aims. This methodology allowed us to focus on a more sensitised response to the research findings, drawing on a distinctive tradition of qualitative inquiry, including recent interpretive approaches to review.

Part 1) Rapid literature review

The rapid literature review adopted an approach outlined by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. The databases searched were: MEDLINE, IBSS, CINAHL, the Cochrane database, Web of Science and Scopus (January 2022).

The following search strategy was used for MEDLINE and translated for the remaining databases: (TI (("trauma informed") AND ("care" OR "practice" OR "approach*")) OR AB (("trauma informed") AND ("care" OR "practice" OR "approach*"))) AND (TI (women* OR woman* OR female*) OR AB (women* OR woman* OR female*)) AND (TI (prison* OR jail* OR incarcerated) OR AB (prison* OR jail* OR incarcerated)). Additionally, a number of relevant papers were retrieved from Google Scholar using the search terms "evaluation of trauma-informed care for women in prisons".

The search resulted in a total of 156 papers. This figure was reduced to 73 after removing duplicates. The titles and abstracts were screened for relevance. In total, 46 papers were considered not relevant to the current review, either because they dealt with separate, or broader, populations, or were not directly focused on TIC. The remaining 27 papers were retrieved and reviewed in full.

Part 2) Lived experience critical interpretative synthesis

CIS is characterised as iterative, interactive, dynamic and recursive. This approach was appropriate to bring a lived experience perspective to the rapid review and include relevant topics that were not captured within the limits of a traditional review (c.f. Greenhalgh et al., 2004). A key feature of the CIS process is its aim of being critical; thus it was used to question and broaden the concept and understanding of trauma-informed care.

Based on the standpoint of lived experience, the expert by experience researcher used purposive sampling (Seale, 1999) to deliberately select academic and grey literature covering areas of interest, and theoretical and disciplinary approaches relevant to female forensic TIC (Annandal et al., 2007). Websites searched included relevant third sector organisations such as: Women in Prison, the Howard League for Penal Reform, HMIP, Birth Companions, CLINKS, WISH. Relevant lived experience blogs and testimonies were reviewed. Academic databases searched included ETHOS and GoogleScholar.

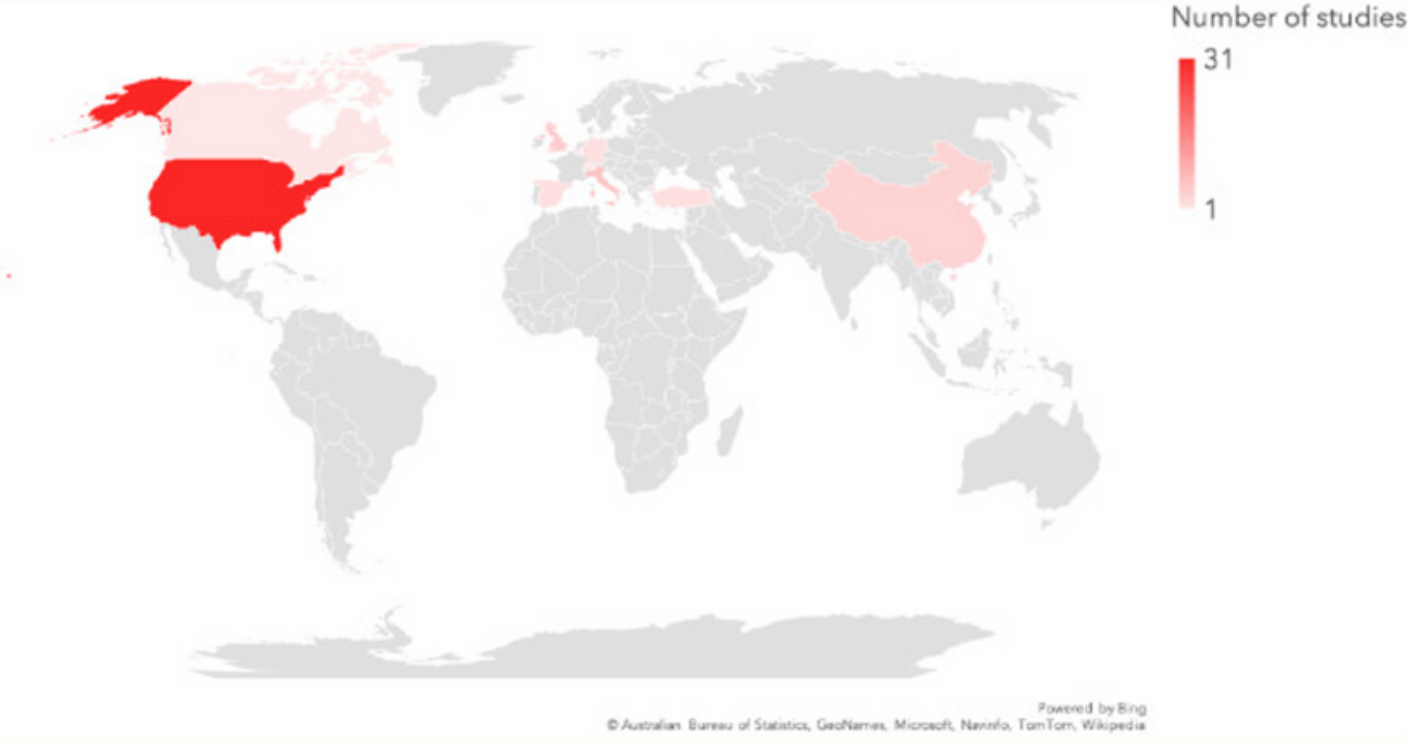
Part 1) Rapid Literature Review Findings

Prevalence of likely trauma in prison

A significant proportion of people in the criminal justice system (CJS) are likely to have experienced trauma of some kind, especially those who experience mental health problems (Liu et al., 2021). Gender plays an important part in the aetiology of trauma as Liu et al. comment: 'Gender differences in PTSD have been identified, with the odds of PTSD associated with sexual trauma among females but with non-sexual interpersonal trauma among males'.

It is important to note that there is a variation in the country of origin of published studies on trauma, mental health disorders and prisons as the diagram from Liu et al. (2021) shows much of the quality-assessed published research emanates from the United States and Canada.

Figure 2 Distribution of quality-assessed studies in the meta-analysis by Liu et al. (2021)



The relationship between trauma, mental health disorders and gender have been tested in one female prison in the North West of America (Wolff et al., 2011). In a sample of female prisoners 'soon to be released' the group were assessed in relation to mental health status, past history of trauma and likely needs for complex trauma services. Table 1 is reproduced from the paper by Wolff et al. (2011). There is a significant association between any form of previous abuse, be that physical or sexual, and serious mental illness (SMI). Thus 61% of women who had experienced physical abuse had a SMI, and 68% who had experienced sexual abuse were also diagnosed with a SMI. Overall, 87% of the sample had experienced traumatic events in the past.

In a large sample of imprisoned women, Aday et al. (2014) divided the sample into those that had been sexually abused (n=1250) and those that had not (n=1,680). They found that abused women were more likely to report increases in most health problems but also mental health diagnoses. This was also true of other self-reported mental health conditions, such as paranoia, depressive symptoms, anger, and lifestyle changes. Respondents with extensive sexual abuse histories were also more likely to suffer higher levels of paranoia, depression, chronic health problems, and attempted suicide. All in all, abused women had twice the number of mental health diagnoses (1.6) in comparison to those not abused (0.8).

Table 1 Adapted from Wolff and Shi, 2011

	Men		Women	
Community Victimization History	No mental illness	Mental illness	No mental illness	Mental illness
Prior to age 18, %	54.2*	71.8	48.2*	74.3
After age 17, %	35.2*	44.2	41.9*	60.5

* significant P≤ 0.05

These findings are repeated consistently in a number of studies. For example, Kennedy et al. (2021) found, in a random sample of 187 female prisoners, that the reporting of suicidal ideas, psychosis and dissociation were highly (and significantly) associated with witnessing acts of violence as a child, being sexually abused as a child and what the authors describe as 'severe poly-victimisation'. It would seem clear that a compelling majority of women in prisons have experienced trauma, often multiple traumas, prior to imprisonment. The most comprehensive and recent review of this research can be found in Liu et al. (2021).

Models of TIC delivery in women's prisons

A number of different interventions have been offered to women in prisons under the banner of 'trauma-informed' care. Kubiak et al. (2014) report the development of TIC in a US state woman's prison with 1,800 prisoners. The prison adopted the 'Beyond Violence' programme described by Covington (2013). This is a prevention program for women that is intended for women convicted of a violent offence. The intervention is considered trauma-informed and it includes attention to women's victimization history, the likelihood of substance use and/or mental health disorders and gender socialisation. The intervention aims to simultaneously address these issues as they are strongly correlated and interconnected factors are commonly present in the lives of women involved in the CJS. The theoretical basis to the programme is given in Appendix A alongside the component modules. The programme was well evaluated by the participants especially those women serving a life sentence. The intervention was assessed for feasibility in a prison environment and found to be straightforward to organise aside from the usual barriers such as lock-downs/transfers (although this was before COVID-19 of course). This paper (and the book by Covington) provides much detail about the intricacies of implementation and are worth further consideration.

In an earlier more discursive paper (Moloney and Moller, 2009) some examples of TIC interventions are considered. For example, the paper describes TIC for women in the Canadian penal system. Here, all women housed in detention facilities have access to group and individual trauma counselling by community agencies that deliver both education and awareness programmes, and intervention-oriented programmes (Fortin, 2004). However, these opportunities are only offered to women who have sentences of two years or more (who are under the federal rather than the provincial system). Moloney and Moller also describe developments in Australia. A programme has been designed for aboriginal people who have suffered high levels of victimisation. This structured programme adopts culturally derived individual and interpersonal (i.e., parenting and community) healing practices however little more detail is given.

In England, in 2005, a pilot project was financed by the Home Office called the 'Together Women Project' (TWP). Here, the TWP was designed as a one-stop facility. It delivered psychosocial interventions focusing specifically on resolution of the unmet needs that underlie criminality and integrates multi-agency service provision to build upon and link existing criminal justice and community structures. Hogarth (2017) laid out the assumptions underpinning TWP in England and as she stated:

> '....it is patently wrong that women experiencing severe and multiple disadvantage (SMD) and often repeatedly failed by health and social care systems, should only get attention, support and a policy focus once enmeshed in the CJS. It is pertinent to note that the specification for the five TWP women centres, aimed at diverting women 'at risk' as well as 'reducing re-offending', was based on two well established centres: Calderdale Women Centre, which had a long-established track record in supporting women's complex and often health related needs in the community and Asha women's centre'

These community initiatives are arguably outside the brief of this review; however, it should be noted that the Corston Review (2007) argued that imprisonment was entirely inappropriate for the majority of non-violent female offenders. She argued that smaller scale residential community-based women's centres would be the ideal. The unhelpful nature of incarceration for most women is a constant theme that runs throughout the papers reviewed here. This raises the question of where TIC is best delivered.

Outcomes of delivering TIC in women's prisons

Papers that reported outcomes are briefly reviewed in this section and inevitably overlap with the section above on models of delivery. Perhaps the most useful publication is that of Malik et al. (2021). In this study, sixteen studies that had offered TIC to men and women in prisons were identified. In relation to gender, 9/16 of the studies quality-assessed and used in the meta-analysis focused on females only.

The most commonly delivered trauma-focused therapies in prison settings were phase 1 (stabilisation interventions, distress tolerance, cognitive restructuring, or problem-solving) (n=11). Five studies evaluated interventions involving phase 2 trauma processing components, such as Cognitive Processing Therapy, a NICE-recommended trauma-focused CBT intervention (CPT=1), traumatic incident reduction (n=1), and expressive trauma-based writing exercises (n=3). No studies utilized Eye Movement Desensitization and Reprocessing (EMDR) or other NICE-recommended interventions (e.g., narrative exposure therapy, cognitive therapy). Facilitators of the interventions were either at graduate (n=4), master's (n=5), or doctorate level (n=3); this information was omitted in three studies. Most included studies delivered group therapies (n=14), with 12 of these providing phase 1 stabilization interventions, and two group therapies facilitating traumatic memory processing through writing interventions. Brief descriptions of the studies are given in Appendix B.

The meta-analysis found a small but significant effect size in the reduction of PTSD and other trauma-related symptoms, however, no strong conclusions can be drawn from this as the studies included were not analysed by sex or gender. The groups of women offered TIC in prison were varied as was the actual intervention offered and the number of sessions. However, it should not be assumed that delivery of TIC to women in prison is not without its complications and the next section explores the issue of implementation.

Finally, it is important to note there has been a programme to implement a version of TIC (called Healing Trauma) in prisons in England, these prisons were: HMP Bronzefield, HMP Send, HMP Peterborough, HMP Foston Hall, HMP Drake Hall, HMP New Hall and HMP Sutton Park. The intervention consists of six, 90-minute sessions delivered to closed groups of up to 10 women by peer facilitators. The training is based on that described by Covington and Russo (2016). In addition, training for prison staff, in 'Becoming trauma-informed' (BTI) commenced in 2015 and has been extensive (across all 12 female prisons). BTI training in the long term high secure estate commenced in May 2018. Across the women's custodial estate approximately four thousand members of staff have been trained in trauma-informed practice. Healing Trauma was first delivered in HMP Send in February 2017. Almost five hundred women had completed the programme. These numbers are rendered more significant by the fact that participation in Healing Trauma is voluntary. Most women self-refer to the programme. It cannot be enforced as part of a sentence plan. The impact of Healing Trauma on 30 participants has been reported by Petrillo and her colleagues (2019). In a mixed methods study, pre and post symptom data were collected and showed significant reductions in depression, anxiety, psychological distress, and symptoms of PTSD. The qualitative data analysed from focus groups held on each site showed that the following themes were key: opening up/disclosing; the safety of the group; positive personal changes; and increased coping skills.

Challenges in the delivery of TIC in prisons

One major challenge to the delivery of TIC in prison, is the environment of prison itself. Jewkes et al. (2019) discuss how the architecture and custodial function of a prison could easily lead to the triggering of PTSD/anxiety, they state:
'Put bluntly, then, while there can be little argument that custodial spaces are brightened by a lick of paint, it is nonetheless the case that long corridors, right-angled pathways with poor sightlines, metal staircases, hard surfaces, bars on windows, clanging doors, jangling keys, a performative, macho officer culture, and all the other aesthetic and aural cues associated with confinement, do not mitigate against the 'abnormality' of being deprived of one's liberty and confined against one's will in an institution'. (p.2)

Earlier research had established, in both male and female custodial settings, that there are certain principles that should be incorporated into prison design if mental health issues and trauma were not to be triggered (Jewkes, 2018). These are listed below and it is clear that very few prisons could meet these criteria.

- A need for privacy, for socialization; for warmth when it is cold and for effective ventilation when it is hot
- For some freedom of movement outside as well as inside
- For regular, high-quality family visits
- For meaningful and appropriately paid work/education/activities (including essential transferable skills, e.g., use of digital technologies)
- The ability to undertake a pastime or hobby beyond those traditionally permitted within custodial settings
- Facilities to cook one's own food (and perhaps for one's family) at least occasionally to experience interaction with nature
- Crucially, to have a high degree of choice, autonomy and control over all these fundamental actions

Although there is a growing interest in trying to design prison environments that are less traumatising, the question remains should non-violent women, the majority, be in prisons at all. A great deal has been written about 'ideal' prison environments (see for example, Ahalt et al., 2021; Jewkes et al., 2019; Jewkes et al., 2020; Karthaus et al., 2019 and St John et al., 2019).

There seems to be a consensus that the best model prison design in the world is to be found in Norway at the Halden Prison. Here units are small, prompting walking between sites; there are countryside views from the accommodation which is light airy and as non-custodial as possible. Doors are not locked to promote socialisation and the focus is very much on rehabilitation rather than punishment. Thus, there is a strong focus on education and training. The photographs below show some typical rooms at Halden:

Apart from the environment of prisons, another key feature is the staff. To deliver TIC means that prison staff themselves should have a good grounding in the principles of TIC and how these might be operationalised in the context of their roles. Miller and Najavits (2012) discuss this issue in relation to the likely scenarios staff might well face:

'*Staff may have experienced direct exposure to trauma from witnessing prison violence, on the job injuries, during prior military service or in their personal lives. They may have learned to function at the workplace in a state of constant hyper-vigilance or in numb detachment*'

A study undertaken in the United States examining the health status of prison officers found that 53% of prison officers experienced PTSD (Jaegers et al, 2019). In this manner, a trauma-informed environment, can make both female prisoners and prison staff feel safe and provide a firmer foothold for the purposes of rehabilitation. It is likely that any TIC initiative embarked on in a prison will demand that the nature and form of prison staff training is carefully considered as well. For example, in the English case study of the implementation of TIC (Petrillo et al., 2019) as well as peer-led TIC being introduced to female prisoners a BTI training package has been offered to 4,000 members of staff working across the female prison estate.

Thus, different levels of TIC should be examined. These have been articulated in a paper that described establishing TIC in a Youth Offending Institute in Scotland (Vaswani and Paul, 2019). The different levels of training are outlined below.

Trauma informed: The baseline knowledge and skills required by everyone in the Scottish workforce

Trauma skilled: The knowledge and skills required by all workers who have direct and/or substantial contact with individuals who may be affected by traumatic events, whether or not trauma is known about

Trauma enhanced: the knowledge and skills required by workers who have more regular and intense contact with individuals who are known to be affected by traumatic events, and who provide specific supports or interventions

Trauma specialist: the knowledge and skills required by staff who play a specialist role in directly providing or managing evidence-based psychological interventions or therapies to individuals affected by traumatic events

Although there is a growing interest in trying to design prison environments that are less traumatising, apart from the environment of prisons, another key feature is the staff. To deliver TIC means that prison staff themselves should have a good grounding in the principles of TIC and how these might be operationalised in the context of their roles. Prison officers are of special interest in implementing TIC as many have previous combat experience themselves from military service.

Adapted summary of Armed forces experience and Prison service joining profiles

	Former staff	Current staff	All staff
Mean year of joining the military	1982	1988	1984
% Army	69	66	68
% RAF	16	30	22
% Navy	16	11	14
Average number tours of duty	4	5	4
% Who saw combat	65	59	61
Mean length of military service in years	10	12	11
Mean year of joining prison service	1995	2005	1999

Moran, D., & Turner, J. (2021). Drill, discipline and decency? Exploring the significance of prior military experience for prison staff culture. Theoretical Criminology, 13624806211031248.

14 Part 2: Critical Interpretative Synthesis

In line with an adapted critical interpretive synthesis approach, this section uses the lead researcher's lived and professional experience to expand upon the findings of the rapid literature review by focusing on seven key topics. These topics were selected for their importance to the field of trauma-informed care in UK female prisons. The topics are: 1) trauma specific and trauma-informed care; 2) trauma-informed substance misuse and addiction interventions; 3) trauma and 'personality disorder'; 4) trauma and physical health; 5) self-harm; 6) vulnerable populations in women's prisons; 7) the role of lived experience.

1) Trauma specific and trauma-informed care

When thinking about trauma-informed care in female prisons, it is important to understand the difference between trauma-informed and trauma specific. The term "trauma specific services" refers to evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma. Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of peer participation in the development, delivery, and evaluation of services (DeCandia, Guarino & Clervil, 2014).

Many researchers conclude that trauma specific therapies should only be offered as a community-based intervention. This is because the prison environment cannot guarantee the physical and psychological safety that is crucial to undertaking trauma work (Baldry, 2008; Scott, 2001). Despite concerns raised by critics, female prisoners do request and find some benefit from interventions that specifically address and support them with their extensive poly-victimisation trauma histories (Player, 2017). Part 1) of this review identified several trauma-specific interventions running in UK women's prisons. In addition, there is evidence to suggest that the 'Trauma Specific Treatment Programme' (TSTP) in Australia showed a reduction in self-blame and improved mood (Dornan, 2021). Furthermore, there are emerging studies to support the use of more unconventional interventions such as transcendental meditation in female prison environments (Nidich et al., 2017).

Given the rates of complex trauma in this population, there is a pressing ethical need to integrate trauma-specific therapies more widely into forensic pathways, with a focus on interventions before imprisonment and during the crucial resettlement period after prison. This is especially the case given the amount of research to show that mental health interventions based within the prison are often ineffective (Sered, et al., 2021). Partnership models should be encouraged with third sector organisations specialising in these approaches, for example, Rape Crisis. The introduction of the C-PTSD diagnosis in ICD-11 means that there is now a growing community based- evidence for treating complex trauma (Karatzias., 2019), which could be expanded into probation services and youth offending prevention programmes.

REFERENCE FOR EVIDENCE BASE FOR TRAUMA INTERVENTIONS

Intervention/Recommendation	Reference
Multiple approaches and choice superior to phased based interventions	Coventry et al., 2020
Phase 1 limited efficacy without phase 2	Coventry et al., 2020; Norman et al., 2019
Individual therapy superior to group therapy	Malik et al., 2021
Long term superior to short term approachs	Karatzias et al., 2019; Melton et al., 2019
Domestic violence focused psychology	Hameed et al., 2022
Trauma-focused CBT	Cole et al., 2007
SHARE group sexual violence therapy	Zielinski et al., 2021
Transcendental meditation	Nidich et al., 2017
Helping Women Recover and Beyond Trauma	Messina et al., 2012; King, 2017
Healing Trauma	Covington & Bloom 2016; Petrillo et al., 2019
Esuba sexual abuse intervention	Ward & Roe-Sepowitz, 2009; Roe-Sepowitz et al. 2014; King 2017
Animal assisted therapy	Eaton-Stull et al., 2022; Villafaina-Domínguez et al., 2020; Dell & Poole., 2015
Therapeutic community more effective that CBT	Sacks et al., 2012
Trauma informed yoga	Tibbitts et al., 2021
Gender-specific mental health care	Bright et al., 2022

If trauma specific approaches are to be used in prisons, extreme caution must be taken when implementing interventions that focus on sexual and domestic abuse. Watkins and Dunn (2010) conducted an evaluation in two UK women's prisons of the Freedom Programme – a prison support programme for women who have experienced domestic abuse. They found that, contrary to its aims, the programme undermined rather than enhanced women's safety. Thus, it is not just about delivering more trauma specific therapies into women's prisons, it is about how these are operationalised and what meaning is made of the content by women themselves.

For a programme to have any chance of being useful to imprisoned women, it needs to be delivered either by prison-experienced women or by an independent organisation that is integrated within and influences the structure and culture of the prison (Bennet, 2001). Prison staff attitudes towards trauma-based interventions need to be understood in relation to the machismo and persistent misogyny of prison cultures (Scott, 2004). Therefore, trauma specific interventions need to be enabled and supported by careful selection and training of staff who are capable of maintaining a trauma-informed, compassion-focused attitude towards women.

The prison context is also an important factor to consider when planning trauma-informed approaches. There is a vast difference in culture between an open prison and a closed prison. Forensic therapeutic communities have much to offer in terms of trauma-informed provision. An intervention or trauma-informed approach may be somewhat effective in one type of prison but harmful if implemented under a more restrictive regime. Whilst there are progressive approaches used by the Canadian federal prison system, where women are placed in a variety of other non-prison environments, have private family visits, trauma counselling by outside bodies and live in self-care housing, these continue to be fraught with problems put down to 'a lack of culture change' (WPIR., 2008, p.6). Implementing TIC in different prison cultures and structures will require tailored approaches. Switching from a punitive, behavioural-based approach to a rights-based approach will be of key importance to any prison wishing to successfully facilitate trauma-based interventions:

> 'Whilst we recognise that existing power relations in prisons guarantee an unpromising setting for rehabilitative efforts, we contend that a rebalancing of penal power need not be unattainable. Its achievement depends heavily upon a fundamental reappraisal of the priorities that attach to different penal theories and their underlying rationales.' (Gender and Players, 2020)

2) Trauma-informed substance misuse and addiction interventions

A recent meta-analysis including 285 international studies found that domestic violence was significantly related to substance use (Cafferky, 2018) and 95% of participants considered their substance use to be at least somewhat related to traumatic experiences in the past (Dermondyet al., 2017). Given these facts, substance misuse programmes should integrate trauma-informed principles and be tailored towards the needs of the very different populations of women detained in prison. Women with lived experience have asked for very specific things with regards to future trauma-informed, substance misuse initiatives (Pollack, 2008). These should include:

- **The establishment of a key worker system among the staff**
- **More flexibility in the programmes**
- **More support from women who had had similar experiences**
- **Advocates to help them to know their rights**
- **The development of an addictions treatment model incorporating a variety of methods of treatment and including a peer support component**
- **Increased opportunity for women to have temporary absence passes to attend addictions counselling in the community from organisations that specialise in trauma and addictions**
- **Increased opportunity for women to serve their time or be released on day parole into addiction treatment centres that have a woman-centred understanding of trauma, loss and addiction**
- **An expansion of the sexual abuse counselling programme and the continued use of outside counsellors**

TIC & Substance misuse interventions

Coolmine community-based therapeutic community model has shown promising results for women with dual substance misuse issues and convictions (Babineau & Harris 2016), and prison-based therapeutic communities (TC) show strong evidence for reducing drug use and exposure to trauma (Sacks et al., 2012). Despite TCs' superiority over CBT based approaches, it is worth noting that there there is a good evidence-base emerging for the Seeking Safety, CBT based, treatment programme shown in the next table.

Integrated Treatments for Comorbid PTSD and Substance Use (McCauley et al., 2012)

Type	Trial design	Sample	Outcomes	Refs
TREM	Quasi- Experimental, Non-Equivalent Group TREM as part of a larger comprehensive treatment model v. TAU at community substance use treatment program; 6 and 12 month follow-up	342 women with a trauma history and SUD, presenting for SUD treatment	Significantly greater reduction in drug use and PTSD symptoms among integrated treatment (including TREM) group compared to TAU	Harris, 1998;Amaro at al., 2007
Seeking Safety	Uncontrolled Trial, 3 month follow-up	17 females with PTSD and SUD, incarcerated sample	Significant improvement in PTSD symptoms (53% no longer met criteria at post-treatment); Improvement in PTSD maintained at follow-up; Significant reductions in SUD symptoms, with only 35% reporting use within 3 months of prison release.	Zlotnick et al., 2003
Seeking Safety	Quasi-experimental, SS group v. TAU	313 women with trauma history, substance use disorder and comorbid Axis I or Axis II disorder	SS group showed greater treatment retention over 3 months and greater improvement in PTSD symptoms and coping skills than TAU	Gatz et al., 2007
Seeking Safety	Controlled Trial SS v. wait list control	114 incarcerated women reporting trauma history, history of SUD, and at least moderate PTSD symptoms	SS group demonstrated decreased depression, improved interpersonal functioning, and decreased maladaptive coping compared to control	Lynch et al., 2012

3) Trauma and 'personality disorder'

The Offender Personality Disorder Pathway (OPD) has been tailored to deliver services to a relatively wide population of women prisoners, despite the fact that few of them meet the dangerousness criteria that determine access for men (Player, 2017). One of the aims of the OPD is to provide access to more psychologically informed environments within the prison. However, it is unclear how these fit with trauma-informed principles or how individual pathways are being operationalised. More importantly, we have no clear sense of how women in prison experience these services. There are legitimate concerns about programmes that foster individualised and 'pathologised' understandings of women's distress.

Whilst a diagnosis of personality disorder might be beneficial in that it may enable women to access some offender focused interventions and/or better environments whilst in prison, it is important to understand that labelling a woman with a personality disorder may also have harmful consequences in terms of increased stigma and accessing support once released into the community (Buckman & Grainger., 2021; Lewis & Appleby., 1988; National Confidential Inquiry., 2018). There are long-standing problems and conflicts in terms of how the personality disorder diagnosis is used in this population (Timoclea & Taylor, 2020) and community-based trauma survivors have recently highlighted a need for trauma-specific pathways that are separate from personality disorder pathways (Lomani et al., 2022).

Given that the OPD pathway currently seems to focus on identifying and diagnosing women with 'personality disorder', rather than offering meaningful interventions that meet the needs of those identified (Treblicock et al., 2019), it is unclear how this approach can fit within a trauma-informed framework. Some research suggests that the few interventions framed within a personality disorder approach (such as DBT) may in fact be harmful because they prioritise prison system goals over the trauma-specific needs of women (Pollack, 2005; Player, 2017). It is also clear that DBT is not a trauma-specific intervention and is actively harmful for women with unaddressed trauma needs (Barnicot & Priebe, 2013). There is also strong evidence to show that DBT may increase self-harm for some people (Simon et al., 2022) As an alternative, both Pollack and Player recommend approaches that contextualise women's distress.

4) Trauma and physical health

Whilst trauma is often thought about in terms of psychological harm, a truly trauma-informed approach needs to consider all bio-psycho-social needs of women. We are only beginning to understand the profound and varied consequences that trauma can have on the body, including increased rates of inflammation, obesity, diabetes, and cardiovascular disease (Messina & Grella, 2006; Parker & Nemeroff, 2021; Schiff et al., 2021). The well-known Adverse Childhood Experience (ACE) study, for example, revealed the impact of child abuse histories on obesity (Felitti, et al., 1998). Trauma-informed training needs to integrate the latest research in this area to ensure that women's physiological responses to trauma are understood and responded to appropriately.

A study by McMillan et al. (2021) found that 78% of women prisoners in Scotland had a history of significant head injury – most of which occurred in the context of domestic abuse that often lasted over periods of several years. Findings from traumatic brain injury studies call for standardized screening for all women in prison and the development of focused interventions to prevent further harm to this population (O'Sullivan et al., 2021). TIC approaches require women's basic health needs to be met before any TS therapy can be considered. Research by Douglas et al. (2009) revealed that women are being detained in unhygienic facilities by regimes that operate to disempower them, including in the management of their own health. Despite policy initiatives to introduce health promotion in prisons, there is little evidence of its effectiveness.

5) Self-harm

The impact of Covid-19 appears to have had devastating consequences on self-harm rates in women's prisons. A recent inspection at HMP Foston Hall found record levels of self-harm and the poorest safety outcomes to date (HMIP, 2022). A third of women reported feeling unsafe and the response to women in crisis was deemed as too reactive, uncaring and often punitive (HMIP, 2022). Given the unique, gender-related difficulties already highlighted in this review, it is not surprising that women often have significant mental health concerns and are more likely than their male counterparts to engage in self-harm (Prison Reform Trust, 2017). There are numerous reasons why women engage in self-harm in prison, as well as differing degrees of pain and injury (Fitzpatrick et al., 2022).

Recent research has shown that it is important to challenge previous narrow understandings of women's self-harm as arising from "interpersonal issues" such as relationship difficulties with partners (Walker et al., 2017). Emerging findings show that self-harm can often happen as a result of frustration and a lack of control in custody and may be a natural response to incarceration (Griffiths, 2020; Sim, 2019). Self-harm is such a commonplace occurrence in women's prisons that there is a risk that staff become desensitised to its seriousness. Any trauma-informed interventions must include the latest research around this area promoting interventions that include listening to women without judgement, paying attention to their individual feelings and experiences, and crucially, not causing further harm (Sim, 2019). The rising levels of self-harm in women's prisons is a grave cause for concern and indicative of severe distress. Trauma-informed initiatives should therefore aim to stabilise this situation first before introducing more formal trauma-specific interventions.

6) Vulnerable populations in women's prisons

In addition to the general principles of trauma-informed recommendations for commissioning, extra thought should be given to uniquely vulnerable populations within the female prisoner community. Three of the most prevalent groups will be considered here, although further work needs to be carried out to consider the specific needs of Black, Asian and minority ethnic women, women in sex work, older women, women with disabilities and additional needs, lesbian women and trans women.

a. Women with long sentences

Women serving long sentences have different needs to those serving shorter sentences. Although we agree that trauma-informed provision should be implemented in community settings, it is important to note that this approach has diverted attention from the experience and rehabilitative needs of the minority of women prisoners serving long periods in custody (Genders and Player, 2020). By the end of 2019, the number of women serving life and other indeterminate sentences had trebled to 346, with 178 women serving 10 years or more (Ministry of Justice, 2019).

b. Foreign national prisoners

A sensitive and culturally informed approach must be taken when trying to implement trauma-informed approaches with foreign nationals. There is currently an over-representation of foreign national women in prison, particularly amongst those on remand (Prison Reform Trust, 2018). Foreign nationals are a discriminated population within the prison system (Prison Reform Trust, 2018) and many have additional complex needs and vulnerabilities as a result of being victims of human trafficking or modern slavery.

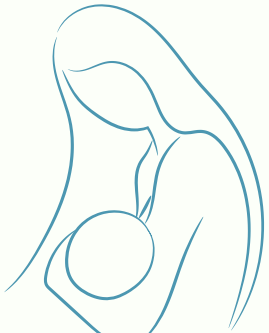
Specialist charities like the Hibiscus Initiatives should be provided with adequate and ongoing funding to make sure that trauma-informed principles can be applied in a culturally sensitive way to this highly vulnerable population. It is important that external and independent organisations are commissioned to work with this population. Initiatives originating from within the prison system have had limited success (HMIP, 2018), probably in part because the overriding purpose of these interventions is to expedite deportation (PRT, 2018).

c. Mothers in prison

Most women in prison are mothers (Prison Reform Trust, 2019), however, there are two groups of mothers who require extra consideration for trauma-informed care: pregnant women and women separated from their children. Pregnant women and new mothers are particularly vulnerable. They often have extensive histories of trauma (Fogel & Belyea, 2001; Knight & Plugge, 2005), which will increase their need for support during their perinatal period in prison. Birth Companions, the specialist organisation working in this field, has developed 'The Birth Charter' – a set of recommendations for the care of pregnant women and new mothers in prison – which has an accompanying toolkit to offer practical guidance for its implementation.

Six of the 12 women's prisons in England have a specialist mother and baby unit (MBU), however, research has shown that women who do not access MBUs are a more vulnerable group of women facing increased disadvantage and more mental health problems (Dolan et al., 2013). Separation from children is related to mental health exacerbations, suicide and self-harm (Independent Advisory Panel on Deaths in Custody, 2017), and is one of the most traumatic aspects of prison for women (Douglas et al., 2009). Whilst this is acknowledged in policy, there is rarely any specific support provided (Powell et al., 2017; Powell, 2018). Furthermore, the prison environment exacerbates the trauma of separation (Walker & Towl, 2016) and staff do not feel confident in providing support (Powell et al., 2020). Women who are separated remain disadvantaged on release as it is more difficult to access housing and support which would allow them to regain custody of their children (Dolan et al., 2013).

Trauma-informed approaches exist in Europe, where women are separated from children far less frequently. In Frondenberg, Germany, for example, 16 mothers live with their children up to the age of six in self-contained flats and the staff do not wear prison uniforms (ICPS., 2008). Providing trauma-informed support to mothers and reducing the number of mother-child separations would improve long-term outcomes for both women and children.



7) The role of lived experience

Formalised peer support has been an established part of prison life in England since 1991 (Davies, 1994). There are many third sector organisations who employ former prisoners in recognition of the skills and expertise they bring.[1] Many women feel more comfortable talking to other female prisoners rather than officers about issues such as self-harm (Griffiths et al., 2020). Research has shown that women in prison use peer support strategically, selecting different 'inside' and 'outside' sources of support depending on the specific nature of the problems they are experiencing (Jaffe, 2021). Thus, it is important to understand what kind of peer support model would best help women to deal specifically with the impact of traumatisation.

Despite not being labelled formally as 'trauma-informed interventions', peer support, lived experience models and prisoner empowerment approaches fit within many of the key trauma-informed principles (Sweeney et al., 2016). Lived experience researchers and practitioners can be a crucial asset to commissioners and service managers. They offer a unique and dual perspective on the everyday experience of prison life and can identify barriers to implementation that may otherwise have gone unnoticed without a lived experience perspective. Lived experience academic, Michaela Booth, explains that her success was not attributable to prison policy or specific interventions but to 'individuals who have taken personal responsibility to be inclusive.....people who have met me and seen my potential and given me a chance' (Booth, 2021). Former prisoners who work in the area of penal reform should be seen as key elements in trauma-informed commissioning. This might include, for example, co-designing and co-delivering trauma-informed training to staff, delivering peer support interventions with external organisations, and advising on policies.

[1] For example, UserVoice, Women in Prison, WISH, Working Chance

24 Conclusions

Experiences of trauma are highly prevalent in female prisons, and they are often associated with psychiatric diagnoses such as depression, anxiety and PTSD. A two-part, co-produced review, drawing upon critical interpretive synthesis methods, was undertaken of TIC conducted with women in prison. The most significant paper identified in the systematic search was a recent meta-analysis of TIC in prisons. Here, 16 studies were identified that met quality criteria, nine of which focused only on women. TIC significantly improved symptoms associated with PTSD, however, conclusions on evidence-based must take into account that the original analysis did not separate out sex or gender. Although many different models of intervention exist, most are offered in a group format and session lengths vary. Definitions of TIC seem to vary across services.

The second part of the review highlighted that a distinction needs to be made between trauma-informed and trauma-specific care. There are many challenges to be faced in implementing TIC, not least within the context of the offender personality disorder pathway, which will require particular care and thought. Any future commissioning of TIC must take into consideration the unintended harms or re-traumatisation that might occur as a result of interventions in prison.

Overall, the implementation of TIC in prisons raises formidable issues, not least of which is the traumatising and triggering nature of prison itself. This is in addition to considering the needs of vulnerable and minority groups in female prisons, where the current evidence base is lacking. It would be important to conduct an equality impact assessment if a new initiative is to be taken forward.

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Appendices

Appendix A Theoretical Underpinning of the 'Beyond Violence' programme

Trauma theory provides a foundation for the intervention with the basic tenet that early trauma influences both perceptions of and reactions to life events, especially for women. Moreover, exposure, particularly early and/or ongoing, to traumatic events may result in repressed anger and the use of alcohol and other drugs. For women, trauma is an antecedent to substance abuse whereas for men, trauma often occurs after the development of a substance use disorder. Anger is confounded with emotional pain and often lacks healthy expressions, leading to the continual repression of anger and pain that may result in assaultive and violent behaviour for women. Based on the existing literature about interventions that have been successful with female offenders, Beyond Violence utilizes a multi-modal approach and a variety of evidence-based therapeutic strategies (i.e. psycho-education, role playing, mindfulness activities, cognitive behavioural restructuring and grounding skills for trauma triggers)to address issues of mental health, substance abuse, trauma histories and anger regulation The materials are organized based on the social–ecological framework to assist women in understanding various forms of violence (see Box 1). The model recognizes the individual's responsibility in violence perpetration, as well as the context and influence of other factors such as the individuals' relationships, the communities they reside in, and the larger society which dictates social norms, as the foundation for guiding violence prevention efforts

Box 1. Beyond violence manual components.

Opening session	
Module A: Self	Session 1: Thinking our thoughts Session 2: Feeling our feelings Session 3: Violence and trauma in our lives Session 4: The effects of trauma Session 5: Women and anger Session 6: Understanding ourselves
Module B: Relationships	Session 7: Our families Session 8: Communication Session 9: Power and control Session 10: Conflict resolution Session 11: Creating our relationships
Module C: Community	Session 12: Our communities Session 13: The importance of safety Session 14: Creating community Session 15: The power of community
Module D: Society	Session 16: Society and violence Session 17: Creating change Session 18: Transforming our lives Session 19: Honoring ourselves and our community

Appendix B Aspects of the studies included in the Malik et al (2021) meta-analysis which focused on females only

Author and year	Location - setting	N	Mean Age	Intervention	Format	Session length
Cole et al, 2007	Washinton State Prison, US	9	31	Trauma focused	Group	16 sessions (2.5 hrs)
Ford et al (2013)	York State Prison, US	72	35	TARGET	Group	12 sessions supportive therapy
Lynch et al (2012)	NW State prison, US	114	34	Seeking safety	Group	24 sessions
Mahoney et al (2020)	Female prison, UK	86	34	Survive and thrive	Group	10 sessions
Messina et al (2010)	California State Prison	115	36	Beyond Trauma	Group	28 sessions
Swopes (2017)	Mid-western prison, US	56	36	Beyond Trauma	Group	36 sessions
Tripodi et al (2019)	North Carolina. US	33	43	Seeking Safety	Group	24 sessions
Zlotnick et al (2009)	High Secure State Prison, US	44	35	Seeking safety	Group	18-24 sessions