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Psychological perspectives for addressing mental health within the criminal justice system

Paola Castillo and Andrew McGrath*

GUEST EDITORIAL

THis is our first special issue dedicated to “Psychological perspectives for addressing mental health within the criminal justice system”. We commence this special issue with a study examining the effectiveness of a new cognitive skills intervention program - “Thinking minds” in a forensic psychiatric population. The authors; Jane Ireland, Carol Ireland, Maria Atiénzar Prieto and Katie Lambert put forward a novel treatment evaluation approach which focuses on both individual and group treatment effects. The paper offers valuable insights on how changing our approach to treatment evaluation can provide a clearer and more integrated picture of the effectiveness of interventions in such populations.

Following on from the topic of treatment evaluation, our second paper examines Jail to Community Medication-Assisted Treatment (JTCMAT) programs for substance abuse commonly used in the United States. This qualitative study provides a unique and in-depth exploration of the perceived strengths and weaknesses of the program from an end-user and service provider perspective. Examining the lived experiences of end-users and service providers offers a refreshing yet crucial understanding of treatment effectiveness. The authors; Michele Bratina, Michael Antonio, Mary Brewster and Jacqueline Carsello also put forward pragmatic strategies that can inform the development of effective programs and policies targeting substance abuse and recidivism.

Next is a discussion paper by Jonathan Evans, Dusty Kennedy, Tricia Skuse and Jonny Matthew which explores the complementarity of Trauma-Informed practice and Desistance theories when working with children in conflict with the law. This topic will be of considerable interest to practitioners in different jurisdictions. The need for trauma-informed care when dealing with young people in contact with the care and justice systems is becoming increasingly evident in the literature and this paper

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highlights its relevance to practice. The authors provide an excellent preliminary evaluation of the enhanced case management approach (ECM) and provide guidelines to assist practitioners interested in this area.

Moving from treatment evaluations, our next paper by Zoe Cross explores the characteristics of a ‘good quality’ working relationship between practitioners and children within the criminal justice system. This qualitative study provides an initial but in-depth examination of practitioner and child views of what constitutes a ‘good quality’ working relationship and the detrimental impact discrepancies in such views can have on desistance from crime. Practitioners working with children and interested in desistance will find this paper useful. The findings highlight the importance of individual and social factors in the development of a good quality working relationship.

The next paper in this special issue is a critical essay by Stuart Thomas on fatal encounters between police and people experiencing mental illness. This paper offers an important overview of the risk factors associated with the use of fatal police force when dealing with mentally ill individuals. It describes how factors such as perceptions of risk, time, proximity, training, experience and decision making can increase the chances of fatal force. The author uses recent Australian coronial investigations to reflect on the changes in policy and practice based on the recommendations made in these inquests. The essay concludes by proposing a revised approach to de-escalation, limit setting and training.

The concluding paper in this issue also explores the topic of mental illness. However, the focus is on police officer’s mental health. This qualitative study explores the impact of police culture and stigma on police officers with diagnosed PTSD. Saleha Hakik and Kory Langlois examined government documents and a collection of new media articles. The authors concluded that police culture is detrimental to discussions around mental health and help-seeking behaviours of police officers with a diagnosed mental illness. The authors conclude the paper by outlining the implications of these findings for practice.

We hope the special issue stimulates discussion and opens new lines of enquiry to improve and reflect on current practices addressing mental health within the criminal justice system.

Dr Paola Castillo and Associate Professor Andrew McGrath (Guest editors)

ABOUT THE EDITORS

Paola Castillo, PhD, is a Lecturer of Psychology at Charles Sturt University. Her PhD research focused on the detection of deception in cross-cultural contexts. Her current research interests include accent-related effects on judgements of credibility and deception in various contexts (e.g., online), intergroup attitudes, stereotypes, prejudice and discrimination with a focus on minority groups.

Andrew McGrath is an Associate Professor in Psychology at Charles Sturt University. He has a longstanding interest in juvenile delinquency dating to his Honours research on the correlates of offending frequency in a group of young people in NSW, and his PhD research, in which he interviewed 200 hundred young people immediately after their appearance before the NSW Children's Court for sentencing. A journal article based on this research was later awarded the Allen Austin Bartholomew Award for best article published in the Australian and New Zealand Journal of Criminology in 2009. Since then he has published a number of articles in both Australian and International journals on topics ranging from the impact of custodial penalties on re-offending, the sentencing of young Indigenous offenders, serious and violent offending careers, and juvenile risk assessment.

Thinking Minds - a cognitive skills intervention: A preliminary study capturing treatment effects, with forensic psychiatric patients

Jane L. Ireland,* Carol A Ireland, Maria Atiénzar Prieto, Katie Lambert

ABSTRACT

Presented is a preliminary study into the effectiveness of a cognitive skills programme, *Thinking Minds*, conducted with an adult male forensic psychiatric population (n = 27; 18 treatment, nine waiting list controls). It also addresses the approach to evaluating treatment effectiveness by capturing both group and individual effects. All participants were given a series of measures, to assess domains where treatment effect was thought likely to occur. This included impulsivity, coping, emotional control and self-esteem. It was predicted the treatment group would evidence positive change following the intervention, with no change in waiting list controls. Results indicated partial acceptance of the group effect prediction, with the waiting list control demonstrating no group change across time and the treatment group demonstrating improvement in rational and detached coping and in the social component of self-esteem. The individual change results demonstrated a mixed picture. It confirmed improvement in adaptive coping and social self-esteem for the treatment group but widened positive effects to cover aggression control. It also indicated evidence of deterioration on outcome measures. Deterioration was noted across all measures for the control group, suggesting that a degree of deterioration may be a naturally occurring process on self-report measures, regardless of intervention. This is an issue that future evaluations need to reflect on and accommodate. Results are discussed with regards to how the findings can begin to influence our approach to treatment evaluation.

Keywords: Cognitive Skills; Thinking Minds; Forensic patients; Treatment Evaluation; Clinical change.

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INTRODUCTION

Cognitive skills interventions have been considered valuable in the rehabilitation of offenders. Such interventions capture several aspects of how individuals perceive and engage effectively with others. They do this by focusing on social problem solving, managing impulsivity, enhancing coping skills, developing perspective taking (i.e., considering the views of others) (Friendship et al., 2003; Ireland et al., 2016), and by tackling offence-supportive beliefs (e.g., Wilson, Bouffard & MacKenzie, (2005).

Among prison-based studies, mixed results have been noted. These have focused on group effects. Some have reported a positive treatment effect (Friendship et al., 2003; Roberts, 2004), while others have failed to do so (Falshaw et al., 2004), or reported only limited effects (Cann, Falshaw, Nugent & Friendship, 2003). However, this treatment effect has generally focused on re-conviction as an outcome measure. This arguably provides limited application of the potential for a treatment effect and, at most, re-conviction represents a measure of the successful detection and conviction of an offender. They also fail to account for therapeutic impact. There has, however, been use of psychometrics to also ascertain therapeutic outcome, in some studies. Positive impacts have been reported, with improvements in impulsivity, offence-supportive attitudes (McDougall et al., 2009; McGuire & Hatcher, 2001) and increased personal responsibility indicated (McDougall et al., 2009). Such findings have extended to studies that consider a treatment-group only (e.g., Gobbett & Sellen, 2014). In addition, in Ireland et al. (2016) we reported positive change in the prisoner treatment group in relation to cognition, problem-solving (namely coping with social situations), impulsivity and self-esteem. The latter was also found by McGuire and Hatcher (2001). Thus, there appears some consistency in the application of an expected treatment effect following engagement in a cognitive skills programme, at least to some degree, even if this does not routinely translate to a reduction in reconviction.

Interventions have focused, however, on application to male prisoners, as opposed to those detained in forensic psychiatric settings. In addition, here has been a focus on examining group effects, as opposed to

individual client change (Ireland et al., 2016). Research considering such change argues for *levels* of positive change to be considered. In Ireland et al. (2016), we argued for levels of individual change as particularly important, noting how *progress towards* treatment aims were key potential indicators of programme success as opposed to evidence solely of *absolute clinical change*. This is far from a new proposal, with Wise (2004) noting value in considering *improvement* as opposed to clinical *recovery*, when determining a treatment effect. Wise (2004) was not, however, concerned with the forensic application of treatment change, which is perhaps why it was not immediately identified by forensic intervention studies. Such studies have demonstrated a clear preference for analyses of group treatment effect.

The value in refining consideration of what is meant by a treatment effect is worthy of revisiting. Indeed, in Ireland et al. (2016), using adult male prisoners, although ‘recovery’ was not indicated using a strict application of clinical change, there was evidence for ‘improvement’ in relation to offence-supportive cognition, problem-solving, locus of control and self-esteem. The value of accounting for improvement was noted, particularly in relation to forensic samples being unique and where seeking a statistical means of assessing ‘recovery’ could consequently be challenged. Evidence for ‘improvement’ would not have been identified by group analysis alone. This points to a need to consider in more detail how we conduct treatment evaluation analyses and not just focusing attention on the content of our evaluation programmes. It appears the latter has represented a dominating feature in the literature, with additional focus on what promotes engagement/responsivity to such treatment (Cornet et al., 2015). There remains remarkably little commenting on the analysis component of such programmes (Hanson, 2000; Serin et al., 2013). Although there has been research emerging in the forensic arena that has sought to apply a more sophisticated approach to the analysis of treatment effects (e.g. Walters, 2017), such publications are rare, with the reason for this unclear.

The current preliminary study examines the effectiveness of a cognitive skills treatment programme - Thinking Minds (TM) – to a high risk forensic psychiatric sample, with a further aim of considering

approaches to the analysis of treatment effects. It aims to achieve the following, 1.) Consideration of the treatment effectiveness of a cognitive skills programme to a neglected population of clinical study - forensic psychiatric patients; 2.) To identify both group and individual treatment effects and, in doing so, to consider what future approaches to analysis could reflect on. It was predicted that those completing TM would evidence improvements in impulsivity, effective coping, emotional-control and self-esteem, with no differences found for waiting-list controls. It was further predicted that those completing TM would evidence individual recovery across on these domains.

METHOD

Participants

All participants (n = 27) were adult men detained in a high secure forensic psychiatric hospital, which houses men with complex presentations with regards to mental health and/or personality. Their placement was an indication of a high level of risk to themselves and/or others, thus requiring conditions of enhanced security. All had a history of offending and were detained due to their risk in this regard. The hospital houses approximately 200 patients at any one time, with most presenting with comorbid major mental illness and personality disorder. The current sample represented all patients referred for a cognitive skills programme, over a 36-month period. The waiting list represents those who were awaiting treatment. Patients were placed onto the treatment programme when one became available. No further details were permitted to be gathered for the evaluation.

Treatment evaluated: Thinking Minds

Thinking Minds (TM: Ireland & Gredecki, 2009), is a 45 session cognitive skills programme, conducted at a frequency of three sessions a week, with each session lasting two hours. It comprises 10 modules, as follows; Module 1 (getting started), Module 2 (looking forward), Module 3 (coping with difficult situations), Module 4 (what is problem solving), Module 5 (understanding what goes on around me), Module 6 (developing my thinking), Module 7 (decision making), Module 8 (putting it in to practice), Module 9 (building resilience) and Module 10 (planning for my future). It is conducted with groups of between five and seven participants, with two

trained facilitators running each session. Facilitators are either psychologists or qualified psychiatric nurses. Programme integrity (e.g., manual adherence) was maintained through regular supervision, including via direct observance of sessions by a treatment lead.

Measures

The following measures were completed by all participants. Higher scores on each measure reflected a greater endorsement of the construct under study. For the treatment group these were completed prior to and post therapy completion (Time 1/Pre and Time 2/Post). The control group completed the same self-report measures at two time points, equal to the treatment group:

- *Barratt Impulsivity Scale* (BIS: Patton et al., 1995), a 30 item measure of attentional, cognitive and behavioural impulsivity. Previous internal reliability has been assessed, as 0.83 (Stanford et al., 2009).
- *Coping Style Questionnaire* (CSQ: Roger, Jarvis & Najarian, 1993), a 41 item measure of adaptive (i.e. detached and rational) and maladaptive (emotional and avoidant) coping. Internal reliability has been assessed as .85 for rational coping, .90 for detached, .74 for emotional and .69 for avoidance coping (Roger et al., 1993).
- *Emotional Control Questionnaire* (ECQ: Roger & Najarian, 1989), a 56 item measure capturing four elements of control; (cognitive) rehearsal, emotional inhibition, aggression control and benign control. Internal reliability for each of the four elements has been reported as .77 (emotional inhibition), .79 (benign control), .81 (aggression control) and .86 (rehearsal) (Roger & Najarian, 1989).
- *Culture Free- Self Esteem Inventory* (CSE: Battle, 2002), a 40 item measure of self-esteem that captures general, social and personal self-esteem. Internal reliability has ranged from .74 to .78 (Shine et al., 2002).

Procedure

All participants were approached and asked to complete the measures. The data analysis were completed by those unconnected to the development or

delivery of the treatment programme (i.e., authors KL & MAP). This managed the conflict of interest in the outcome of the treatment programme. The group and individual analyses were also completed separately, so each were blind to the results. KL undertook the group analyses and MAP the individual.

RESULTS

Collected data were screened for missing entries. Any missing data were replaced with the mean item score, except when a whole measure had not been completed by the participant. In such instances this remained a missing value. A Kolmogorov-Smirnov test of normality demonstrated that the data were not normally distributed. Consequently, group effects were assessed using a non-parametric, paired samples Wilcoxon test. These are presented in Table 1 for each measure and its respective subscales.

Table 1. Group effects for treatment (n = 18) and waiting list controls (n = nine).

Measure	Pre/Time 1		Post/Time 2	
	Treatment Mean (SD)	Control Mean (SD)	Treatment Mean (SD)	Control Mean (SD)
Impulsivity Total (BIS)	59.5 (10.6)	54.4 (15.18)	57.6 (12.6)	55.6 (14.19)
Attentional	17.9 (3.98)	16.4 (4.27)	16.9 (4.32)	16.4 (3.75)
Motor	19.9 (4.42)	18.3 (6.20)	20.2 (6.37)	19.3 (5.77)
Cognitive	21.7 (4.06)	19.7 (5.98)	20.5 (3.75)	19.7 (5.63)
Coping Style* (CSQ)				
Rational	39.4 (5.59)	41.9 (10.68)	44.0 (5.66)	44.2 (9.11)
Detached	31.2 (3.82)	34.2 (3.67)	34.6 (3.79)	33.7 (4.96)
Emotional	37.9 (5.27)	34.6 (8.19)	37.4 (5.33)	35.3 (6.96)
Avoidant	31.5 (5.09)	29.1 (5.90)	30.9 (4.91)	27.8 (6.03)
Emotional Control (ECQ)				

Rehearsal	5.5 (3.05)	3.3 (3.57)	5.4 (3.88)	3.8 (3.49)
Emotional Inhibition	6.7 (2.63)	8.6 (3.47)	6.0 (3.47)	8.2 (3.70)
Aggression Control	8.4 (2.12)	8.1 (2.71)	8.6 (2.77)	7.3 (2.71)
Benign Control	8.6 (2.41)	9.2 (3.12)	8.4 (3.23)	9.1 (3.52)
Self Esteem Total (CSE)	20.2 (4.14)	20.3 (4.87)	19.5 (4.60)	20.6 (5.04)
General	10.6 (2.65)	10.3 (2.35)	9.7 (2.59)	10.2 (2.68)
Social	5.1 (1.17)	5.7 (.97)	5.8 (1.34)	5.7 (1.92)
Personal	4.5 (2.00)	4.2 (2.94)	3.9 (2.20)	4.6 (2.52)

*n = 17 for the treatment group, with 1 missing; **Significant difference pre and post are in bold.

There were no differences between Time 1 and Time 2 for the waiting list control group. Differences pre and post for the treatment group were restricted to significant improvements post in CSQ rational coping ($p = .03$, $r = 0.38$), CSQ detached coping ($p = .004$, $r = 0.50$) and social self-esteem ($p = 0.03$, $r = 0.37$).

Following an assessment of group effects, focus moved to individual change. This was examined using:

1. Reliable change (RC) criterion using pre-group/time 1 SD and published reliabilities of the outcome measures. A confidence level of 95 per cent was utilised (1.96) and SE of change calculated;
2. Determination of a clinical cut-off to indicate if post therapy/time 2 scores moved into a “recovery” (i.e. functional population) range, determined as 2 SD or more from the pre-therapy mean (Atkins, Bedics, McGlinchey & Beauchaine, 2005). This method is also used for the Jacobson-Truax approach to determine clinical significance, whereas others argue that 1 SD and 0.5 SD cut-offs can be employed to indicate improvement/partial response and minimal positive response, respectively, with an RCI (Reliable

Change Index) criterion of 1.96 considered too conservative (Wise, 2004). Consequently, the full range of possible outcomes are indicated (i.e. recovered, improved/partial response, minimal).

3. Classification of participants using the stringent Jacobson-Truax method into “recovered”, “improved”, “unchanged” and “deteriorated” (see Ireland et al., 2016).

This were completed for the treatment group and waiting list control group. The results are shown in Table 2 and Table 3 respectively.

Table 2. Individual change effects for treatment group (n = 18; CSQ n = 17).

Measure				Cut-off*	Jacobson-Truax method
	SE of Change (RC)	Reliable Improvement n (%)	Reliable Deterioration n (%)	n (%) recovered n (%) improved/ partial response n (%) minimal	n (%) recovered n (%) improved n (%) unchanged n (%) deteriorate
Impulsive total (n=18)	6.18 (12.11)	1 (5.6)	8 (44.4)	1 (5.56) 4 (22.22) 3 (16.67)	0 1 (5.6) 9 (50.0) 8 (44.4)
Attentional impulsivity	3.52 (6.89)	6 (33.3)	5 (27.5)	1 (5.56) 3 (16.67) 2 (11.11)	1 (5.6) 5 (27.8) 7 (38.9) 5 (27.8)
Motor impulsivity	3.59 (7.04)	1 (5.6)	8 (44.4)	0 3 (16.67) 6 (33.33)	0 8 (44.4) 9 (50) 1 (5.6)
Cognitive impulsivity	3.04 (5.95)	6 (33.3)	7 (38.9)	1 (5.56) 3 (16.67) 2 (11.11)	1 (5.6) 5 (27.8) 5 (27.8) 7 (38.9)
Rational Coping	3.53 (6.91)	11 (61.1)	5 (27.8)	2 (11.1) 5 (27.78) 2 (11.11)	3 (16.7) 8 (44.4) 1 (5.6) 5 (27.8)
Detached	2.45	10 (55.6)	2 (11.1)	2 (11.11)	2 (11.1)

Coping	(4.81)			5 (27.78) 6 (33.33)	8 (44.4) 5 (27.8) 2 (11.1)
Emotional Coping	3.61 (7.07)	2 (11.1)	7 (38.9)	0 1 (5.56) 3 (16.67)	0 2 (11.1) 8 (44.4) 7 (38.9)
Avoidant Coping	3.94 (7.71)	2 (11.1)	6 (33.3)	0 3 (16.67) 3 (16.67)	0 2 (11.1) 9 (50) 6 (33.3)
Rehearsal	1.61 (3.16)	6 (33.3)	10 (55.6)	0 4 (22.22) 3 (16.67)	0 6 (33.3) 2 (11.1) 10 (55.6)
Emotional inhibition	1.78 (3.50)	7 (38.9)	5 (27.8)	0 8 (44.44) 2 (11.11)	0 7 (38.9) 6 (33.3) 5 (27.8)
Aggression Control	1.31 (2.56)	10 (55.6)	5 (27.8)	1 (5.56) 5 (27.78) 2 (11.11)	1 (5.6) 9 (50) 3 (16.7) 5 (27.8)
Benign control	1.56 (3.06)	6 (33.3)	7 (38.9)	0 2 (11.11) 8 (44.44)	0 6 (33.3) 5 (27.8) 7 (38.9)
Self esteem total (CSE) (n=18)	2.55 (5.00)	4 (22.2)	12 (66.7)	0 4 (22.22) 1 (5.56)	0 4 (22.2) 2 (11.1) 12 (66.7)
General esteem	1.59 (3.12)	2 (11.1)	11 (61.1)	0 2 (11.11) 3 (16.67)	0 2 (11.1) 5 (27.8) 11 (61.1)
Social Esteem	1.10 (2.15)	9 (50.0)	4 (22.2)	1 (5.56) 6 (33.33) 4 (22.22)	1 (5.6) 8 (44.4) 5 (27.8) 4 (22.2)
Personal Esteem	1.33 (2.60)	4 (22.2)	9 (50)	0 2 (11.11) 2 (11.11)	0 4 (22.2) 5 (27.8) 9 (50)

RC= Reliable Change Criterion; *SD positive cut-off; 'Recovered'= 2 SD from pre-mean; 'Improved/partial response'= 1 SD from pre-mean; 'Minimal'= 0.5 SD. The remainder represent no change.

When considering improvement, recovery and deterioration scores collectively (i.e. Jacobson-Traux, Reliable Improvement and Reliable Deterioration), an emerging pattern in the treatment group represented some improvement in impulsivity, but not uniformly so, and certainly not in relation to overall impulsivity. There was more consistency in relation to improvement on rational and detached coping, ECQ aggression control and social self-esteem. This was broadly consistent with the group effect findings, although the ECQ aggression control was not identified as an area of group improvement.

There was also deterioration noted, particularly with regards to emotional coping, avoidant coping, ECQ rehearsal (rumination) and self-esteem (overall, general and personal). This indicates a mixed picture of treatment effects, when accounting for individual change.

Table 3. Individual change effects for waiting list control (n = 9).

Measure				Cut-off*	Jacobson- Truax method
	SE of Change (RC)	Reliable Improvement n (%)	Reliable Deterioration n n (%)	n (%) recovered n (%) improved/ partial response n (%) minimal	n (%) recovered n (%) improved n (%) unchanged n (%) deteriorate
Impulsivity Total (n=9)	8.85 (17.35)	0	3 (33.3)	0 1 (11.1) 2 (22.2)	0 0 6 (66.7) 3 (33.3)
Attentional impulsivity	3.77 (7.39)	0	4 (44.4)	0 0 3 (33.3)	0 0 5 (55.6) 4 (44.4)
Motor impulsivity	5.04 (9.87)	0	5 (55.6)	0 0 2 (22.2)	0 0 4 (44.4) 5 (55.6)

Cognitive impulsivity	4.47 (8.77)	0	3 (33.3)	0 0 4 (44.4)	0 0 6 (66.7) 3 (33.3)
Rational Coping	6.74 (13.21)	0	2 (22.2)	0 2 (22.2) 1 (11.1)	0 0 7 (77.8) 2 (22.2)
Detached Coping	2.36 (4.62)	0	5 (55.6)	0 1 (11.1) 3 (33.3)	0 0 4 (44.4) 5 (55.6)
Emotional Coping	5.6 (10.98)	0	6 (66.7)	0 1 (11.1) 0	0 0 3 (33.3) 6 (66.7)
Avoidant coping	4.56 (8.94)	0	2 (22.2)	1 (11.1) 0 2 (22.2)	0 0 7 (77.8) 2 (22.2)
Rehearsal	1.89 (3.7)	0	4 (44.4)	0 0 3 (33.3)	0 0 5 (55.6) 4 (44.4)
Emotional inhibition	2.35 (4.61)	2 (22.2)	4 (44.4)	0 2 (22.2) 2 (22.2)	0 2 (22.2) 4 (44.4) 4 (44.4)
Aggression control	1.67 (3.27)	0	4 (44.4)	0 1 (11.1) 1 (11.1)	0 0 5 (55.6) 4 (44.4)
Benign control	2.02 (3.96)	0	5 (55.6)	0 2 (22.2) 1 (11.1)	0 0 4 (44.4) 5 (55.6)
Self esteem total (n=9)	3 (5.88)	0	4 (44.4)	0 1 (11.1) 2 (22.2)	0 0 5 (55.6) 4 (44.4)
General Esteem	1.41 (2.76)	2 (22.2)	5 (55.6)	0 2 (22.2)	0 2 (22.2)

				0	2 (22.2)
					5 (55.6)
Social	0.91	4 (44.4)	3 (33.3)	1 (11.1)	1 (11.1)
Esteem	(1.78)			4 (44.4)	3 (33.3)
				0	2 (22.2)
					3 (33.3)
Personal	1.95	0	1 (11.1)	0	0
Esteem	(3.82)			1 (11.1)	0
				3 (33.3)	8 (88.9)
					1 (11.1)

RC= Reliable Change Criterion; *SD positive cut-off; ‘Recovered’= 2 SD from pre-mean; ‘Improved/partial response’= 1 SD from pre-mean; ‘Minimal’= 0.5 SD

The individual change approach demonstrated no notable improvements in the waiting list control group; the proportion of those falling outside of the ‘unchanged’ or ‘deteriorated’ was minimal, with most scores presenting with no Reliable Improvement. The main exception to this appeared to represent social self-esteem, where there was 44% Reliable Improvement across time points.

DISCUSSION

The results from this preliminary study demonstrated some group treatment effects in the expected direction, with an improvement in adaptive coping, namely rational and detached. There was also improvement in the treatment group with regards to a single discrete aspect of self-esteem, specifically social. These findings supported the prediction that there would be improvements in coping and self-esteem, but it presented as localised with regards to the latter. Nevertheless, the positive treatment effects regarding these variables were broadly consistent with treatment group effects noted by others (Ireland et al., 2016; McGuire & Hatcher, 2001). However, the absence of a group treatment effect in relation to impulsivity and emotional control indicated that the prediction was only partially supported, with the absence of support for a positive impact on impulsivity inconsistent with previous research (Ireland et al., 2016; McDougall et al., 2009; McGuire & Hatcher, 2001).

However, the lack of group changes for waiting list controls did support the prediction, providing an indication that what was being indicated in the treatment group was influenced by engagement on the Thinking Minds program. Furthermore, the current study demonstrated, with regards to individual change, a general ‘unchanged’ or ‘deterioration’ presentation in the waiting list controls. This was a distinct pattern from the treatment group, where individual improvements were clearly noted. The individual effects were broadly consistent with the group effects but, individually, there was also evidence for positive improvements in relation to some elements of impulsivity and particularly in relation to ECQ aggression control. This was consistent with the prediction that there would be individual improvements in the treatment group across the domains, which would not be replicated in the waiting list control group.

Individual clinical change improvements, in relation to self-esteem and coping, were broadly consistent with the earlier findings of Ireland et al. (2016), but only in relation to the subcomponent of self-esteem, namely social. Indeed, overall and general self-esteem demonstrated the largest proportion of deterioration in individual change scores, followed by personal self-esteem. This indicates that improvement to self-esteem, following a cognitive skills program such as TM, was likely specific to a domain (i.e., social), with this evidenced both as a group and individual treatment effect. However, a proportion of the waiting list control group (44.4%) were also able to evidence reliable improvement on social self-esteem. This suggests it is potentially a variable that fluctuates across time but may not be dependent on engagement in treatment.

Overall, the findings suggest additional positive treatment effects that can be accounted for, if the results are investigated individually. Nevertheless, there was also evidence of deterioration in the treatment group, most notably in relation to emotional and avoidance coping. This indicates a more complicated picture of treatment effectiveness is emerging than if we rely purely on a group effect. The point to be made, however, is that developing a view on treatment effectiveness is likely best achieved through consideration of *both* group and individual clinical change effects. This allows for a more integrated interpretation of treatment effects and post-treatment deterioration.

The treatment effects presented a relatively clear positive outcome on adaptive coping. This is arguably significant for a program of relatively short intensity. Indeed, broader changes in impulsivity and emotional control are arguably likely longer-term effects, unlikely to be detected in a short-term follow-up. This may be particularly the case for a high-risk sample, such as the current study, where challenges with impulsivity and emotional control, for example, likely represent entrenched difficulties. However, teaching individuals new *skills* they can begin to immediately apply (e.g. adaptive coping) are arguably amenable to a more rapid and positive treatment response. Thus, it could be speculated that improvement from the TM program was focused on the *skill-enhancement* aspect of a positive treatment outcome as opposed to the more entrenched challenges of impulsivity and control. It could be expected that application of these skills across time would prompt positive change in impulsivity and control. Improvement in coping could also, arguably, contribute to a raising of self-confidence in social interaction. Although speculative, the finding that it was social self-esteem that significantly improved for the treatment group suggests it is an avenue worthy of future research.

The current study is not without limitations, certainly when accounting for this representing the first evaluation of Thinking Minds, the sample size, a lack of randomisation and its specialised nature. This makes it a challenge to generalise beyond the current population and to make assertions about the ultimate treatment value of the program presented here. Equally, it is not possible to capture re-offending data (or re-conviction) on the sample since this information was not available and the clients were retained within secure services. However, a need to gather behavioural indicators of real-world change, such as incident data, could have been a consideration. Notwithstanding this, there are some important reflections and directions for future research that can be drawn from the findings and how treatment effectiveness was approached. The latter is not a new consideration, but it is one that appears rarely commented on (e.g. Hanson, 2000; Serin et al., 2013). Indeed, there appears a focus on what treatment programs such comprise and what outcome measures should be employed, as opposed to *how* the analysis should be approached. The current study demonstrated clear evidence of value in applying clinical change as an approach to analysis, and accounting for the concept of

improvement as opposed to recovery. In unique samples, where non-normality is arguably expected, there is a risk that determining progress using traditional measure cut-offs and reliability becomes challenged, making the use of RC and the Jacobson-Truax method more difficult to apply. Consequently, considering evidence for statistical ‘improvement’, a less stringent assessment, as opposed to ‘recovery’ may be more valuable in directing treatment providers on what aspects of their interventions are having at least some effect.

Equally, methods such as Jacobson-Truax also allow for an estimate of ‘no change’ and ‘deterioration’. The latter is perhaps missed and, of course, we would not ethically wish to place individuals onto a treatment program knowing that it could afford them worse outcomes. Adopting a more individualised approach, as opposed to solely group effect, could potentially allow for these finer aspects of treatment delivery to be identified. Perhaps crucially, however, was the finding that the waiting list control group demonstrated deterioration on every measure. This is an important consideration since it would refine the issue of ethically placing clients onto programs where we expected deterioration in presentation, to one of not placing them onto a program where there would be a deterioration *in addition* to that expected for those not receiving treatment. It could be argued that deterioration is a natural function of the passage of time for some populations and our role is not to worsen their presentation beyond that which would occur ‘naturally’ (i.e. without intervention).

Of course, the issue of treatment evaluation will further be influenced by the intervention measures applied. Emphasis should not be placed on measures that are limited in identifying clinical progress. Indeed, a limitation of the current study, and general criticism of this area of research, is the relative absence of clinical measures sensitive enough to measure change across time. Instead, there seems a preference for research measures, which are not designed to be sensitive to change (e.g. Ireland et al., 2016; McGuire & Hatcher, 2001). This is an area future research could consider; one where we could perhaps focus more on the method of analysis applied to determining the impact of evaluation and the measures we choose to assess this impact.

Equally important is recognising evidence of deterioration within the treatment group; some treatment participants clearly deteriorated in certain areas (e.g. emotional and avoidant coping, impulsivity, several areas of self-esteem). Exploring the reasons for this deterioration becomes important, moving us beyond concluding an intervention is 'effective' on certain domains, when only group effects have been considered. It also becomes essential to determine why some individuals are not presenting with positive change or, at least, evidencing no change in those areas where the majority are improving. A standard treatment evaluation would miss such anomalies, with these perhaps crucial to consider for future research. This is equally important for domains where a group effect analysis concludes there was no treatment effect; the current research demonstrates that when individual effects were included there were areas, such as impulsivity, where participants were clearly worsening, even though there was no group effect. Concluding there is 'no effect' appears, therefore, overly-simplistic.

As noted, the current study is preliminary and it assessed a new program. Making firm conclusions is beyond the scope of the data. What we can suggest is evidence of improvement following the completion of this particular cognitive skills program in specific areas of adaptive coping and social self-esteem. Also recognised are the areas where change did not occur or where there was individual deterioration. Although we cannot generalise from such individual change with a limited sample, it highlights value in further researching this area along the lines indicated here and revisiting how we approach treatment evaluation. This may include taking a more pragmatic approach to including measures, which could include considering re-offending as opposed to reconviction.

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Jail-to-Community Medication-Assisted Treatment: Perceptions of clients and staff

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Abstract

This article presents the perceptions of clients and staff involved in a jail-to-community medication-assisted treatment (JTCMAT) program involving the administration of the extended-release injectable naltrexone drug, Vivitrol. The program was delivered in one rural county jail in the northeastern region of the United States. Through semi-structured interviews with inmates and key program staff, we gathered data regarding the criminal history, history of victimization, and mental health status of inmates enrolled in the JTCMAT program. We also investigated inmates' and service providers' perceptions of the strengths and weaknesses of the JTCMAT program itself. Findings suggest a general level of satisfaction among program clients and service providers, although some challenges following reentry were identified.

Keywords: addiction, correctional treatment, MAT, re-entry, naltrexone, Vivitrol

INTRODUCTION

Each year from 2000 through 2017, there has been a significant increase in the number of overdose deaths, with opioids and particularly synthetic opioids being overwhelmingly responsible (National Institute on Drug Abuse, 2019; see also Rudd et al., 2016). The Centres for Disease Control and Prevention (2019) reported that there were over 70,000 overdose deaths in 2017, with 68% of those being opioid-related. Research indicates that the number of individuals in need of drug and alcohol treatment and rehabilitative programming is significant and increasing, particularly among those under correctional supervision.

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The Prison Policy Initiative reported that the most recent national data about substance use in prison is from 2009 (Troilo, 2018). The 10-year-old data revealed that 58% of inmates in prison and 63% of inmates in jail are dependent on substances and, since being admitted to a facility, only 28% of those in prison and 22% of those in jail had received substance abuse treatment (Bronson et al., 2017). Upon release from prison, those with a history of drug use are at a higher risk for relapse and overdose, if they have not received any treatment to help address their addiction while incarcerated (National Institute on Drug Abuse, 2019).

People released from jail or prison (PRJP) have been found to be particularly vulnerable to opioid-related overdose due to a number of factors (Binswanger et al., 2013). For example, those who suffered from chronic pain, HIV, or some form of trauma are at an increased risk of overdose upon reentry (Joudrey et al., 2019). Among incarcerated individuals with severe chronic pain, 70% were given access to prescription opioids (Williams et al., 2014). Among PRJP, victims of physical trauma were 36 times more likely than others to suffer a non-fatal overdose, and 48% of victims of sexual violence were likely to suffer a non-fatal overdose (Lake et al., 2015).

Those who have been recently released from prison may also overdose on opioids due to the challenges of reintegrating into society (Joudrey et al., 2019). Factors such as stigma, restricted housing, and social supports can lead PRJP to turn to opioids as a coping mechanism. One study found that 18% of PRJP resumed using drugs and 23% continued abusing alcohol (Chamberlain et al., 2019). Mental health disorders can also exacerbate the stress of reintegration. Individuals suffering from mental health disorders, including some resulting from sustained solitary confinement, often used drugs and/or alcohol to cope (Binswanger et al., 2012; Hagan et al., 2018). The risk of overdose among PRJP reveals the necessity for treatment programs for incarcerated individuals with substance abuse problems

Medication-Assisted Therapy (MAT) programs involve therapy and medication (SAMHSA, 2019a). Essentially, treatment providers supplement therapy with drug treatments that assist individuals by weaning themselves off the substance(s) that they have been abusing (SAMHSA,

2019a). For those addicted to opioids, there are three types of medications administered in MAT programs to prevent substance abuse: methadone, buprenorphine, and naltrexone (SAMHSA, 2019b). Both methadone and buprenorphine are opioid agonists, reducing withdrawal symptoms and craving for the previously-abused opioids. Methadone treatment, a full opioid agonist, involves the daily administration of the medication within a treatment clinic to avoid misuse. While much research has found methadone to be effective in treating addictions (Green et al., 2018; Lincoln et al., 2018; Russolillo et al., 2018), unfortunately methadone overdoses have increased as have prescriptions for this synthetic opioid (Kuehn, 2012; Whelan & Remski, 2012).

Buprenorphine, on the other hand, can be prescribed and dispensed by physicians because it is a partial opioid agonist, with a lesser euphoria from the drug and so a reduced likelihood of misuse (SAMHSA, 2019a; Whelan & Remski, 2012). Naltrexone is an opioid antagonist that, rather than suppressing cravings for an opioid like buprenorphine and methadone, will prevent the euphoria the opioid normally provides if someone should relapse (SAMHSA, 2019b). Naltrexone comes in pill form that requires daily administration as well as extended-release injectable form (i.e., Vivitrol) that requires monthly injections (SAMHSA, 2019a).

For substance-abusing individuals revolving through institutional corrections, an overdose is most likely to occur within two weeks post-incarceration at a rate that is 42 times higher than that of the general population (Troilo, 2018). Despite an increasing number of justice-involved opioid users, many facilities have not allowed individuals to start or continue using MAT programs (Green et al., 2018). Some of the primary reasons for this resistance include costs; potential for illegal distribution of the drugs among inmates; lack of resources; the stigmatisation of inmates, drug use, and drug offending; and opposition to the drugs utilised in MAT programs (Kulaga, 2019). Some of these challenges, however, are beginning to dissipate.

MAT programs using methadone and buprenorphine have been most commonly implemented, with much research supporting their effectiveness, while naltrexone has only more recently been FDA

approved (Gordon et al., 2015). The extended-release injectable Vivitrol received FDA approval for the treatment of opioid-dependent patients in 2010. Naltrexone, including Vivitrol, is beneficial “to patients and providers who are unlikely to access opioid-agonist maintenance treatment or who prefer a relapse-prevention medication” (Lee et al., 2016, p. 2). The use of naltrexone is beneficial in the criminal justice system because drug diversion is not possible, overdose is highly unlikely, and the extended-release injectable drug does not require daily administration as with the use of methadone and buprenorphine (Gordon et al., 2015).

Medication-Assisted Treatment (MAT) Evaluations

There have been generally positive results in evaluations of MAT programs involving the administration of methadone, buprenorphine, and naltrexone in conjunction with other traditional treatment/counseling programs (Lee et al., 2016, 2018; Lincoln et al., 2018; McDonald et al., 2016). Much previous research has indicated that adherence to MAT programs has reduced the risk of death during custody and immediately following release (e.g., Lee et al., 2018; Lincoln et al., 2018; Velasquez et al., 2019), while others have warned that additional research is warranted to examine some serious side effects and an unsettling number of fatal overdoses (Wolfe et al., 2011). In a study of a jail-to-community MAT program (using methadone, buprenorphine, or naltrexone) in the Rhode Island Department of Corrections, Green et al. (2018) examined overdose fatalities in the same six-month period in 2016 (before the implementation of the program) and in 2017 (following the implementation of the MAT program). There was a 12.3% decrease in overdose related deaths from 2016 to 2017, presumably due in large part to the MAT program (Green et al., 2018). Another study showed that all three MAT programs (naltrexone, buprenorphine, and methadone) available to inmates starting while they were incarcerated and continuing post-release, resulted in more individuals continuing with treatment and fewer individuals relapsing (Lincoln et al., 2018). Lincoln et al. (2018) concluded that it is beneficial for these types of programs to begin in jail or prison and continue post-incarceration rather than starting them once the inmate is released.

In another study, Velasquez et al. (2019) compared four (non-randomised) treatments of individuals being released from jail and entering

the community. Interviews were conducted with 33 adults who were opioid dependent and being treated using methadone (9/33), buprenorphine (4/33), naltrexone (11/33), or receiving no MAT (9/33) (Velasquez et al., 2019). Those receiving naltrexone who relapsed briefly during the study did so either because they forgot they received the injection, or because they wanted to test whether the medication was working (Velasquez et al., 2019). With naltrexone, there were no reported overdoses on any opioids and some participants said they lost their cravings altogether, while others received a few injections before stopping treatment altogether (Velasquez et al., 2019). Those who used buprenorphine and methadone reported that the effects of the medication were helpful, but most were unhappy with the fact that treatment was required daily and because they were misinformed about some of the undesirable side effects of the treatments (Velasquez et al., 2019).

To be eligible to use naltrexone, a person must first be detoxified. According to the pharmaceutical manufacturer, those who have not detoxed are at risk of overdosing after a relapse (Alkermes, Inc., 2019). In a study comparing the naltrexone extended-release injectable, Vivitrol, and buprenorphine (Suboxone), more individuals using Vivitrol dropped out of the study before treatment began (79/283) than did those using Suboxone (17/287); these individuals who dropped out of the study relapsed (Lee et al., 2018). However, of the individuals who remained in the study (204/283 using Vivitrol and 270/287 using Suboxone), both medications had similar results in terms of negative effects, such as overdosing, and in effectiveness once treatment began (Lee et al., 2018).

In another study, Lee et al. (2016) compared naltrexone (Vivitrol) with an alternative treatment that involved counseling and referrals to treatment programs (i.e., the usual treatment). This study found that individuals who used Vivitrol had zero instances of overdose, both fatal and non-fatal, during the 78 weeks that treatment was administered; whereas those who received the usual treatment resulted in five overdoses during the first 24 weeks (0-25), and a total of seven overdoses by the end of the 78 weeks (Lee et al., 2018). During the first 24 weeks, 43% (153/308) of the individuals who received Vivitrol relapsed compared to 64% (155/308) of the individuals who received usual treatment (Lee et al.,

2018). Additional long-term studies are required to determine whether naltrexone treatment benefits are consistent and to see whether any additional improvements might be needed.

While several research studies have evaluated MAT programs that use one or more of the three pharmaceutical treatments in terms of relapse and overdose, few research studies have been conducted to gather and examine qualitative data regarding the actual experiences of participants and providers in these programs (e.g., Velasquez et al., 2019). Given the exploratory nature of research designed to examine the structure and function of newly emergent correctional-based drug treatment programs, qualitative approaches can provide valuable perspectives related to substance use and motivation for change and program design and content. The current research study provides some preliminary qualitative data related to one county's MAT program.

County Jail-to-Community Medication-Assisted Therapy (Vivitrol) Program

In January 2017, an evidence-based MAT program was implemented in a rural county in the northeastern United States. The primary aim of the program was to address substance abuse disorders among individuals incarcerated in the county jail who were soon to be released into the community. This jail-to-community medication-assisted therapy (JTCMAT) program relied heavily on key jail and community-based personnel who would monitor the treatment of eligible individuals within the county jail and within the community, post-release. The program was supported by access to jail and community-based treatment opportunities designed to address the individual needs of inmates with both alcohol and opiate use disorders. The aim of the JTCMAT program was to minimise obstacles for individuals who were incarcerated and transitioning to the community, and to maximise the positive development of an inmate's cognitive, behavioural, social, vocational, and other skills to address the underlying causes of substance use and related problems. The program was comprised of traditional treatment (e.g., group and individual counseling) and the administration of extended-release naltrexone (i.e., Vivitrol) injections, with the initial injection given prior to reentry into the

community. The county provided the transportation of incarcerated program participants to the various community treatment centres.

The purpose of our research was to explore the backgrounds and needs of the inmates enrolled in the JTCMAT program, to gather information regarding their experiences in the JTCMAT program, and to examine the perspectives of both program participants and program staff regarding the general strengths and weaknesses of the program. Utilising data obtained through one-on-one semi-structured interviews with inmates and key program personnel, this study sought to answer three main research questions:

Research Question #1: What are the individual life experiences of inmates who are enrolled in the county JTCMAT program related to prior criminal behavior, substance use or abuse, history of victimisation, and experiences with emotional and mental illness?

Research Question #2: What are JTCMAT program participants' beliefs about the strengths and weaknesses of the program?

Research Question #3: What do community treatment providers believe are the strengths and weaknesses of the county JTCMAT program?

METHOD

Participants

All inmates targeted for one-on-one interviews in this study were 18 years of age or older, enrolled in the JTCMAT program, and at varied stages of the correctional process (incarcerated, re-incarcerated, or under community supervision). Inclusion in the program was determined by the county jail exclusively and, although convenience sampling was utilised, it was based, in part, upon the inmate's individual need and willingness to participate in substance abuse treatment, substance abuse history, receptivity to treatment, and anticipated date of release from jail. Key program staff targeted for interviews included the county jail health service administrator—who referred patients meeting inclusion criteria to the JTCMAT—and other service providers. For the purposes of this study, key provider staff included program directors, case managers, psychiatrists, counsellors, and nurses based at two community-based

agencies—one, a drug and alcohol rehabilitation centre, and the other, a federally qualified health centre (FQHC).

Participants were informed that the researchers would be available on certain days/times to discuss their experiences in the program. There was no compensation to research subjects for participating in the study, nor any impact on inmates' access to jail or community services or their correctional supervision. The employment status of staff who chose not to participate was not impacted either. All participants were instructed that they could withdraw from the interview at any time.

Data Collection/Interviews

In the context of health promotion and disease (e.g., substance abuse) prevention, it is essential to identify core determinants that may influence effective health practices, which may include one's knowledge of health risk/benefit, perceptions of ability to control health risk, outcome expectations/goals, and perceived social facilitators and impediments to positive change (Bandura, 2004). Based upon these considerations, we included questions designed to assess participant socio-demographic information, family history, social and personal risk history, history of substance use/abuse, medical, mental health status, prior victimisation/traumatisation, prior hospitalisations, medications, housing status, and community needs.

The interview tool for use with program staff included questions designed to elicit staff/county provider perceptions about client needs and risks (individual and social), efficacy or clients' ability to successfully participate/complete the program, and perceived usefulness or effectiveness of the program in its current form—including benefits and impediments to MAT and community-based treatment/supports. Staff were also asked to make any recommendations for change or improvement based upon their assessments of program effectiveness.

Over a two-month period in the spring of 2018, the researchers collected data through interviews with a convenience sample of 10 inmate participants and nine provider staff. After obtaining informed consent, face-to-face individual interviews lasting approximately one hour were conducted in a private room at the jail, FQHC, or substance abuse

treatment program. All interviews were audio-recorded and later transcribed by the researchers.

Data Analysis

Both quantitative and qualitative interview data were analysed. Descriptive analyses of the quantitative data documented program participants' self-reported demographic and other personal characteristics, financial and family support, motivation for change, history of violent and property crimes, involvement with substance abuse, incidents of victimisation, and mental and emotional health problems.

Extensive qualitative data were obtained through program participants' and program staff members' narrative responses to several open-ended questions asked during their individual, one-on-one interviews. All interview responses were digitally recorded and then transcribed verbatim into a relational database. Content analysis techniques were used when reviewing these narratives (Holsti, 1969). Narrative responses were reviewed, and conceptual categories or themes were identified by the research team. Next, coding rules were established for each category or theme. Each member of the research team then reviewed the interview transcripts again and coded the narrative responses using the objective criteria established. For the present analysis, themes and categories related to the perceived strengths and weaknesses of the program design, Vivitrol injections, other drug options, clients' insurance, and motivation to change behavior were examined.

RESULTS

Program Participants

Table 1 reports findings (n=10) about program participants' demographic characteristics and reported history of victimisation. The interview respondents were predominantly non-Hispanic white (90%), female (80%), single (60%) or divorced (30%), and had earned at least a high school diploma or GED (60%). Program participants ranged in age from 22 through 50, with a median age of 31.5 (mean=34.67; SD=12.74). Seventy percent of the participants were responsible for dependent children (median=1.5; range=0 through 5).

Table 1 also highlights information about the financial status and family support of program participants. As shown, the majority had worked as unskilled laborers (70%), with 40% of respondents reporting that their financial stability was supported predominately from their own employment or disability benefits, while others reported that they were supported mainly by their family (30%) or through a combination of employment and family financial support (30%). Many (80%) of the participants reported strong family support systems, even if this support was not financial. Finally, the table reveals what participants reported as motivating factors to be successful in their recovery. These factors included having contact with their children (40%), attaining a healthy lifestyle both in body and mind (30%), and maintaining stable employment (20%).

Table 1 *Participant characteristics, financial and family support, and motivation for change*

	(n=10)	%
<i>Respondent Characteristics</i>		
Race/Ethnicity		
non-Hispanic white		90
non-Hispanic, non-white		10
<i>Gender</i>		
female		80
male		20
<i>Marital Status</i>		
never married		60
divorced		30
married		10
<i>Education</i>		
no high school diploma/GED		40
completed high school/GED		30
some college		10
graduate degree		20
Age	Median=31.5; range=22-50 $\bar{x}$ =34.67; s=12.74	

<i>Number of dependents</i>	Median = 1.5; range = 0-5	
0 children		30
1+ children		70
<i>Employment</i>		
formerly/currently unskilled laborer		70
formerly/currently skilled laborer		30
<i>Financial Dependence/Independence</i>		
main income source was/is employment/disability		40
benefits		30
main income source was/is family members		30
combined sources of self-support/family support		
<i>Social Support</i>		
strong family support		80
social non-familial support		10
no social support		10
<i>Motivation for Change</i>		
children		40
employment		20
healthy body/mind		30
other motivators		10

Table 2 reveals findings (n=10) about participants' self-reported involvement in criminal behaviour that led to prior incarceration, as well as use/abuse of alcohol and other drugs. Only 30 percent of participants reported no prior incarceration, while the remainder reported prior incarceration for violent crimes, including simple assault (30%), domestic violence (20%), and robbery (10%); property crime, including burglary (40%) and theft (20%); and/or DUIs (30%). Participants reported a variety of involvement with substance use/abuse including most commonly reported heroin (80%), other opiates/opioids (50%), alcohol (50%), cocaine (50%), crack (50%), and/or marijuana (30%).

Table 2*Participants' self-reported history of violent and property crimes and drug use*

(n=10)	%
<i>History of Prior Incarceration</i>	
No prior incarceration	30
Prior incarceration for violent crime	
Simple assault	30
Domestic violence	20
Robbery	10
Prior incarceration for property crime	
Burglary	40
Theft (felony and retail)	20
DUIs	30
<i>History of Substance Use/Abuse</i>	
Alcohol	50
Amphetamines	10
Bath salts	10
Cocaine	50
Crack	50
Crystal methamphetamine	10
Heroin	80
Marijuana	30
Other opiates/opioids (other than heroin)	50

Table 3 reveals findings (n=10) about participants' self-reported experiences of victimisation and mental and emotion health problems. As shown, participants described a history of victimisation, including emotional abuse (40%), physical abuse (50%), and sexual abuse (60%). Also, 50 percent of the participants reported victimisation through one or more forms of abuse, and 20 percent reported abuse that had occurred during childhood. The respondents who reported histories of childhood trauma were reluctant to elaborate about this form of victimisation during the interview.

Table 3 also shows participants’ self-reported history of mental and emotional health problems. Most respondents (70%) reported having one or more types of mental and emotional health problems (MEHP). Specifically, participants reported experiencing anxiety (40%), depression (30%), post-traumatic stress disorder (30%), mood disorders (20%), panic disorders (10%), and/or obsessive-compulsive disorder (10%). Additionally, though not reported in the table, 60 percent of the respondents reported one or more prior inpatient hospitalisations for mental health, substance abuse, or co-occurring substance abuse and mental health problems.

Table 3
Percentage of participants reporting history of victimization and mental and emotional health problems

(n=10)	%
<i>History of Victimization</i>	
emotional abuse	40
physical abuse	50
sexual abuse	60
one or more types of abuse	50
abuse during childhood	20
<i>Mental & Emotional Health Problems (MEHP)</i>	
anxiety	40
depression	30
mood disorder	20
panic disorder	10
post-traumatic stress disorder	30
obsessive compulsive disorder	10
one or more types of MEHP	70

Offender and Treatment Providers’ Perspectives Regarding the JTCMAT Program

Program participants and staff shared their perceptions of the JTCMAT program during semi-structured one-on-one interviews. Several themes emerged from these narrative accounts and are summarised in Table 4.

Program Design. Aspects of out-patient treatment therapy, including group sessions facilitated by community providers, were well received by program participants. Program participants reported feeling comfortable and supported during group therapy sessions with others who were struggling with issues of addiction. One participant mentioned how connected she was to the group, "...anybody I could relate to almost, everybody has a story there, I could relate to anyone I could talk to".

Responses provided by program staff also were favourable. Staff, however, discussed in greater detail specific aspects of the program design that were conducive to learning and fighting addiction. One staff member liked that the county jail "let [the offenders] come out of the jail to be able to participate in this treatment.... they really understand why they are here, they are supportive of one another. I feel that gives them more support because in jail they are alone a lot or they are with negative people". Another staff member liked that the program linked group treatment and individual counselling to receiving the Vivitrol injections, "a lot of our clients, they will tell you that getting the Vivitrol is a big motivator to stay in treatment...they will tell you that is why they like to stay engaged with counselling, it is beneficial, but they really enjoy the fact that they can get the MAT part of it, the medication".

Staff from the community treatment providers generally reported a good working relationship with the county jail. A staff member commented, "Once someone is in and we need to schedule individual sessions, something outside the normal group, I think that goes really well. We never had a problem with availability for scheduling, never had a problem with transportation for individuals, so once we schedule with the jail, our clients are here and everything is going well". Another staff member praised the program for allowing the clients to start the Vivitrol injections while inside the jail:

I think what that allows the patient to do is to get the experience for the first time of this is what sobriety feels like. They can both have a visceral/physical experience, but also the psychological experience of 'I am thinking clearer, other people are noticing that about me'. That's huge because that they hit the community with

that already in place, so they don't immediately go back to the one coping skill they know, which is the addictive behaviour.

There were some criticisms of the program design however. For example, some program staff were concerned with the continuity of care, citing a lack of access to Vivitrol as a common obstacle. One staff member commented,

I feel that the grant coverage for the jail program seems disconnected. The jail has tons of Vivitrol, but the community/provider does not. We've had to call over to the jail to request a supply of Vivitrol. [The jail administrator] will tell me he has plenty of supply, but then only sends enough for one month. I am often wondering why he just does not send us several months' worth of injections at a time, since he seems to have a huge supply there.

Although improvements could be made, participants and staff overwhelmingly agreed the program was designed in a manner that worked for everyone. Modeling the JTCMAT program after other successful MAT programs that used group counselling sessions and referrals may have facilitated such positive outcomes here.

Vivitrol Injections. Another theme that emerged from the interviews related to the Vivitrol drug itself. Program staff reported Vivitrol was the most appropriate medication to use with inmates suffering from substance abuse issues. Many staff spoke favourably about the monthly injection versus taking other kinds of medication every day. Clients made similar comments. For example, one stated, "for me, I was always chasing the high. So, it wasn't for me. I wasn't ...I couldn't medicate myself properly. So, Vivitrol is one time, done, that's it". Some service providers believed the monthly injections reduced the likelihood of "forgetting" to take the medication, especially because community centre staff were responsible for administering the doses, but other advantages included reducing the likelihood that the participant's own family members or friends would steal and/or coerce them into sharing the medication. Staff also reported taking medication every day is symbolic of taking illicit drugs, which is an association they wanted to break.

Other staff mentioned how Vivitrol negates any effects of drug use. Essentially, Vivitrol impedes “getting high”. One staff member described that “...if they have Vivitrol in their system and they drink or they would use an opiate, they are not going to feel it...they are spending the money and they use the substance, but they are not getting the payoff. And that is a common thing that they say, that ‘it would be a waste if I did it’”. Individual program staff perceived this effect as a great deterrent to future drug use. The comments provided by program staff in this study echoed findings from previous research about the benefits of Vivitrol to reduce cravings and to minimise urges to start reusing in the future.

Vivitrol Compared to other Drugs. During the one-on-one interviews, program participants and staff compared the Vivitrol drug to other medications designed to combat addiction. Program participants reported a preference for the Vivitrol injections compared to other treatment options including Suboxone. For example, participants described that Vivitrol reduced the cravings for additional drugs/narcotics, while Suboxone caused a “high” among users. One respondent commented, “...if you’re an addict, you’re going to chase that high” if on Suboxone. Another described Vivitrol:

There's no high, there's nothing like it. All it is a shot, done, there's nothing to it. The Vivitrol eliminates all cravings and anything like it. For me, personally speaking, I can say ...Suboxone, Subutex...I got high off it when I first started it. And like I said, you're gonna crave that high. That's how I was, I was an addict.

Several staff concurred that Vivitrol was a better option than other drugs currently available. Program staff described Vivitrol as a relapse prevention medication, while other drugs, like Suboxone, are harm reduction medications that are initially used regularly, then tapered off gradually. One staff member mentioned that Vivitrol offers a better path for recovery, as the program participants are not taking something every day. She noted,

With Suboxone you are still taking something every day, so when our clients get down to none, they still have that desire to take something. People will commonly go back to either buying

Suboxone off the street or they will start taking something else. With Vivitrol, they are not doing that. They have the medication, the anti-craving medication, and they also are not on an opiate anymore.

However, some staff warned that Vivitrol may not be the drug of choice for all inmates who were suffering from drug addiction and encouraged examining other drug therapies, depending upon the needs of the target population. According to one treatment provider, the effectiveness of MAT may depend on the stage of addiction. For example, one staff member commented, “there are different types of MAT and some work better than others, depending on the client’s status...In particular, Vivitrol works well earlier in a client’s addiction, as it blocks the craving and the injections must be administered under the care of a physician and only once a month”. This staff member continued by explaining that Vivitrol would not work on individuals who had an active addiction,

You also have to look at frequency. When you take someone who is incarcerated who may be in active addiction, you can't give them once a month injection, and once a month individual therapy and expect to impact change. So, I think we've handed some folks back depending on their severity of when they walked in the door.

Other staff indicated Vivitrol was not appropriate for use with pregnant clients.

Staff also mentioned that other types of MAT are preferable for a number of reasons, including their risk of relapse and an ability to access the drug. One staff member mentioned, “...using Suboxone (buprenorphine), which has been found to be an effective alternative approach to addiction and is less costly. It is also available in injectable form, which would prevent abuse”.

Some staff mentioned the importance of waiting until after detox is completed before administering Vivitrol to clients. Other staff warned of the drug backfiring when clients try to achieve the previous effects of drugs while Vivitrol is preventing these desired effects. For example, one service provider stated,

...generally, if you use heroin or drink alcohol, you won't feel a high or anything and you won't get sick. People think, maybe if a use a little more I can overpower it. They will either continue to drink or they will use more and they will start getting physically sick because they are putting a poison in their body but they are not feeling a high from it...One of [the county's] first clients with Vivitrol was on it for alcohol and he started drinking and he thought he could override it and he ended up in the hospital.

Similarly, another service provider warned against using Vivitrol for people who have overdosed previously, as they are more likely to repeat that behavior while they are attempting to overcome the impact of the Vivitrol. Despite these setbacks for some people, Vivitrol injections, as previous research has shown, have been utilized quite successfully in other MAT programs. The majority of participants and staff associated with the JTCMAT program spoke favourably about using Vivitrol compared to other drug substitutes.

Insurance. Another theme that emerged from the interviews related to financial expenses. Specifically, staff discussed concerns about who would be responsible for the financial costs associated with the Vivitrol injections. Some staff discussed how the cost of the Vivitrol medication and injections were covered by the county jail through grant monies. The cost would continue to be paid by the county as long as the participant was incarcerated and actively enrolled in the program. Upon discharge from the county jail, the client's own health insurance would be billed for expenses. Staff indicated that many insurance companies would not cover the Vivitrol injections which they estimated to cost between \$1,200 - \$1,500 per injection. Staff reported they were instructed by the insurance companies to find less expensive alternative medications. One staff member described, "Vivitrol is not a preferred medication by medical assistance and few commercial insurances. They would argue the patient could take one of the other alternative choices...or try taking the Vivitrol tablet".

Motivator to Work on the Underlying Causes of Substance Abuse. Some staff and clients pointed out that Vivitrol can be a motivator for working on underlying issues. One staff mentioned,

A lot of our clients they will tell you that getting the Viv is a big motivator to stay in treatment because the way our program is set is they have to be engaged in counselling to get the Vivitrol. And so they will tell you that is why they like to stay engaged with counselling, it is beneficial but they really enjoy the fact that they can get the MAT part of it, the medication.

Also, some staff and clients recognised that Vivitrol was not a panacea that would cure addiction without working on the underlying issues. One service provider stated,

It does reduce the craving, but it's a behaviour. Like, the medication helps with the craving and the physical aspect, but the behaviour of addiction...until they address the behaviour of addiction, a lot of times, somebody's always gonna want that feeling...to be high. It doesn't take care of the psychological aspect of why we need to be in treatment...

In previous addiction and MAT research (e.g., Najavits et al., 2017), several clients pointed to histories of trauma and mental health problems during their interviews, and some were motivated to work on rekindling positive relationships with children and other family members through sobriety and therapy. Given the frequency with which mental health disorders and substance use co-exist, especially among adults with opioid use disorder (Jones & McCance-Katz, 2019), the urgency for the inclusion of therapy and counselling while in the correctional and community settings cannot be overstated; this is particularly important at the point of reentry. As one client lamented, “when something goes wrong in my life, I just wanted to use to deal with my problems”. Consistent with previous studies on addiction, the present analysis illustrates that one issue which often leads people to abuse substances involves the motivation to alleviate underlying psychological needs.

Table 4: *Most common themes identified in interviews with JTCMAT participants and service providers*

Strengths

Program design

Transportation from jail to community-based treatment providers

Group counselling relatable for clients

Vivitrol convenience (monthly injection)

Vivitrol effectiveness in eliminating cravings

Vivitrol advantages over opioid agonists (methadone and buprenorphine)

Timing of the first Vivitrol injection (pre-release)

Access to Vivitrol as a motivator to work on underlying issues

Challenges

Continuation of treatment after reentry – less of a controlled environment

Vivitrol's cost relative to other medication options

Access to Vivitrol – cost and insurance denials

Can increase likelihood of overdose due to efforts to overcome the effects of Vivitrol

Detox before Vivitrol administration

Vivitrol is not suitable for everyone (e.g., pregnant women; those with overdose histories)

Vivitrol is not a panacea

DISCUSSION

The purpose of this study was to better understand the JTCMAT program participants and the strengths and weaknesses of the program identified by participants and providers. Findings gathered through this project can: 1) add to the current body of research about effective correctional intervention techniques, 2) have practical implications for county officials to develop more effective inmate programs, policies, and strategies to reduce habitual substance abuse and recidivism, and 3) be used as a model to replicate the research on larger samples in other jurisdictions.

Findings showed that the county JTCMAT program participants were diverse in terms of their life experiences, including their history of

prior incarceration for various violent and property crimes, self-reported use or abuse of illicit substances, history of victimisation, and mental health diagnoses. Staff or counselors of Vivitrol programs held in small communities or with county jail populations may find it more challenging to facilitate group discussions with a diverse population as compared to larger state or federal prison systems where participants can be better grouped and enrolled in programming based on participants' background and life experiences.

Responses provided by subjects in this study revealed that the diversity of individual participants in group counselling did not detract from the discussion; rather, it was used to encourage discussion and to identify commonalities. Indeed, findings uncovered from one-on-one interviews with staff and program participants revealed a general satisfaction with group sessions. Participants reported feeling supported during groups and comfortable interacting with others who struggled with issues of addiction. Overall, the groups appeared to be facilitated in a manner where everyone could find something to relate to.

Other findings uncovered here included themes that emerged from one-on-one interviews with program participants and staff. With respect to program participants, we observed life trajectories that paralleled those found in previous research. In particular, there is a substantial body of evidence that links abuse and traumatisation to the use of substances as a negative coping mechanism; this is especially exacerbated in cases where mental illness is present (Najavits et al., 2017). Consistent with these outcomes, participants revealed complex histories of exposure to multiple forms of trauma (abuse, neglect, polyvictimisation) and mental health conditions that, for many, led to early experimentation with drugs/alcohol. Over time, their substance use has transformed into dependence and addiction. While not explored in our analysis, it is possible that underlying mental health conditions that have been left unaddressed and untreated may lead to complications that prevent optimal success in an MAT program—a finding supported by prior studies (Hien & Levin, 2012; Zeledon et al., 2020).

Despite some anticipated challenges, there was a general consensus among community treatment providers and clients that the JTCMAT

program was conducive to learning and fighting addiction. Staff liked how the program was designed to allow inmates a temporary release from the jail setting to take programming in the community. Staff also praised the program for linking the Vivitrol injections to the program itself, and for administering the first injection prior to reentry into the community. They perceived this as a motivating factor for participant attendance. Findings here also suggested that hybrid, jail-community based programs like this require a strong working relationship and coordinated efforts between the correctional setting and the community treatment provider.

Much insight was provided during interviews about the Vivitrol drug itself and comparisons were made to other medications designed to alter an addict's behaviour. First, staff and clients extolled Vivitrol because of the need for monthly, not daily, injections and how the drug would negate any effects of other drug use. Both staff and clients described Vivitrol as a relapse prevention medication, while drugs like Suboxone, are harm reduction medications. These other drugs often leave participants with a lingering desire to continue taking medication of some kind, while with Vivitrol the cravings are eliminated. Some staff viewed this outcome as having a great deterrent effect, including curbing other drug use while on the Vivitrol injections, while others warned that some might try to overcome the effects of Vivitrol with a higher quantity of drugs that might lead to overdose. Other staff pointed out that Vivitrol cannot safely be administered to pregnant women. Methadone is the only medication of the three that pregnant and breastfeeding women can use safely (SAMHSA, 2019b).

Another common drawback identified by community treatment providers and clients involved the financial cost of injections. During the evaluation period, the cost of the Vivitrol medication for incarcerated participants was paid for by the county jail. Once released from prison, community providers reported the participant's own insurance (either private insurance or medical assistance) would be billed for expenses. Oftentimes insurance companies were unwilling to incur the expense and encouraged other less expensive treatment options including Suboxone. Recent research findings, however, suggest that a cost savings may be

realised by significantly reducing the dosage of naltrexone without negatively impacting the drug's effectiveness (Sidana, Das, Bansal, 2019).

CONCLUSION

From 1999 through 2017, rates of fatal drug overdoses in the US increased more than 250% (Centres for Disease Control, 2020). Given their vulnerability to substance abuse, persons in prisons and jails have been the focus of many researchers and policy makers. The importance of substance abuse treatment programs that straddle incarceration and the community following reentry has been highlighted repeatedly by several researchers (e.g., Binswanger et al., 2007; National Institute on Drug Abuse, 2019; Ranapurwala et al., 2018). While previous research has shown that relapse occurs at rates similar to those for other chronic illnesses such as diabetes, hypertension, and asthma (National Institute on Drug Abuse, 2018), MAT programs are likely the best available options for substance-abusing offenders both during incarceration and following release to the community. These programs allow clients and treatment providers to work on the underlying causes of clients' substance abuse while maintaining sobriety. The focus of our study was one that included group and individual therapy and the administration of (naltrexone) Vivitrol injections.

In general, clients revealed various life experiences (e.g., prior physical and sexual abuse) and mental health issues that lessened the odds for successful recovery from addiction. However, responses gathered during interviews with the JTCMAT program participants and staff were overwhelmingly positive, corroborating the earlier research by Velasquez et al. (2019). The logistics of the program (e.g., eligibility screening, treatment, transportation to the community treatment facilities, Vivitrol injections, etc.) provided a relatively seamless treatment protocol during the incarceration period. Upon reentry, transportation issues and insurance denial of coverage for Vivitrol sometimes become critical issues. Supplemental interviews should be administered with program participants, including inmates currently enrolled in the program, inmates who have completed the program and have successfully transitioned back into society, and inmates who were reincarcerated after completing the program. These interviews would help us to gain a deeper understanding

of the strengths and weaknesses of the program, as well as risk and protective factors that might impact treatment results.

Although the presence of co-occurring substance use and mental health disorders among survivors of trauma and abuse is a well-established research finding, there is a need for improved understanding of their prevalence and related mental health treatment requirements among justice-involved individuals. Our study design did not lend itself to more fully examine these relationships; however, we encourage further exploration in future research endeavours with offenders engaged in similar jail to community programming.

In addition, further research is needed to examine the potential for “fatal overdose at the end of a dosing interval, after missing a dose . . . after discontinuing Vivitrol treatment [or during] attempts to overcome blockade” (USFDA, 2019). Additionally, research that can more carefully establish which pharmaceutical treatment is most effective with clients with different patterns of abuse will help to establish a protocol that will result in more personalised and effective MATs.

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Trauma-Informed Practice and Desistance Theories: Competing or Complementary Approaches to Working with Children in Conflict with the Law?

Jonathan Evans*, Dusty Kennedy, Tricia Skuse and Jonny Matthew.

ABSTRACT

This article considers two practice developments in Welsh (UK) youth justice: desistance-informed practice and the trauma recovery model (as applied in an intervention known as enhanced case management). The potential complementarity of these two approaches to working with trauma-experienced young people in the criminal justice system is explored with reference to the theoretical literature and an evaluation of enhanced case management.

Key Words: Desistance; Trauma; Youth Justice; Practice.

INTRODUCTION

This article considers the convergence, and potential complementarity, of two recent developments in youth justice practice in Wales (UK): the application of desistance theories with children in conflict with the law; and the use of trauma-informed approaches with young people assessed as having had adverse childhood experiences (ACEs). The policy and practice framework of the ‘New Youth Justice’ (Goldson, 2000), established by the Crime and Disorder Act 1998, was informed by the Risk Factor Prevention Paradigm (Farrington, 2007) which identified and addressed those risk factors likely to predict future offending. More recently, interest in desistance theories has been rekindled and practitioners across England and Wales have been exhorted to adopt practices likely to promote desistance (HMPI, 2016). Whilst it has been argued that ‘what works’ approaches drawing upon RNR (Risk Need Responsivity) principles (Andrews & Bonta, 2014) and core correctional practices (Ugwudike & Morgan, 2014) are compatible with desistance

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theories (Maruna & Mann, 2019), the implications of shifting to a desistance paradigm are potentially profound.

In Wales, the growing awareness of the extent to which young people in the youth justice system are exposed to childhood adversities led to the adoption of enhanced case management (ECM), an approach based on the trauma recovery model (TRM) (Skuse & Matthew, 2015). The positive evaluation of the approach (Cordis Bright, 2017) was regarded as broadly consistent with the prevailing philosophy of ‘Children First, Offenders Second’, a central organising principle of the Welsh strategy (Welsh Government & Youth Justice Board, 2014), and resulted in trauma-informed practice being given prominence in the *Youth Justice Blueprint for Wales* (Ministry of Justice & Welsh Government, 2019a). In recognition of the gendered nature of offending careers and desistance processes (Giordano, Cernkovich & Rudolph 2002), it is important to mention that a *Female Offending Blueprint for Wales* is also being developed (Ministry of Justice & Welsh Government, 2019b). At the outset, it is important to acknowledge that there is need for more research and innovative practice with this vulnerable group.

This article first explores the theoretical and research context of these practice developments by outlining the salient features of desistance theory and reviews the literature upon which the TRM is based. The second section considers the nature of desistance-informed practice before describing how trauma-informed interventions are being developed. The final section draws tentative conclusions about what is known about the effectiveness of the trauma-informed approach being developed and the extent to which it can complement current interpretations of the desistance literature.

THEORETICAL CONTEXT

Desistance Theories

The Edinburgh Study of Youth Transitions and Crime, which tracked a cohort of 4,300 young people, suggests that offending is normative amongst young people. McAra (2018, p. 6) reports that 96% of the cohort admitted to committing at least one offence, but 56% had desisted by the age of 18 years and 90% by the age of 24 years. A key implication,

therefore, is that pathologising ‘offenders’ should be avoided. Desistance theorists and researchers ask why young people stop or continue offending, rather than why they commenced in the first place. The four main findings of the Study can be summarised as follows (McAra & McVie, 2010): persistent offending is associated with victimisation, vulnerability and social adversity; early identification of ‘at risk’ children is not an exact science, and contact with both the criminal justice and welfare systems risks labelling (Lemert, 1951), stigmatising and increasing the probability of re/offending; pathways into and out of offending are facilitated or impeded by critical moments and key decisions made by practitioners and other significant adults; and diversionary strategies facilitate the desistance process. It should be noted that the case for the positive impact of diversion on the desistance process has recently been strengthened by findings from a longitudinal twin study (Motz et al., 2020).

It should be acknowledged that ‘Desistance Theory’ is not a monolithic theoretical edifice; rather, there is a wide range of desistance theories that some have sought to organise into a coherent set of explanations. One such attempt groups these theories under ‘internal’ and ‘social’ factors influencing desistance (Maruna, Coyle & Marsh, 2015).

Internal factors can be divided broadly into those that relate to the maturation process and those concerned with identity and cognitive transformation. Understandings of maturation draw upon neuroscientific evidence on the development of the adolescent brain, including the process of synaptic pruning and changes in the limbic system. The evidence derived from Functional Magnetic Resonance Imaging indicates that the pre-frontal cortex, which is responsible for cognitive functioning and impulse-control, reaches maturation when young people are well into their twenties or beyond (Blakemore & Choudhury, 2006; Cohen et al., 2016). The maturation process is, however, highly individualised and can be accelerated or impaired by environmental factors, including child-rearing practice (Copeland et al., 2018; Teicher & Samson, 2016). The risk of placing an exclusive emphasis on the maturational account is that it can lead to a rather deterministic outlook. Some might argue that little meaningful work can be undertaken with adolescents until they exhibit clear signs of maturing. In the case of those whose development has been

delayed as a result of trauma, this deterministic perspective risks descending into pessimism. Conversely, if practitioners take full account of the adolescent development research (including the impact of trauma), they can calibrate their practice to the cognitive and emotional needs of the individual service user. Encouragingly, literature from the field of neurobiology also points to the neuroplasticity of the brain and opportunities for recovery, especially during adolescence (Blakemore, 2013; Hughes & Baylin, 2012).

The second area that could be placed under the ‘internal’ heading comprises three main elements: ‘narratives’ and ‘scripts’ (Maruna, 2001); identity (Paternoster and Bushway, 2009; and ‘hooks for change’ (Giordano, 2016). The concept of ‘scripts’ is integral to the narrative approach to working with young people and is based on the idea that children receive and internalise clear messages about the nature of their personalities as well as sets of expectations about future conduct and prospects. Early scripts are written by parents, teachers and significant others, but will continue to shape the behaviour of individuals into adulthood. Many young people in conflict with the law will have received negative messages, including the ascription of the master identity of ‘offender’ that are described by Maruna (2001) as ‘condemnation scripts’. Such scripts curtail ambitions and undermine belief in personal agency. In other words, the future is not freely chosen, it is pre-ordained. However, when people realise they are not condemned to repeat these ‘condemnation scripts’, it becomes possible for them to write their own ‘redemption scripts’ and navigate their way toward prosocial behaviour. Past actions and the challenging circumstances of the present inevitably place material constraints on their range of choices, but the epiphany that even limited choices are available can be the beginning of a process of change. Positive relationships with trusted adults are the vehicle through which much of this change occurs.

Linked to this belief is the idea that people can also choose to be different. The notion that identity is neither pre-determined nor fixed and is instead fluid and open to change is important. Paternoster and Bushway (2009) refer to ‘the working self’ (the present) and the choice that should be made between the ‘feared self’ (the sort of person one is likely to

become if a current trajectory is followed to its likely destination) and the ‘desired self’ (the type of person one ideally would like to become).

In order to undertake such a personal journey there need to be supports and opportunities in place to reach the desired destination. Giordano (2016) describes these catalysts as ‘hooks for change’. These can take the form of employment or training opportunities, stable accommodation, a valued leisure pursuit or a significant personal relationship. Such ‘hooks for change’ must be valued by the individual, who must also be cognitively and emotionally ready to take advantage of them (Hunter and Farrall, 2018). These personal odysseys are seldom linear and are typically characterised by lapses, reversals and – due in part to diffidence - self-sabotage. Additionally, it cannot be assumed that non-offending brings its own rewards as it can involve relinquishing material goods, valued friendships and excitement. Nevertheless, with appropriate support a positive direction of travel can be sustained. The empirical work of McMahon and Jump (2018) challenge the pessimistic presumption that adolescent desistance from offending is impossible.

The social factors that can enhance the desistance process have been summarised pithily as ‘a good job; a good relationship; and involvement in prosocial hobbies and interests’ (Maruna et al., 2015, p.162). Given the deprived neighbourhoods and marginalised communities from which most clients of the youth justice system are drawn, the legitimate opportunity structures available to them are scarce. Practitioners must therefore not only be good at working with children in a way that is sensitive to their individual cognitive and emotional needs, but also adept at intervening proactively on their behalf in such domains as education, training, employment, health, welfare benefits, accommodation, public care and, of course, criminal justice. Youth justice workers should be involved in assembling the structures and systems that can support and sustain the personal change these young people are attempting to effect in challenging circumstances.

Skills needed to facilitate desistance

Some of the practitioner skills identified as facilitating the desistance process are summarised below:

1. Helping the individual young person identify and remove barriers to their own desistance.
2. An empathic professional relationship utilising interpersonal and interviewing skills to assist and support the individual's attempts at desistance.
3. The model of change adopted should be one that assists the individual to acquire and maintain motivation, learn and refine skills (human capital), and access opportunities (social capital).
4. Practitioners should act as motivational counsellors, educators for human capital and advocates for social capital.
5. Practitioners should be active in the removal of barriers to desistance and intervene in systems in order to promote positive outcomes for service users. (Deering & Evans, 2018, pp. 10-11)

From the perspective of developmental psychology, there is a set of other considerations that are fundamental and have been largely neglected by the desistance literature. Firstly, a young person needs to have developed a sense of safety and trust in others (Geddes, 2006). Ideally, this evolves over time from the establishment of a secure base with the child's caregivers during infancy. Whenever a baby is dysregulated and a responsive parent meets this need appropriately, the infant calms down: they have, effectively, been co-regulated by their parent. If the parent/carer continues to meet the infant's needs then they become the 'secure base' for that child (Ainsworth & Wittig, 1969; Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1953 and 1988; Hughes, 2004). In responsive, nurturing care-giving environments the infant learns that adults are helpful, kind and trustworthy. Under normal circumstances this co-regulation is accompanied by positive attunement, attention, and time from focused caregivers. The combination of co-regulation and attunement feeds into the child's template for their understanding of the world. This internal working model (Bretherton & Mulholland, 2008) is located on a positive-negative spectrum. Those with a positive internal working model will have a worldview based on feeling valued and generally safe, and a sense that other people are available and trustworthy; whilst those from less nurturing environments are more likely to be less secure and trusting. If the internal working model is linked to the notion of 'scripts' (Maruna, 2001), it can be seen how positive relationships may serve as a portal to 'redemption'.

Another key task that begins in infancy is learning about feelings and how to manage them. Emotional regulation skills start to develop during the early years of life via co-regulation by a trusted adult (Fonagy, Gergely, Jurist & Target, 2002; Hughes & Baylin, 2012). Physical feelings such as hunger, thirst, temperature and fatigue are children's first experiences. Through repeated co-regulation from the caregiver, children learn to self-regulate their feelings by taking appropriate actions (e.g., pulling a blanket over them when they are cold). With continued co-regulation by the parent/carer, children learn to manage other feelings such as frustration, anger, excitement, sadness and happiness.

These fundamental components of normal child development may take place very early in life (Addyman, 2020) and appear a long way from the life of a young person involved in persistent offending, yet they are the building blocks upon which later functioning is based. Children that do not receive adequate co-regulation during infancy from attuned and responsive carers often display under-developed emotional self-regulation skills and exhibit lack of trust in others. Early years experiences may also impact on developing cognition (Bernier, Beauchamp, Carlson & Lalonde, 2015; Sutton, Utting & Garrington 2004). Securely attached children will explore their environment more than others (Hazen & Durrett, 1982), which in turn brings an associated higher degree of opportunities to learn and develop. If appropriate intervention is not put in place to help children attain these basic life skills, the resultant difficulties can persist into adolescence and beyond (McInerney, Finnegan, Ryan McGee & Gaffney, 2018; Pinto, Pereira, Li & Power 2017; Teicher, Samson, Anderson & Ohashi, 2016).

From a psychological perspective, it is not that desistance approaches lack utility; rather, they are only part of the solution. The desistance-informed approaches identified can work well with many young people who enter the youth justice system. However, for young people with a range of adverse childhood experiences and few opportunities to develop resilience, conventional desistance approaches are often beyond their reach as they rely on a level of emotional and cognitive skills that they may not have had the opportunity to acquire. To engage with a practitioner, one needs to be able to trust that s/he will not

inflict harm and can actually help. Participation in offending behaviour work, anger management programmes, victim empathy work, motivational interviewing, and restorative justice requires the individual to be able to sit calmly in a room with another individual, take turns in a conversation, understand things from someone else's viewpoint, weigh up the arguments, reason appropriately, consider future options, and consistently apply learning to behaviour. To take advantage of the available 'hooks for change', one needs to be able to recognise the benefits of doing so. These are all cognitive tasks. They are premised on the notion that individuals will have already attained relational skills that ordinarily develop in early childhood. They also rely on the ability to feel safe with adults, manage one's own feelings and feel positive enough about oneself and others to feel able to apply cognitive lessons. Moreover, one needs to be able to think beyond one's own lived experience, conceive a different future and feel sufficiently invested in it. If children's experience has consistently involved neglect, abuse, violence, insecurity, and a lack of care, young people will have little confidence in trusting others and will struggle to regulate their emotions. Moreover, they will find it difficult to predict a future that lies beyond the immediacy of daily survival.

This points to the need for practitioners working with this subgroup of young people to be mindful of individuals' developmental needs by tailoring and sequencing youth justice interventions in such a way that allows them to acquire the requisite skills. An understanding of what happens when children do not experience 'good enough parenting' is key to translating desistance-informed approaches into effective practice with those young people with complex needs. The previously mentioned elements that enhance desistance (Deering and Evans, 2018), 'hooks for change' (Giordano, 2016), and both the positive social factors (Maruna *et al*, 2015) and redemption scripts advanced by Maruna (2001), are all valid; but what is missing is when, how, and why they work. What is needed is an approach that pulls together knowledge of desistance theories, child development theory and research, the impact of adverse childhood experiences, and clinical practice. The TRM, developed in Wales, is an attempt to do this.

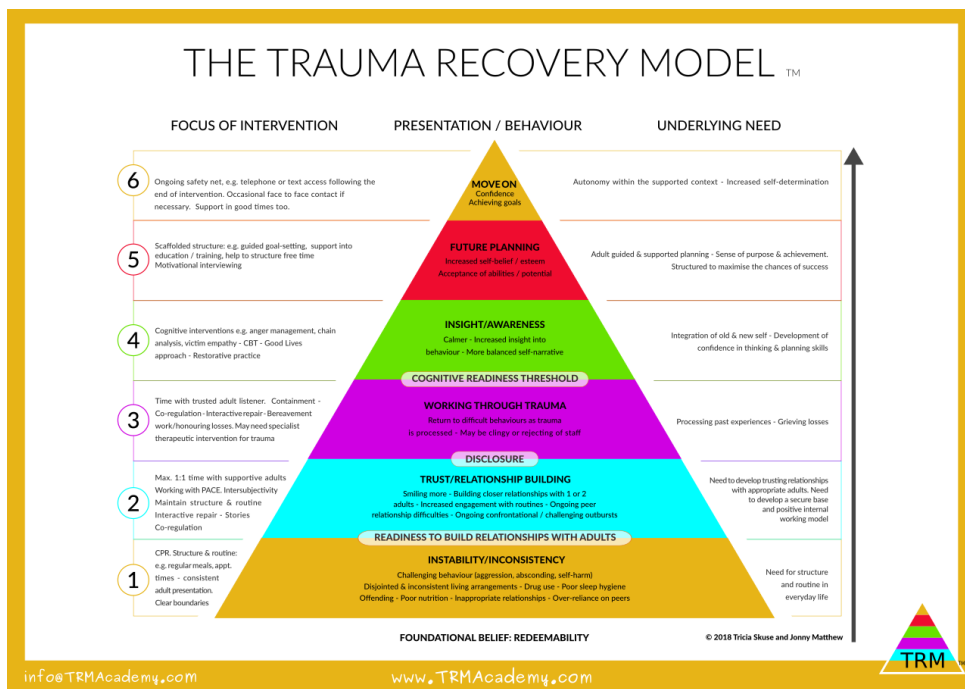
The Trauma Recovery Model

The trauma recovery model (Skuse & Matthew, 2015) comprises a series of layers of intervention that are sequenced according to developmental and mental health need. Essentially, it is based on a form of relational therapy that aims to mitigate the impact of developmental trauma in order to facilitate effective cognitive interventions. There are three key features to the Trauma Recovery Model:

- Presentation / behaviour
- Underlying need
- Focus of intervention

The information summarised within the triangle (Figure 1 below) relates to the presentation of the child; their behaviour; and current difficulties. On the right-hand side, outside of the triangle, are the kinds of underlying needs fuelling those problems; whilst the left-hand side contains a summary of the types of interventions best suited to address those needs. Application of the model assumes that if the developmental needs of the child can be met, the presenting problems will begin to fade. In this way, the TRM facilitates a way of working with children that places the emphasis on keeping development central and focuses both assessment and intervention planning along developmental lines.

Figure 1 *The Trauma Recovery Model*



The lowest two levels of the model draw on Maslow's hierarchy of needs (Maslow, 1943) which assumes that basic safety (e.g., from danger or abuse) and good physical care (e.g. warmth, food, stimulation) must be attained for healthy psychological development to occur. The initial emphasis of the intervention is on working in ways that offer as much consistency as possible. It is through consistency of time, place and personality over many weeks that the child starts to be able to trust the practitioner. This relationship then provides the vehicle through which opportunities for co-regulation, attunement and interactive repair can be maximised. The focus of the work is on the relationship with the practitioner, rather than on the offence. Once this relationship is established and becomes a secure base for the young person, s/he can start to process some of the trauma and adversity they have experienced. The TRM suggests that it is not until children feel safe, trust adults, and have had the opportunity to begin to make sense of what has happened to them, that they are ready to undertake more conventional cognitively based interventions. It is not until this point that young people are cognitively

ready to fully engage in traditional offence-related work or participate in the choices that Paternoster and Bushway (2009) or Giordano (2016) describe. Finally, the upper two layers of the model posit that services should aim to replicate what is routinely provided by caring parents in 'normal' child development. As their children mature, parents do not leave them to fend for themselves completely. They provide practical advice with college applications, take them to interviews and help with opening bank accounts. At this stage, parents do not undertake tasks for their children, but rather scaffold the activity to maximise the chance of success in order to support the behaviour and build confidence. Furthermore, when children are living independently, parents do not sever links. Instead they provide a safety net of support. Whilst this is more difficult for agencies to emulate, the opportunity for young people to 'touch base' by phoning in with news (good or bad) can often represent sufficient support and is in keeping with what would normally happen for young people when they leave their secure base.

Practice Implementation: Trauma-informed practice and the Enhanced Case Management Approach.

Trauma-informed practice is based upon an appreciation of the extent to which the capabilities, behaviours and emotional effect of systems (individuals, organisations or wider structures) are adversely influenced by challenging events and experiences that disrupt their ability to adapt successfully. This is coupled with an increased understanding of an evidence base relating to the prevalence of such events in the lives of both service users and staff within organisations that help people. Moreover, there is heightened sensitivity to how the very systems and processes established to help can unintentionally re-traumatise service users and staff. Thus, the experience of public care is too often characterised by multiple placements, serial changes in social worker, and the risk of criminalisation (Prison Reform Trust, 2016; Evans, 2018). Interest in how best to work with individuals in a trauma-informed way has thus developed into how services and wider systems, particularly those upstream of the criminal justice system, can be adapted and reformed to support trauma-informed practice. The definition of trauma has also widened to include not only severe 'events' that bring the risk of death or serious injury, but

also the cumulative impact of prolonged adverse experiences and/or complex combinations of adversity such as neglect and poverty. This has profound implications for public policy and practice. A recent systematic review of the literature (Walsh, McCartney, Smith & Armour, 2019) found a strong association between lower childhood socio-economic position and exposure to adverse childhood experiences and maltreatment. They conclude that not only should those affected receive appropriate support at the appropriate time, but macro-economic and social policies should aim to address poverty and inequality in order to reduce the risk of future generations of children being exposed to damaging experiences. In the meantime, it is important for practitioners to develop anti-poverty strategies and practices with children, as is being done in the field of social work (BASW & CWIP, 2019).

Reforming agencies and building trauma-informed organisations that empower practitioners to develop safe and positive practices with service users is a work in progress, but there are promising examples of good practice from which lessons can be drawn (Brown, Harris & Fallot, 2013; SAMHSA, 2014). While most governmental monitoring and inspections frameworks judge the efficacy of organisations through the lens of efficiency, monitored via a number of process measures or service delivery/intervention outcomes, these trauma-informed frameworks focus instead on how organisational behaviour takes account of service user and staff perceptions and feelings. They prioritise service user and staff involvement in organisational design and decision making through consultation, collaboration and co-creation. The ECM's focus on the relational understanding of children, their developmental experiences and the contexts they inhabit, tends to result in better engagement and fewer resources required to enforce compliance. Similarly, structures and systems built on this trauma-informed approach have the potential to deliver better and more cost-effective services because they understand and involve the people they serve.

The ECM developed in response to the high prevalence of adverse childhood experiences in the Welsh youth justice cohort and a collective desire to test a theoretical and practice framework that could help facilitate the desistance of the most prolifically offending young people in Wales.

In 2012 YJB Cymru undertook a study profiling 112 children who had criminal histories of 25 or more convictions and an average re-offending rate of 86%. This revealed significant levels of traumatic experience and distress. Most of these children (predominantly boys) were aged 16 or 17, 84% had no written record of any educational achievement (formal or informal qualifications), 41% had been on the child protection register, nearly half had witnessed domestic violence, and almost two-thirds had suffered early childhood trauma or neglect (Johns, Williams & Haines, 2017). The study itself was prompted by claims from youth offending team (YOT) managers in Wales that the reductions in numbers of children receiving a caution or conviction in England and Wales - down by 85% between 2007 and 2010 (Ministry of Justice 2018) - had left a residual 'hard core' of persistently offending children with complex needs and experience of adversity. It appeared that while the youth justice system was effective at diverting most young people from formal sanctions or facilitating desistance at the lower level tariffs, there was need to work in a different way with those children with more complex case histories; a way which sought to address underlying needs before attempting to address offending behaviours.

In response to the findings of the study, YJB Cymru issued a call for practice to the youth justice sector to find new ways of working. Among those responding were those who had developed the TRM in a secure setting and who recommended this be trialled within the community-based youth justice system. Following their presentation to the Wales Practice Development Panel (comprising representatives from YJB, Welsh Government, the youth justice sector and Welsh universities), there followed a period of collaborative work with YOTs to devise a process through which the TRM could be integrated into youth justice work with these more challenging children. This was tested in three YOTs in three regions of Wales over three years from 2013. Enhanced Case Management has six key elements:

1. Training for all YOT personnel in both the TRM and the theoretical/technical foundational knowledge that underpins it - including attachment theory, child development and neurobiology.

2. A clinical psychologically-led team case formulation meeting, in which a physical timeline of key events in the child's life is charted to inform interventions (the meeting involves as many key agency staff as possible, takes account of information provided by family members and by the child, and focuses on positive as well as adverse factors).
3. A clinical psychology formulation report with a set of recommendations for both the type of interventions that match the child's developmental and cognitive level but also the manner and sequence in which these interventions are best delivered.
4. Clinical supervision from a clinical psychologist for practitioners (considered essential due to the higher emotional engagement from practitioners required).
5. Regular reviews where the formulation is revisited, and adjustments made to take account of the child's progress, new challenges or information.
6. Guidance for YOT middle and senior management to facilitate building trauma-informed organisational scaffolding to enable this more relational way of working.

Whilst this may sound expensive, in practice it has largely involved a redistribution of existing resources, such as greater direct contact with youth justice workers at the earlier stages of intervention with a corresponding reduction in staff time dealing with non-compliance and breach later in a court order. The key additional resource is the introduction of clinical psychology. However, as this is a consultation-only approach rather than direct therapy, it is comparatively cost efficient. For the annual cost of one bed in a young offender institution (£117,165) (legislation.gov.uk), a clinical psychology service could support 44 children in the community. This would include the added benefits of keeping children in their home areas and improved coordination of support between local YOTs, health services, education, housing, youth work and community resources.

Initial results of the ECM were encouraging. An evaluation of a three year 'proof of concept' test (Welsh Government, 2017) showed a range of benefits; a selection of which are summarised below.

- *Better engagement from young people:* The majority of interviewees agreed that young people's engagement with the YOT and with the requirements of their Orders improved during participation and was often described as being better than expected or hoped, based on previous experience of working with the young person and/or with someone with similar needs. Some cases were highlighted where previous work with young people prior to the test had been extremely difficult (e.g. high conflict, low engagement, low attention, low trust, low or no communication). Stakeholders described how the ECM had enabled better quality relationships, leading to a 'breakthrough' with these young people, (e.g. improving communication and increasing engagement).
- *Aspects of life that support desistance had improved for the young people during the ECM:* Improvements in areas such as emotional resilience, self-confidence, and independent living skills were reported by staff. Young people broadly agreed, highlighting reduced substance misuse, increased ability in efforts to reduce financial debt, improved anger management and conflict management skills.
- *Collaborative and Integrated Working:* The approach facilitated closer working between youth justice, social care, out of home care, education, housing and mental health services, and helped move many young people who were on the cusp of custody to re-engage with education, training and employment.
- *Reductions in the frequency and severity of re-offending and an increase in the intervals between offences.* There was evidence that the ECM appeared to facilitate the desistance process.
- *Staff reported gains in their own abilities:* Practitioners reported improvements in the identification of young people's underlying developmental and mental health needs, as well as being more able to address them effectively.

The ECM evaluation recommended a wider trial of the approach, which since 2017 has duly been followed in all seven local authorities in the South Wales region (a second evaluation is now close to completion).

The approach has also been endorsed for national implementation (Ministry of Justice & Welsh Government, 2019).

CONCLUSION

The salient points to highlight from the first evaluation of the ECM are those relating to increased practitioner engagement with children and the greater degree of insight it afforded into their lives and feelings. It is these factors that are perceived to have led to the children involved achieving emotional and cognitive readiness to take advantage of the ‘hooks for change’ that have been the staple of YOT work for almost 20 years (and, arguably, for probation and social workers for a century before that). The ECM and the adoption of TRM did not halt the YOT focus on education, training, employment, housing and finance; but for those children least able to take advantage of opportunities or ‘hooks for change’, they fulfilled a kind of corporate parenting role that represented a secure base from which they could develop a more confident and self-assured internal working model (which could be translated into the language of desistance in terms of ‘scripts’ and ‘narratives’). Practitioners have reported that a surprising measure of progress towards emotional self-regulation and the higher cognitive levels of the TRM can be made through consistent application of relatively simple ‘being with’ interventions at the lower levels of the model. These interventions appear to disproportionately fill the gaps in development left by inconsistent, neglectful or negative parenting (generally provided by adults who experienced similar childhoods or found themselves parenting in circumstances of acute adversity).

This article has argued that trauma-informed practice and key ideas from the desistance literature are complementary. Nevertheless, children should not have to wait until they are in the youth justice system before receiving interventions designed to meet their welfare needs. It is to be hoped that the promising approach described in this article will influence practice with children in other domains, thereby diverting many more from the process of criminalisation.

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The working relationship and desistance: What constitutes a ‘good quality’ working relationship?

Zoe Cross*

ABSTRACT

This paper presents findings from a small-scale exploratory piece of research that examined perceptions of what constitutes a ‘good quality’ working relationship between the practitioner and the child, within the criminal justice system. Using a qualitative approach, focus groups and interviews were conducted with practitioners and children, based in two Youth Offending Teams in Wales, United Kingdom. The study sought to explore the characteristics of a ‘good quality’ working relationship, from two different perspectives: (1) the practitioners and (2) the children. Using thematic analysis, findings revealed that whilst both practitioners and children perceived trust to be an important characteristic of a ‘good quality’ working relationship, differences between their perceptions did exist, with practitioners focussing more on the characteristics of reliability and time; and children highlighting the characteristics of genuineness and comfort. It was concluded that such disparity between the way practitioners and children perceive a ‘good quality’ working relationship has important implications for youth justice practice and desistance for children.

Keywords: desistance, practitioner, children, relationship, youth justice.

INTRODUCTION

To begin, this paper positions the research within the broader context of desistance literature, and this will be followed by an overview of the research approach and methodology used by the study.

Context

Whilst the number of First Time Entrants (FTEs) to the criminal justice system (CJS) has fallen by 86% since 2008, the number of children reoffending has increased in the same period, rising from 38% to 41% (Ministry of Justice, 2019). Reoffending by children was estimated to cost

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England and Wales £1.5 billion during 2016-2017 (Newton et al., 2019). Policy makers would benefit from understanding more about what works to increase desistance, as fewer offences would not only reduce economic costs and make communities safer, but would afford children their rights to achieve their full potential and to reintegrate into society (Unicef, 2020).

In England and Wales, children who commit criminal offences are dealt with by Youth Offending Teams (YOTs), which were established by the *Crime and Disorder Act 1998* (GOV.UK, 1998). This Act also established the Youth Justice Board (YJB) to oversee and direct YOT practice. Usually, the police are the first people to contact their local YOT, however, family members and friends can also contact the YOT if they are concerned about a child's behaviour. As well as supporting the child to desist from offending, YOT practitioners also help children and their families in other ways, such as supporting children and their families at court, supervising children serving a community sentence, and maintaining contact with a child whilst they serve a custodial sentence. Whilst YOTs are part of local councils and are separate from the police and the courts, they do work closely with other services, including police, schools, probation and children's services. When a child is first known to the YOT, they are assessed in an attempt to understand the factors that might have brought the child into contact with the YOT. This assessment also helps the practitioner to identify the specific needs of the child, allowing an individualised support package to be put in place. Assessments are conducted using the AssetPlus framework (GOV.UK, 2020), which as a tool offers end-to-end assessment for children (GOV.UK, 2020).

In fairly recent years, research has moved away from a risk-based, offender-related approach to reoffending, and instead, has started to take a more desistance-focused, strengths-based approach (Fortune, Ward, & Willis, 2012). Whilst there is no single theory of desistance, a number of strands have been highlighted as being important, including the role played by social factors (such as social capital). Whilst there is no single definition of social capital, it has been defined as “the links, shared values and understandings in society that enable individuals and groups to trust each other and so work together” (OECD Insights, 2020). Research suggests that individuals that have strong bonds, for example to family, friends,

romantic partners, employment and education, are more likely to desist (Doekhie, 2017; Farrington, 2015; Hirschi, 1969; Lee, Moon et al., 2017; Sampson & Laub, 1993; West & Farrington, 1973). However, existing literature also emphasises the importance of individual factors, such as the transformation narrative, where an individual replaces their past, criminal self with a new, pro-social self (King, 2013; Liem & Richardson, 2014; Stevens, 2012; Stone, 2015; Stone, Morash et al., 2018; Vaughan, 2007).

Although research suggests that each of these elements play a role in desistance, more recent research has consistently highlighted the importance of the working relationship between the practitioner and child, which falls into the social strand of desistance. A report published by Her Majesty's Inspectorate of Prisons (HMIP, 2016, pg7) stated that having "a balanced, trusting and consistent working relationship with at least one worker" was linked to an increased likelihood of desistance from offending. Nacro (2013) also highlighted the importance of building positive working relationships between practitioners and young adults who have offended, suggesting that such a relationship is an integral part in the desistance process; thoughts echoed by Drake, Fergusson, and Briggs (2014) and Lewis (2014).

Research by Creaney and Smith (2014) posits that when a practitioner is respectful to a child and listens attentively to their narrative; and is also genuine in doing so, barriers to desistance can be overcome, and desistance is made more likely. Furthermore, research has emphasised the need for practitioners to take a more humanistic approach when working with children (Mason & Prior, 2008), with research by Everall and Paulson (2002) showing that children were more responsive to practitioners who presented themselves as allies, rather than authoritative figures.

Developing a 'good quality' working relationship is, according to Prior and Mason (2010), key to engaging children in interventions aimed at increasing desistance; arguing that passive involvement by the child, will result in desistance being less likely. Trevithick (2005) also commented that a practitioner is more likely to be effectively persuasive and directive, if they have a good relationship with the child they are working with. What is not fully understood though, is what constitutes a

‘good quality’ working relationship (Prior & Mason, 2010), which is the focus of this research paper.

Social Bonds theory (Sampson & Laub, 2005) states that offending is a normal activity that is the result of a lack of social controls, which are usually built through social bonds and turning points over a life course. Turning points are referred to by Elder (1986) as changes in the life course that have the ability to alter an individual’s life trajectory. Doherty (2006) also found support for the link between social bonds and desistance, with findings indicating that as the level of social integration increased, the probability of offending decreased. The same was also true of self-control: as a child’s level of self-control increased, the likelihood of offending decreased. The Social Control theory (Hirschi, 1969) sees offending behaviour resulting from social institutions losing control over individuals, and posits that crime occurs when social bonds are either not strong in the first place, or become weakened. Research indicates that individuals who have strong social bonds to institutions will be less likely to commit offences for fear of disappointing those individuals they value (Costello & Laub, 2020).

However, research also emphasises the importance of having quality social bonds, thus indicating that it might not be enough to be in a relationship; the quality of the relationship might also matter (Barr & Simons, 2015).

Individual Factors

A relatively recent research focus has placed increased significance on the role played by individual processes such as identity change, suggesting that desistance maybe more cognitive and individualistic than once thought (Paternoster, Bachman, Kerrison, O’Connell, & Smith, 2016). For instance it has been suggested that an individual who has offended has (1) a ‘*working identity*’ (current) that has linked preferences and social networks; (2) a ‘*positive possible self*’ (the person they wish to be), and (3) a ‘*feared self*’ (the person they fear they might become). Paternoster and Bushway (2009) go on to suggest that an individual is committed to their ‘*working self*’ until they determine that the cost of this commitment is greater than the benefits; and a process named *crystallization of discontent*

occurs when the person links their life failures to the anxiety they feel about becoming their 'feared self'. This is what motivates them to change initially; and brings with it, a new set of preferences and social networks, as the newly emerging sense-of-self (pro-social) begins. McNeill, Farrall, Lightowler, and Maruna (2012) talk about the need for children who have offended to develop a pro-social identity, suggesting that individuals who desist tend to have high levels of self-efficacy; perceiving themselves as having more control over their futures, with a clear sense of purpose in the world.

Youth justice services and the practitioners who work within services, have an important role to play in supporting a child's shift to a pro-social identity (Bateman & Hazel, 2013). It makes sense then, that if a practitioner has a 'good quality' working relationship with a child, they would be in a better position to help support a child shift to a more pro-social identity. Therefore, this paper's focus on exploring what constitutes a 'good quality' working relationship, could potentially have important implications for the way in which practitioners help foster a positive identity in the children they work with, helping them along their desistance journey.

Whereas Laub and Sampson (2001), and indeed Giordano et al. (2002), suggest that identity transformation takes place during the secondary desistance phase King (2013) instead posits that identity formation takes place much earlier. This has significant implications for practitioners in terms of the role they play in offering children recognition that they are desisting successfully, incorporating this sense of achievement into the child's desistance narrative as early as possible.

The findings of the research will be framed thematically based on the perceptions of practitioners and the children, addressing three research questions:

1. What are the characteristics of a 'good quality' working relationship from the perspective of practitioners working within the Youth Offending Service?

2. What are the characteristics of a ‘good quality’ working relationship from the perspective of children known to the Youth Offending Service?
3. What is the degree of consensus between practitioners and children regarding the characteristics of a ‘good quality’ working relationship?

METHOD

Methodological Approach

Prior to the commencement of the fieldwork, ethical approval was gained from the Ethics Committee at the University of South Wales. A qualitative research framework was chosen for this study because of its suitability to the overall aim of the study which was to explore the working relationship; which in turn led to the development of the three research questions that elicited perspective, experience and meaning from the participants (Hammarberg, Kirkman, & de Lacey, 2016).

Using a qualitative research approach, this study used semi-structured interviews with both practitioners and children, and focus groups with only practitioners. The rationale for conducting focus groups with only the practitioners was two-fold. Firstly, it was deemed unethical to put a group of young people who had offended, together to discuss sensitive issues, in front of peers; and secondly, for pragmatic reasons, in that working with children is rarely straightforward. Semi-structured interviews were conducted first and were chosen because they allowed the interview to remain concentrated on the desired line of enquiry, i.e. perspectives of a ‘good quality’ working relationship. Due to its semi-structured nature, optimum use was made of the limited interview time with participants, because the interviewer was able to keep the line of questioning focused, using mainly pre-determined questions (DiCicco-Bloom & Crabtree, 2006). However, semi-structured interviews did allow for an element of conversation to take place between the interviewer and the interviewee. Such two-way communication enabled the interviewer to follow topical trajectories within the conversation, where appropriate (Keller & Conradin, 2019).

A focus group was conducted after the interviews, and the themes discussed during the focus group were based on the themes that had emerged from the initial interview analyses. A focus group was used because it allowed the study to gain an in-depth understanding of the practitioner's perspectives of the most frequently stated characteristics of a 'good quality' working relationship, as discussed during the interviews by the practitioners and the children. During a focus group discussion, because the researcher takes on a peripheral role, participants have space to engage in interactive discussions (Krueger & Casey, 2000); and because focus groups are purposely collective in nature, they allow participants to interact and influence each other during the discussion, as they consider each other's perspectives (Patton & Patton, 2002). Furthermore, because the focus group discussion centred on the emerging interview themes, it allowed for an element of triangulation (Bryman, 2015).

Sampling

A total of 18 participants took part in this study: 13 practitioners and 5 children. Whilst this is a small sample group, it is important to highlight that generalisability was not the aim of the paper. Instead, the aim was to provide a rich, contextualised understanding of the working relationship from the perspectives of practitioners and children.

All practitioners worked for a YOT in Wales, and all children were known to the YOTs. As the study was interested in exploring a variation in perspectives among practitioners and children, a heterogeneous purposive sampling method was used, which allowed the study to capture a wide range of perspectives from various angles, affording greater insights to be gained (Etikan, Musa, & Alkassim, 2016). The YOT managers were asked if they could offer job role variety in the sample of practitioners, and due to the vulnerability of the children known to the YOTs, the decision as to which children were suitable to be interviewed, was left to the YOT manager. However, the study did request that only children who had reoffended were considered for the sample and the study also requested for the children to be as varied as possible in terms of offence type. The sample group of practitioners was made up of 8 males and 5 females and were aged between 25 and 64 years; and all children interviewed were male, with ages ranging between 14 and 17 years.

Data Analysis

Thematic analysis was conducted on the transcripts because thematic analysis allowed semantic and latent themes to be identified (Maguire & Delahunt, 2017). To conduct the analysis, the researcher used Braun and Clarke's (2006) 6-step framework because it offered a clear model for doing thematic analysis, which involves: (1) becoming familiar with the data; (2) Generating initial codes; (3) Searching for themes; (4) Reviewing themes; (5) Defining themes; (6) Writing up. Using this framework, data analysis began with the researcher becoming familiar with the material. Interviews and focus groups were transcribed and the transcriptions were read and re-read, with initial thoughts and ideas noted down. Initial codes were then generated, which involved the researcher annotating sentences and paragraphs with key words that they felt captured the essence of what was being said by the participants. This included anything interesting and meaningful. Once initial codes had been generated, themes were identified, and codes were combined into broad themes. Themes were then reviewed and were combined, separated, refined or discarded, where necessary. The researcher ensured that the data coded to the themes were meaningful and made sense; and themes were checked against the material coded into them. The last stage of data analysis involved the researcher developing a thematic map, where themes were organised coherently.

Data analysis revealed four central themes identified by the practitioners and the children as being characteristics of a 'good quality' working relationship: (1) trust, (2) reliability, (3) time and (4) comfort.

FINDINGS AND DISCUSSION

Themes

1. Trust and Genuineness

Both the children and practitioners perceived trust to be a significant characteristic of a 'good quality' working relationship. For children, trust was perceived as being able to rely on their Case Worker, for example "*Someone who you know is always going to be there when you need them*". Children emphasised the importance of practitioners being trusted not to judge them "*They're not going to throw it back in my face*". Other characteristics were also mentioned when discussing trust. For instance,

talking about trust in terms of not being ‘messed around’ by the practitioners, such as being able to trust that the practitioner will do what they say they will do; trust that the practitioner will be straight in what they have to say; which ties in with pro social modelling (Trotter, 2009). For example, *“They ain't there just to mess around; to say one thing and do another. If you say something you got to do it... Don't beat around the bush. They're honest and straight up”*. Children also talked about trust in terms of genuineness, for instance *“I don't like fake people...I like honest and straight up...”* For many children trust does not come easily because they have either never had a trusting relationship before, or they had once trusted but had been let down (All Party Parliamentary Group for Children, 2014). Trust is particularly important to these children because a significant number have suffered trauma during their childhood; for instance, it is estimated that 91% of children known to the YOS, who have committed violent offences, have suffered abuse and/or loss (Wright & Liddle, 2014). Traumatic childhoods for these children are not only common, they can also have a significant impact on a child’s wellbeing, both physical and emotional. This is because, the brain is a ‘social organ’, in a constant state of responding to experience. So if a young person has grown up living in constant fear or danger, their brain becomes *hyper*-alert to fear and danger, and *hypo*-alert to pleasure. The brain of a child constantly changes with experience, and as an adult, if you have been raised in a healthy environment and then something bad happens, that injures only a small piece of the whole brain structure. However, toxic stress in childhood (such as abandonment or chronic violence), has a significant negative impact on the capacity to pay attention, to learn, to see where other people are coming from (perspective taking), making it very difficult for a child to behave in a socially acceptable manner. Research has demonstrated that it is possible to rewire the brain, for instance, by making children feel safe and secure; helping them to create a sense of safety inside themselves (Kolk & Bessel, 2017). This could be a possible function of the practitioners who work with the children: to help a child feel safe and secure, in a bid to rewire the brain and assist them in the process of leading a pro-social life. When a child suffers severe trauma, it impacts negatively, their ability to live their life resiliently, with resilience being regarded as “capacity to adapt in the face of challenging

circumstances, whilst maintaining a stable mental wellbeing” (Mind, 2020, n.d.). Over the past twenty years research has extended our understanding of how trauma impacts a child’s wellbeing, including the neurobiology of trauma (Black & Slavich 2016; Centers for Disease Control and Prevention, 2016). For instance, early trauma has been linked to dysfunctional neural circuits, dysfunctional behaviours, mental health issues, and difficulty managing emotions (Groger et al., 2016), as well as offending behaviour (Smith et al., 2006; Zelechowski, 2016). Trust has also been tied closely to a child’s self-esteem (McCarthy et al., 2017; Weining & Smith, 2012), including in the context of trauma therapy. For instance, in order for a child to engage fully in therapy aimed at building a child’s self-esteem and altering the child’s negative internal narrative, it is imperative that the child trusts the process of therapy (Bradshaw, 2016). This further highlights the importance of the child trusting the practitioner, and children in this current study commented that they were more likely to engage in any support offered by the YOT if they trusted the practitioner who was recommending the support.

Thus, for many children, trust was seen as a paradox: they had learnt over time that it was safer for them not to trust, including practitioners. It was mentioned frequently by the children, that they were able to spot practitioner insincerity very quickly, and to children, falseness was perceived as a lack of priority and effort on the practitioner’s part; giving the children the impression they were not worth the effort; that the supervision meeting, and any support offered, was more about ticking boxes, than truly wanting to help the children.

Conversely, when practitioners talked about trust, they often talked about ‘professional trust’, which they likened to a pseudo-friendship, for example *“There’s a certain level of gaining trust and gaining their friendship almost; not in the true sense a friendship, but its first name basis”*. Practitioners perceived it necessary to build a pseudo-friendship; a professional relationship, in order to build a foundation. With a solid foundation, practitioners indicated that the work they do with the children; the meetings they have with them, become more natural, allowing the practitioner and indeed the child, to gain more out of the supervision. Whilst many of the younger practitioners perceived it important for

children to like them in order to build a ‘good quality’ working relationship, older practitioners focused more on getting children to respect them. For many practitioners, trust and respect go hand in hand, in that they perceived it would be easier for children to trust them, if they respected them as a professional. Trust could be regarded as something that is intuitive (Exploring Your Mind, 2017), and this ties into what the children said about being able to identify genuineness from practitioners almost instantly. Practitioners also commented that trying to develop a working relationship is made more difficult because not only do time constraints get in the way of the working relationship being allowed to develop more organically, but they are being guided by the agenda of reducing the likelihood of reoffending; with some practitioners choosing to keep this agenda hidden, whilst others stated they were upfront and explicit from the first supervision. The importance of trust was also discussed by practitioners in the context of the Enhanced Case Management model (Youth Justice Board, 2017), for instance *“I think this links back to the ECM model and what we try to do there because the primary aim there is to build a positive relationship; trusting, that they think they can come back to you.”* Whilst the number of first time entrants to the youth justice system has reduced significantly in recent years, the young people that remain in the system often have a complex set of needs, and are often troubled; so in 2015 the YJB piloted a new and enhanced way to work with these children, called Enhanced Case Management (ECM), which uses the Trauma Recovery Model (TRM) (Skuse & Matthew, 2015), which was tested by three YOTs in Wales, over a one-year period. Building on the success of the Welsh pilot, the ECM model is currently being trialled across English YOTs (2019-2020). The ECM approach, using the TRM, implies that desistance from youth offending is a lot more complex than previously thought. The TRM is a psychological approach of working with children known to the YOTs with complex needs and theorises that children need to work their way through various progressive stages before they can successfully engage in any intervention designed to reduce their likelihood of reoffending. These stages are: (1) routine and structure; (2) trusting relationships; (3) processing past experiences; (4) integration of old and new self; (5) adult-guided support

planning; and (6) autonomy within a supportive context (Skuse & Matthew, 2015).

2. Reliability

A characteristic that relates closely to trust is the characteristic of reliability (Trotter, 2009). When practitioners and children talked about the role of trust, they often referred to it in the context of reliability and consistency; thus it could be argued that trust is a broader concept that encompasses other elements, such as reliability. Burton (2019) talked about reliability versus trust and concluded that trust is established when we allow a person at least some responsibility for something that we ourselves value, thus making ourselves vulnerable to the other person. In this sense, children trust that practitioners can be relied upon. Often when practitioners talked about reliability they were referring to the practical aspect of the working relationship, particularly the need for practitioners to keep their word; to do what they say they are going to do, for example *“being honest, punctual, being there when you say you will be”*. For many practitioners, reliability was contextualised pragmatically, not just for the benefit of the child in terms of their reoffending, but also for the practitioner, in terms of smooth running and ease. Some practitioners emphasised the importance of reliability for ECM cases *“with ECM, a big part is consistency and reliability. Things like making sure you have your appointments at the same time, making sure that you are a practitioner are there and are on time... So you are building that trust over time. If you say you are going to do something, then you do something.”*

For other practitioners, the importance of reliability went beyond pragmatics and reducing the likelihood of reoffending. For instance, making sure children are humanised, *“I always try to make sure young people don't feel like a number. I try not to tell them I have another appointment... being responsive to what they need”* Interestingly, practitioners talked of children testing the commitment of practitioners, commenting that as children begin to feel safe with a practitioner, they often test the practitioner's commitment by pushing the boundaries. Thus, on the one hand, from a practitioner's perspective, reliability is often referred to in a practical sense, for many children, particularly those who have suffered trauma, reliability is more to do with knowing they can

emotionally lean on practitioners, knowing they will not give up on them. Reliability in this sense implies predictability, and so when practitioners act in a reliable manner, a child's sense of security is enhanced, and removes the uncertainty that comes from changeable and emotionally inconsistent parenting and upbringing. When practitioners behave reliably, they are helping a child recover, indicating that quality relationships can protect (Prison Reform Trust, 2020).

Whilst trust and reliability were regarded as being important characteristics in a 'good quality' working relationship, practitioners commented that this takes time and according to many practitioners, time is not always available to them.

3. Time

Practitioners remarked that children have learned not to trust people, especially adults, and that learnt behaviour is not going to change quickly and easily; it will take time and effort on the part of the practitioner, for example *"a big part of a good working relationship is consistency and reliability... So you are building that trust over time...They don't trust easily and it takes a long time to get that"*. As indicated here, when building trust between the children and the practitioners, it is important for the practitioners to get the basics right: being on time to scheduled appointments and following through with spoken actions. Practitioners commented that whilst such things appear minor, their impact is often great and do not go unnoticed by the children. According to practitioners, displaying reliable behaviour over a period, is one small step on the long journey to building a healthy working relationship, built around trust. Practitioners also said that in their experience, children are more likely to trust their peers over practitioners, and this preference is not likely to be a quick thing to change, which again reiterates time as being an important element in the process of trust-building.

Furthermore, it was apparent that whilst most practitioners were aware of the important role played by time, often in their experience, the courts were not, for example *"courts are asking us to change five years of pre-established patterns of behaviour within 3 months; sorry we are not going to be able to do it"*. Practitioners also spoke about the individualised nature

of time and progress, commenting that any change in a child's behaviour will take time and the amount of time required will depend on the child concerned. Time is particularly important for highly vulnerable children according to practitioners. Whilst some children will have experienced healthy relationships and so are more trusting of practitioners, for those more vulnerable children, with more complex needs, they often do not understand what a healthy relationship is, and they struggle with the notion of trust, particularly with adults in positions of authority. Practitioners perceived that part of their role is to support children and help them to understand what it means to trust, to develop a healthy- relationship blueprint.

It could be argued then, that the youth justice system is out of sync with what is needed (sufficient time, which is individualised); and whilst the YJB has made a commitment to a 'child first, offender second' approach to youth justice, stating it will ensure children are treated in accordance to their individualised needs, it has yet to fully filter through into practice, according to some practitioners on the ground.

4. Comfort

Feeling comfortable around practitioners was the biggest characteristic spoken about by the children, and ties in closely to some of the characteristics already discussed: trust, reliability and honesty. Children talked of being able to 'hang-out' informally with the practitioner during supervisions, rather than always having to participate in formal meetings, for example *"Someone you can laugh around. Sit around"*. Practitioners also saw the value in holding less formal, sit-down meetings, in order to build a good 'quality working' relationship, *"spending three hours walking down Cardiff bay. No eye-contact but you are making that relationship"*.

Often when children talked about feeling comfortable around the practitioner, they referred to laughing, such as *"we always have a laugh; we get on... I open myself up. I'm less likely to open up to someone I don't know... You don't feel wary around them; you can chill around them"*. This could be seen as an attempt to equalise an unequal power relationship. The children also made reference to 'knowing the practitioner' in the sense that

over time, as they became more familiar, more used to the practitioner, they are able to trust the practitioner; trust they can be themselves, without fear of judgement or rejection, such as *“If I was to work with people I didn't know I would feel uncomfortable. Feeling comfortable is important because you get to speak your mind knowing they're not going to say anything”*. It appears that over time trust is built and the children become less cautious and more comfortable around the practitioners. This lowered sense of caution brings with it greater likelihood of engagement and disclosure, putting the practitioner in a better position to be able to help the child to desist. It might be that the characteristic of feeling comfortable around the practitioner is tied closely to a child's self-worth, particularly because often, the children known to the YOTs have never known what it is like to have another person take the time and effort to get to know them, leaving the young person with a lowered sense of self-worth. When children get the sense that practitioners genuinely want to understand them and to help them, this serves to increase the child's self-esteem. Indeed, an increase in self-esteem has been linked to an increase in desistance, as has the role played by practitioners in verifying a positive identity and increasing self-esteem (Stone et al., 2018), which links to the Self-Derogation Theory (Kaplan & Johnson, 2001), which posits that low self-esteem motivates children to try out anti-social acts in a bid to restore their self-esteem. Kaplan and Lin (2007) found that children with negative deviant identities, who developed negative self-feelings, would decrease deviant behaviour as their social bonding increased, which reinforces the importance of having a 'good quality' working relationship, in a bid to increase a child's social capital. Cheng (2014) supported this link between self-esteem and offending, with correlational results indicating that as the level of moral-self-esteem decreased, the likelihood of offending increased. These results suggest that individual's with high internal risks, such as having low self-esteem and low resilience tend to be more vulnerable to external negative factors, such as peer pressure and poor parenting; findings which have been supported by the Scottish Government (2018). Such findings have implications for youth justice practice and in particular the working relationship, in terms of practitioners ensuring the children they work with are afforded the necessary support to

not only reduce their external risks, but are also offered support to increase their internal protective factors, such as self-esteem and resilience.

CONCLUSION

This small-scale study examined the perceptions of what constitutes a 'good quality' working relationship between the practitioner and child within the youth justice system. The importance of the working relationship within desistance was contextualised within broader desistance literature, specifically: individual factors and social factors. Considering the views of both practitioners and children, findings revealed that whilst both perceived trust to be an important characteristic of a 'good quality' working relationship, inconsistency did exist, with practitioners perceiving reliability and time to be important characteristics, and children perceiving genuineness and comfort to be key. Whilst on the one hand, such incongruence between the perceptions of the practitioners and children could be seen in a positive light, in that it brings challenges to practice; offering a chance for policy and practice to grow and evolve; it could be argued that such disparity might negatively impact the likelihood of a child desisting. If practitioners are unaware of the characteristics of a 'good quality' working relationship that children value, then they could at best, be under utilising the time they have with the children; and at worst, be unknowingly, negatively influencing the way children see themselves and the narratives they hold. It could be argued then that findings have important implications for youth justice practice and a child's desistance. Even though findings were promising in that they offered greater insight into what constitutes a 'good quality' working relationship, these findings may not translate to female children and children outside of Wales. This is because only a small sample group of male children was available to be interviewed, and the study was focused on YOTs in Wales. However, it is important to offer a reminder that generalisability was not the goal of this study; but rather the objective was to offer a deeper, perspective-based understanding of the working relationship. Furthermore, findings of this study might still be widely applicable to male children known to YOTs across the UK, because whilst there will undoubtedly be some differences between YOTs in different regions, many similarities will likely be seen due to YOTs being directed by wider YJB policy. With these limitations

in mind, future research would benefit from including larger samples, which include both male and female children, taken from a greater geographical area. This would allow research to see if perceptions of a 'good quality' working relationship differ not only between practitioners and children across the UK, but also between children themselves (males and females). Greater research attention should also be focused on the impact of a 'good quality' working relationship, specifically addressing the question: What is the impact of having/not having a 'good quality' working relationship on a child's desistance? Whilst acknowledging these limitations, this paper achieved what it set out to achieve: to explore further, the working relationship. Youth justice practitioners might, as a result, be a little closer to increasing a child's likelihood of desisting and be a little closer to affording a child their right to lead a good life.

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Critical essay: Fatal encounters involving people experiencing mental illness

Stuart DM Thomas*

ABSTRACT

While the use of force by police is relatively uncommon, research has found that it is used much more commonly in instances where police come into contact with people with lived experience of mental illness. This over-representation is evident in instances where the police have some prior knowledge that the person has a mental illness, when they suspect that the person may have a mental illness, and also when it later becomes apparent that the person they interacted with has a mental illness. In some cases, these situations escalate and result in fatal force being used by police. A critical understanding of the catalysts and other factors associated with the need to use, and ramifications of, fatal force have not been widely articulated. This essay will consider outcomes from some recent Australian coronial investigations into fatal shootings by police of people found to have a mental illness. It will reflect on how the key issues raised and recommendations arising from these inquests contribute to changes in policing policy and practice and a revised approach to de-escalation, limit setting and use of force training.

Keywords: fatal use of force, mental illness, coronial inquiry

INTRODUCTION

Police work can be both challenging and mundane; regardless of the nature of the work it is continuously monitored. A defining characteristic of a police officers' role is their ability to use necessary force to compel people to comply with the law (Akinlabi, 2020; Prenzler et al, 2013). Indeed, the use of force lies at the heart of police actions (Cojean et al, 2020), and has long been seen an essential component of police work (Bittner, 1970). While police officers are legally sanctioned by both statute and case law to use force, instances of police use of force

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are actually rare and instances of fatal force even rarer; this is mainly because the majority of citizens comply with police instructions and with the law. Despite this, the very fact that the police have the right to use force leads to intense scrutiny; this being amplified the most when fatal police shootings occur.

On the most part, different jurisdictions are guided by a use of force model; for Australia and New Zealand, ANZPAA (2018) provide use of force principles. The ANZPAA guidance defines use of force as “any situation where police use force or other techniques, including a weapon, instrument or implement, in the lawful execution of their duty”. The ANZPAA guidance further notes that the use of force should be reasonable, proportionate and appropriate, and not equate to more than would be considered reasonably necessary in the given circumstances. It also notes that individual police are responsible and accountable for their use of force, and that they need to be able to justify their actions.

It is widely acknowledged that the decision to use force is commonly difficult and often forced upon police in situations which can be fast-paced, dynamic, complex and ever-changing (Kesic, Thomas & Ogloff, 2012a). Klinger (2005) makes the poignant point that the decision to discharge a firearm, and for a person to potentially die as a result, is the most important decision a police officer can make. As such, a police officer’s responsibilities are ever-present in their minds, especially when considering the implications of using force and of being viewed and judged, fairly or not, by the public.

An interesting, and potentially informative, way of examining police use of fatal force is to review findings of coronial inquests into fatal police shootings, as the coroner is required to closely scrutinise police actions and make a determination about whether the shooting was justified (AIC, 2013). The inquiries also commonly consider whether alternatives to lethal force were available. This critical essay considers common elements arising from a number of recent coronial inquiries from a range of Australian states and territories, and further contextualises ‘lessons learned’ in the light of the extant international literature.

Common antecedents and risks

A report by the Australian Institute of Criminology (AIC, 2013) noted that 105 people were fatally shot by the police across Australia between 1989 and 2011; the average number of fatalities per year over this time equated to five, however as many as eleven people were fatally shot in one year during this time period. International research into the use of fatal force has consistently reported that the vast majority of suspects/offenders involved in these incidents were armed with a weapon, resisted arrest, were non-compliant with police commands, and that they acted in a threatening and aggressive manner towards the police (e.g., Gill & Pasquale-Styles, 2009; Kesic, Thomas & Ogloff, 2012a; Mumola, 2007). Of note, being alcohol affected has also been found to be a common presenting (and complicating) factor in police-citizen encounters (Chigley, Proctor, Baker & Grech, 2018); there are well-established links between alcohol intoxication, impaired judgement and thinking, and increased risks of aggression (de Tribolet-Hardy et al., 2015). Perhaps of most interest here, though, is the reported frequency that suspect/offender histories of mental illness have been reported in fatal police shootings. These arguments link directly to commonly held perceptions about the increased risks of violence associated with mental illness and the perceived unpredictability of people who are experiencing a mental health crisis.

Perceptions of risk. International reviews of media representations of mental illness have consistently reported on the negative connotations associated with having a mental health diagnosis. For example, Klin and Lemish's detailed review of outputs published between 1985 and 2005 (2008) found that descriptions of mental illness were distorted "due to inaccuracies, exaggerations, or misinformation" (p.434). The authors argued that the selective coverage by journalists served to reinforce the over-generalisation of the connections between severe mental illness and violence, thereby feeding further into misperceptions of risk and dangerousness. Other, more recent, research suggests that these perceptions appear to be particularly associated with people who experience schizophrenic disorders (Robinson et al., 2019). While there is some evidence internationally that these populist representations have shifted over time, and that (mis)perceptions of dangerousness have

decreased, other recent research has found that certain diagnoses (personality disorders, schizophrenia and OCD) continue to be reported in negative, pejorative, and stigmatising ways (Rhydderch et al., 2016). As a result, there continues to be a sense of othering and perceived need for social distance for the protection of the general public (Murphy, Fatoya & Wibberley, 2013). Furthermore, and of note, people with a mental illness continue to be referred to in police training as being unpredictable.

Complications arising with the presence of mental illness. There is a statistical association between serious mental illness and violence; that does not mean that severe mental illness alone causes violence. A compelling systematic review, pooling a total of 18,423 individuals diagnosed with schizophrenia and other psychoses from 20 separate research studies (Fazel et al., 2009), provides a more nuanced understanding here. The authors concluded that individuals with substance use disorders were more dangerous than those diagnosed with schizophrenia and related psychoses. Another informative article by Elbogen and Johnson, published in 2009, notes that if a person has a severe mental illness, but no history of violence or substance abuse, then they have the same chances of being violent as any other person in the community. Both of these influential articles place considerable emphasis on the much more significant role of substance use, rather than mental illness, on violent behaviour.

That being said, research has established that all major mental disorders are over-represented among fatal police shootings (e.g., Kesic, Thomas & Ogloff, 2010). This is a consistent finding across jurisdictions and time; for example, in the AIC (2013) report, fifty-five (42%) of the decedents over that 22-year period were identified as having a mental illness. Research that has considered the role of mental illness in police shooting fatalities posits that the presence of mental illness increases the likelihood that a more physically forceful type of response will be required by police in order to resolve the situation (Miller, 2015). The question here is why?

Research has demonstrated that police use more coercive force on people they think (through their behavioural presentations) or know (through prior histories and/or recorded contacts between police and the

individual involved) have histories of contact with mental health services (Kesic, Thomas & Ogloff, 2010; 2012b; 2013). Research also suggests that police acknowledge this to be the case, and that they commonly associate mental illness with irrational and unstable behaviours (McTackett & Thomas, 2017).

Recent coronial reports into fatal police shootings make reference to a range of mental health concerns being present or documented in the decedent's lives. Sometimes these are well-defined, with the person having documented mental health diagnoses, however there are also examples where it is likely (based upon reports of the person's recent behaviour for example) that the decedent had a severe mental illness, but that they had not been diagnosed and were not otherwise known to mental health services. For example, the coronial inquest into the death of Alexander Kuskoff (Coroner's Court of South Australia, 2019) considered the fatal shooting of a 50 year old man late at night at his rural property in South Australia in September 2015. The inquiry reported that while Mr Kuskoff had no established mental health (or indeed criminal) history, his behaviour leading up to the fatal shooting was very erratic. Based on expert psychiatric opinion obtained after the event, it was determined likely that Mr Kuskoff had been "experiencing psychotic symptoms for a significant period of time but had an ability to cover them up" (p.18). Another example is provided in the inquest into the death of Courtney Topic (Coroner's Court of New South Wales, 2018b). Ms Topic was fatally shot by police close to a busy intersection in Western Sydney in February 2015. The court accepted that she "was suffering [from] undiagnosed schizophrenia and was probably experiencing a severe episode of psychosis" (p.6) at the time of the incident. Of note, the coroner opined that, for these reasons, it was likely that she wasn't able to understand police commands to drop the knife. This is an important consideration, as it suggests that her non-response to police commands/instructions may have been misinterpreted as non-compliance and/or further resistance by the police on scene (Cordner, 2006).

The factor of time. Time is often quoted as an officers' best ally (Vecchi et al., 2005). Elongating time has been found to increase the likelihood of non-fatal outcomes (Lord, 2004), but it is important to note that this is not

always the case (Fyfe, 2000). Increasing time on scene helps officers make more detailed assessments of the evolving situation and operating environment; conduct a more thorough risk assessment, including assessing the behaviours of the suspect/offender; and set up a cordon and manage strategy. It also potentially allows for the crisis to subside naturally (McLeod, Thomas & Kesic, 2014).

Time is a frequently reported factor in fatal use of force incidents. It is commonly reported that events unfold, or escalate, very quickly and that the fatal shots often occur within a matter of seconds or minutes of the police arriving on scene. The inquest into the death of Danukul Mokmool (Coroner's Court of New South Wales, 2019), for example, noted that the speed with which events unfolded, which amounted to 23 seconds after their arrival at the railway station in Sydney, afforded "little to no time [for police] to assess, contain and negotiate..." (p.56). Similarly, details provided in Courtney Topic's inquiry (Coroner's Court of New South Wales, 2018) noted that "less than a minute after police officers arrived [she] was on the ground, fatally shot in the chest" (p.6). Furthermore, in a coroner's report into a series of fatalities that occurred in Queensland over a 15 month period in 2013-2014 (Coroner's Court of Queensland, 2017), it was noted the very short period of time involved in four of the five shootings meant that officers were having to "assess, engage and react very quickly in what [wa]s commonly an extremely stressful and potentially ambiguous situation" (p.55). These findings resonate closely with research by Davies (2017) who reported that the immediacy of the threat posed (by the suspect/offender having a weapon), and the speed with which incidents can unfold, force police to make a use of force decision and that this usually leads to a firearm being drawn.

The acknowledged immediacy of the risk posed effectively precludes opportunities for police to adopt what would be considered best practice principles (Fyfe, 2000; Kesic, Thomas & Ogloff, 2012a). Interestingly, however, the inquest into the death of Daniel Josef Adwent (Coroner's Court of Western Australia, 2019) noted that, even in a situation which escalated rapidly (whereby he lunged at police with a knife), a firearm was only discharged by police after other use of force options (including oleoresin capsicum spray and Taser) had been tried but

had no discernible effect on Mr Adwent (or, in the case of the Taser, had malfunctioned). Commonly the immediacy of the risk, and therefore use of force decision, is determined by the physical proximity of the suspect/offender to the police (or other bystanders).

The factor of proximity. Stoughton, Noble and Alpert (2020) assert that the distance between the police officer and the person of interest is “inversely correlated with the threat of physical harm” (p.167); therefore, the closer the person is the more likely (and immediate) the threat of physical harm. Indeed, the question of proximity is frequently made reference to in terms of police officer decision-making around discharging their firearm. In Danukul Mokmool’s inquiry (Coroner’s Court of New South Wales, 2019), the coroner made specific mention of the “Tueller Drill” (p.57) rule, with officers reporting that they should maintain a distance of seven metres from a suspect/offender armed with an edged weapon. However, Stoughton and colleagues (2020) point out that, contrary to this popular rule, there is no ideal distance to maintain in such a situation. Instead the authors assert that the characteristics of the suspect/offender, those of the police officers involved, and broader issues in the local environment also need to be factored in. Pinizzotto, Davis and Miller (2007) refer to this combination of factors as the “deadly mix” (p.3).

An interesting example recently arose where it was reported that the police commissioner of South Australia challenged the findings of the coronial inquest into Alexander Kuskoff’s fatal shooting (Coroner’s Court of South Australia, 2019; Dornin, 2019). According to a related news report (Dillon, 2019), the coroner suggested that police “should be trained to shoot for extremities, shooting an arm or a leg, in such situations” as this could lead to incapacitation of the suspect/offender but a lower likelihood of fatality. While recognising that this was at odds with South Australian police policy on firearms use, the coroner raised the possibility that the use of fatal force from the police officers involved may not be seen as being proportionate to the level of threat posed by the person. However, this does not take into account the imminent threat posed to the police officers involved. Unlike the other cases considered here, Mr Kuskoff was carrying a high-powered rifle, had fired shots, and had said he “would shoot anyone that came onto his property” (p.4).

The inherent subjectivity and associated individual differences in perceptions of risk are important considerations here. For example, in Courtney Topic's inquest, the coroner noted that Ms Topic was within a couple of metres of the officer when the officer discharged his firearm, and that the officer "had reason to believe his life was in danger" (Coroner's Court of New South Wales, 2018b, pp.6).

Does police presence alone escalate the situation?

International research has shown how the public's perceptions of, and trust in, the police are directly influenced by their (or their peers) treatment by the police and whether this is considered to be procedurally unjust or excessively forceful (Akinlabi, 2020; Maguire et al., 2018). This speaks to the central importance of considering the nature and outcomes of contacts between the suspect/offender and the police, police-community relations, and how these experiences may shape the nature (and potentially the outcomes) of subsequent encounters. These considerations have been brought into question through research that has considered the potential for suspect-provoked shootings, or 'suicide-by-cop' (Best, Quigley & Bailey, 2004; Lindsey & Lester, 2004; Parent & Verdun-Jones, 1998).

Previous estimates internationally have reported that anywhere between 10% and 50% of police shootings meet criteria for what would be considered a suicide-by-cop incident (de Tribolet-Hardy et al., 2015; Miller, 2015). Some have argued that police presence leads the suicidal person to choose to engage in a course of conduct that provokes the police to shoot them. This course of action is evident in the events described in some coronial inquiries and has been specifically discussed in some cases. For example, in Danukul Mokmool's inquiry (Coroner's Court of New South Wales, 2017, p.59), the coroner, reasoned that police's attendance at the scene likely escalated the situation, with witnesses reporting that the entire dynamic of the situation changed after their arrival at the railway station in Sydney. Witnesses, including the police involved, reported hearing the decedent shouting at the police "shoot me, shoot me in the head" (p.7); others reported hearing him say "I just want to die" (p.14). Despite this, the deputy state coroner concluded that they were unable to determine the intentions of Mr Mokmool when he was confronted by the police (p.67).

One factor that seems to differentiate fatal shootings from other similar situations where non-fatal outcomes are achieved, is the extent of prior violence and criminal histories of the suspect/offender, with more entrenched histories increasing the likelihood of fatal outcomes (McLeod, Thomas & Kesic, 2014; Patton & Fremouw, 2016). The inquest into the death of Stephen Paul Hodge (Coroner's Court of New South Wales, 2018a) provides some interesting commentary here. Mr Hodge was fatally shot by police in a Post Office carpark in September 2015 after advancing towards police with a knife raised at head height. The coroner raised the possibility that the deceased had intended to "provoke the police to end his life by shooting him" (p.14). However, the coroner noted that "while there was some evidence of suicidal ideation on the day and in the period leading up to [his] death... such as cutting at his throat and wrists with the knife" (p.13), that the criteria for a suspect provoked shooting could not be concluded. Of note, Mr Hodge had no prior criminal history, but was alcohol intoxicated at the time of the encounter to the extent that "his ability to make judgements and to form rational decisions would have been substantially impaired or entirely absent" (p.7). Findings from the inquest into the death of 36 year old Paul Lambert (Coroner's Court of New South Wales, 2019) also noted an established criminal history, in particular a history of apprehended domestic violence orders. Mr Lambert was fatally shot in November 2016 after a police pursuit and stand-off on the Pacific Highway in New South Wales; he charged at the police holding a raised knife. Despite noting that his behaviour suggested he wanted to be killed, and police finding a note that Mr Lambert had written indicating suicidal intent, the coroner declined to make a finding about his motivation. Instead, she noted that witnesses "describe[d]s change in demeanour more like homicidal or violent rage [rather] than suicidal intent" (p.28).

Training, experience and decision-making. Klein (1993, p.138) provides some useful guidance about how decisions are made in various operational settings. He argues that people adopt a recognitional model, first using a situational assessment process to generate a course of action, and then a mental simulation process in order to evaluate the proposed course of action. This model is based on the premise that people act and react on the basis of prior experiences and select a course of action that is

known or, in the case of not having adequate time, most likely to be successful, leading to a satisfactory outcome.

More practically, Miller (2015) surmises that police make decisions primarily on the basis of the level of resistance experienced, and the observed and reported behaviours of the suspect/offender. Interestingly here, there is a good deal of evidence suggesting that more experienced police officers are more likely to consider a range of force mitigation strategies, such as de-escalation, while those with less experience tend to rely more on tactics involving physical control (e.g., Mangels, Suss & Lande, 2020). This fits well with Klein's recognitional model and the on-the-job learning styles of police, as well as the practice-based wisdom that operational police accumulate over time (Thomas & Watson, 2017).

DISCUSSION AND LESSONS LEARNED

A somewhat unsatisfactory, but pragmatic, conclusion from this is that sometimes fatal force will be inevitable; no other choice may be available, given the very quick escalation of some incidents and significant risks being posed to the safety of the officers or others. Split second life or death decisions will sometimes need to be made. Despite this, several key recommendations have arisen that warrant a continued focus for policing and health services.

Firstly is the central importance of equipping police with practical, hands-on experiences that they can draw upon if, and when, faced with this kind of situation. This makes good, practical sense. To achieve this requires a scaffolded approach to learning, instilling increasing confidence in officers through graduated exposure to a range of possible actions and reactions to presenting and emerging threats (Davies, 2017). Coronial recommendations here make specific reference to expanding training through interactive role play scenarios which lead to what has been termed 'meaningful' learning (Herrington & Oliver, 1995, p.236).

Secondly, coronial and related research findings support the greater integration of mental health-informed training into tactical options training, with an added emphasis on specific de-escalation techniques practiced through interactive role play exercises (Thomas & Watson, 2017). While this does not overcome the inherent subjectivity in

assessments of risk to self and others between individual officers, it may serve to provide officers with practical alternatives. These enhanced skills may help contribute to a satisfactory outcome, while also serving to better, and more fully, integrate mental health as core police business across all police training provided. The language around unpredictability remains contentious and potentially damaging as it relates to police decision-making and responses to mental health-related calls. While a robust evidence base details that there is a statistically increased risk of violence and homicide associated with having a serious mental illness, it is well established that this risk relates to a small sub-group (estimated to be around 1 in 10) of people who receive this diagnosis (Mullen 2006). Evidence arising suggests it may not be so much about the unpredictability of people who are experiencing mental illness, but rather the unsuitability of the traditional police approach and communication style which is known to aggravate and escalate encounters with people in mental health crisis, thereby exacerbating risk and use of force responses (Cordner, 2006; Fyfe, 2000). As such, the content of these roleplays, and related experiential learning, should be scaffolded around the importance of elongating time, maintaining safe space, and effective communication (Kesic, Thomas & Ogloff, 2012a). There is some evidence, both in the Australian context and from overseas, that suggests that specialist training leads to positive changes in officer confidence, attitude and behaviour, (Herrington & Pope, 2014; Watson, Compton & Draine, 2017); the evidence on whether it leads to reductions in use of force, however, remains mixed (de Tribolet-Hardy et al., 2015). For example, a previous wide-scale focus on mental health training for police in Victoria was shown to half the number of fatal police shootings (Kesic, Thomas & Ogloff, 2010), but not lead to long-lasting reductions in fatal use of force (Saligari & Evans, 2016). An ongoing commitment to, and continued refinement of, police training that seeks to embed mental health training across all core police training is required to help teach and reinforce the need for a different approach (de Tribolet-Hardy et al., 2015; Fingeld-Connect, 2009) when responding to people who may be in mental health crisis.

Thirdly, the issue of familiarity (i.e., being known to police or health services through prior contacts), has led many to recommend that there is distinct potential for better information sharing and/or proactive

partnerships between health and justice services. Such platforms and partnerships which allow for the sharing of prior knowledge regarding the risk and vulnerabilities of community members, would serve to better equip first responders with valuable knowledge to help inform their initial approach and engagement strategies. Examples evidenced through the ongoing development and refinement of co-responder models provide compelling evidence of the potential benefits of this more joined-up approach.

Lastly, core issues of community trust remain significant barriers for the police to traverse, especially with groups who continue to experience social marginalisation, and at-risk individuals who are disconnected from health, justice, social and welfare supports. Fatal police shootings have a significant and enduring impact on the police officers involved, as well as on the family of the deceased and the broader community. While each situation faced is unique, the need for transparency and accountability of police actions remains of paramount importance, to support and reinforce both police legitimacy and community safety.

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“To Serve and Protect Their Mental Health”: The Effects of Police Occupational Culture on Police Officers Mental Health

Salehah Hakik* and Kory Langlois

ABSTRACT

This paper focuses on the connections that lie between the police occupational culture and its impact on officers' mental health - PTSD. The main goal was to determine whether a relationship could be identified with the existing police culture and how it stigmatizes any mention of mental illness. Conducting a qualitative content analysis of government documents as well as a collection of news media articles, the study found connections are in fact prevalent and can thus be casually inferred that police culture impacts officers' mental wellness. The lack of dialogue, and negative features of the police culture prove to be barriers that add additional stressors to an officer living with mental health related issues, such as PTSD.

Keywords: Police culture, organisational change, PTSD, policing, traumatic policing, subculture, police occupational culture, stigma, trauma, mental illness.

INTRODUCTION

Public discussions about policing in Canada have recently and increasingly emphasised issues related to occupational stress, trauma, and post-traumatic stress disorder (PTSD) (see Cohen, McCormick, & Rich, 2019; Soomro & Yanos, 2019; Violanti & Owens, 2017). Government reports, investigations, academic scholarship, and audits continue to identify problems related to the prevalence and implications of trauma in policing. Police officers are exposed to traumatic events beyond the regular population, and, undoubtedly, this has an effect upon one's ability to conduct their job (Carleton et al., 2018; Rees & Smith, 2007). It can be said that police officers deal with two competing overarching stressors: *occupational stressors* and *organisational stressors* (Soomro & Yanos, 2019). It is this last point, *organisational stressors*, that this paper

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will seek to explore, within the context of PTSD being exacerbated by the police culture. It has been understood (as will be indicated below) that the culture of policing has an impact on whether police officers will seek treatment (Heffren & Hausdorf, 2016). Therefore, it can casually be inferred that if the police culture is unsupportive and laced with negative interactions, the likelihood that a police officer would seek support for PTSD, or other psychosomatic conditions, is less likely to occur. If a police culture is unaccepting and intolerant of a police officers' mental illness - stigma - the police officer is less likely to get the support they need. Thus, through a qualitative approach, via a convenience sample, this paper will explore newspaper publications along with governmental reports to understand the impact police culture has upon officers with PTSD symptoms and/or diagnoses. Only by understanding this connection of the police culture exacerbating PTSD, can policy be implemented to ensure police culture and officer camaraderie supports an environment of mental health.

Police Culture

Police culture can be seen from both a positive and a negative lens. For example, some authors have revealed that police culture is designed to ensure protection and camaraderie (Chan, 1996; Holdaway, 2013; Loftus, 2012; Murphy & McKenna, 2007). Accordingly, police culture can be explained as a practical, even necessary response to the multifaceted and uncertain nature of doing police work (Loftus, 2010, 2012; Skolnick, 1966; Skolnick, 2005). Police culture offers a form of social regulation and authority: an informal guide and informal rules to situational circumstances of police work (Ericson, 1982, as cited in Murphy & McKenna, 2007). It had been identified that police cultures that incorporate the characteristics of supportiveness, teamwork, empathy and perseverance create an accepting social environment for officers experiencing difficulties related to their work (Chan 1996; McCartney & Parent, 2015). For example, some researchers had stipulated that it can serve as a positive function for those officers that experience dangerous situations (Chan 1996; Loftus, 2010, as cited in Coombe, 2013; McCartney & Parent, 2015; Murphy & McKenna, 2007; Waddington, 1999). If the police culture incorporates an environment characterised by

supportiveness, teamwork, empathy, and respect, then it enables personal resilience among officers, supporting their journey with mental illness, PTSD (McCartney & Parent, 2015; Murphy & McKenna, 2007).

On the other hand, some have suggested that police culture can be highly destructive and toxic affecting police officers' ability to conduct their job (Brodeur, 2010; Loftus, 2010; Loftus, 2012; Murphy & McKenna, 2007; Rees & Smith, 2007). This can be seen from literature speaking to the consequential nature of the police culture impacting officer's willingness to seek assistance with their mental health, PTSD; for example, in an insightful passage, Smith (2009) argues, through a qualitative approach, that a negative police culture contributes to the deterioration of officers' mental health. Furthermore, Smith (2009) highlighted how a pattern of taunts and negative remarks directed at officers' courageous enough to speak willingly about their struggles added to their mental turmoil (see Rees & Smith, 2007 for further discussion). Many of these aspects of police culture have been identified as a manifestation of the traumatic cycle an officer experiences (Rees & Smith, 2007; Smith, 2009). Therefore, it is critically important that we identify the connection between police culture and PTSD.

Defining Police Culture. The foundation of police studies and police occupation culture began from the work of Jerome Skolnick (1966) who defined the police culture to the many features of police work. He argued that police culture arises from the common dilemmas and pressures that are associated with the job of being a police officer (Skolnick, 1966). He goes on to state that the increased isolation of being a police officer does not offer much in terms of maintaining relationships with others (Skolnick, 1966). This strained relationship between the two, ultimately entrenches the officer within the workplace, and as a result exposes them to the police occupational culture. Later, Skolnick (2005) identified three main areas within the role of policing that form what he termed the *working personality* of a police officer. This *working personality* Skolnick (2005) referred to is a contributing factor to police culture. To highlight this, first there is *exposure to danger* and *violence* causing officers to perceive individuals as *symbolic assailants*: individuals who are perceived, through stereotypical social constructs, and characteristics as being affiliated with

crime, consequently the behaviour of the officer may result in extra vigilance (Skolnick, 1966, p. 266). Skolnick (1966) further added that this perception of *danger* that is experienced is then shaped into *suspicion*, thus, making officers highly suspicious in nature. The second feature of the *working personality* is the *entitlement to authority*: socially constructed by the uniform and badge contributing to officers' suspicious nature and social isolation (Loftus, 2012; Skolnick, 1966). Ultimately, this can lead to the *us vs them* mentality that is seen throughout many explanations of police culture (Skolnick, 1966). The third element that Skolnick (1966) identified is *efficiency*; for example, if an officer is unable to perform under the constant demands and pressures, they often feel isolated. Social isolation is problematic, disconnecting officers from the social world outside the force, therefore, they tend to only engage with those within the occupation (Loftus, 2012; Skolnick, 1966).

To further add to Skolnick's (1966) definition, numerous empirical evaluations were reviewed. Reiner (1992) defined the police culture as the "values, norms, perspectives and craft rules which inform police conduct" (Reiner, 1992 as cited in, Loftus, 2012, p.3). Manning (1989) referred to police culture as "the accepted practices, rules and principles of conduct that are situationally applied and generalized rationales and beliefs" (Manning as cited in Loftus, 2012, p.3); Reviewing Chan's (1996) definition, she revealed police culture "as a set of informal occupational norms and values operating under the rigid hierarchical structure of police organisations" (Chan, 1996 as cited in, Loftus, 2012, p.3). Lastly, Murphy and Mckenna (2007) in their literature review for the *Royal Canadian Mounted Police Task Force on Governance and Cultural Change* also identified police culture as the "set of shared values, group attitudes, agreed upon behavioral norms, informal "craft" rules, and a set of common understandings and informal guides for action (Durivage 1992; Goldsmith 1991; Greene et al. 1994; Skolnick 1994, as cited in, Murphy & Mckenna, 2007, p.5). They also added the danger and authority that comes with being an officer, often makes their world uncertain and full of risk; therefore, resulting in the formation of a "reactionary and protective occupational and organisational culture" (Murphy & Mckenna, 2007, p. 5). What is most common amongst these definitions is that there are a set of values, norms,

and beliefs that arise during their profession that determine police officers' behaviours on and off the job.

Common Features of Police Culture. It has been identified by some that police culture is a result of the features of policing (Loftus, 2010; Murphy & McKenna, 2007; Skolnick, 1966). These attributes represent the environment, as well as provide guidelines to an officers' lived experiences on and off the job. However, the features of police culture such as *suspicion, sense of mission, authoritarianism, cynicism, solidarity* and *masculinity* have been scrutinized for their inability to provide open and accepting workplaces in relation to mental illness (Carleton et al., 2018; Holdaway, 2013; Loftus, 2010; Murphy & McKenna, 2007; Rees & Smith, 2007). These features establish a masculine ethos in the workplace, which require officers to portray physical and emotional toughness (Loftus, 2012). An aggressive persona is taken on and officers engage in "masculine" activities, such as heavy drinking after work, and predatory behaviour (Kennedy & Birch, 2018; Waddington, 1999). This can oftentimes be seen as barriers and hurdles when officers are struggling to seek treatment and assistance with PTSD, and other mental health illnesses (Carleton et al., 2018; Holdaway, 2013; Loftus, 2010; Murphy & McKenna, 2007; Rees & Smith, 2007). It has also been noted that officers are fearful to seek assistance due to the barriers created by this toxicity of culture (Rees & Smith, 2007; Smith, 2009).

Post-Traumatic Stress Disorder (PTSD)

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) defines traumatic events that are both direct and indirect forms of trauma exposure (American Psychiatric Association, 2013). Direct exposure to a traumatic event is considered as experiencing the event firsthand or being a witness to the traumatic event; whereas indirect exposure is defined as being confronted with trauma, or learning of the unexpected death, serious harm, or injury of persons close to you (May & Wisco, 2015).

Symptoms. To receive a PTSD diagnosis, it is said that one must react to a traumatic event with intense fear, horror, or helplessness following the incident (American Psychiatric Association, 2013; Pacella, Hruska, & Delahanty, 2013). PTSD can involve a multitude of symptoms

and they are categorised in four clusters: *Re-experiencing*, *Avoidance*, *Numbing* and *Hyperarousal* (American Psychiatric Association, 2013; Bottalico & Bruni, 2012). Firstly, the individual suffering from PTSD would have spontaneous re-experiences of the traumatic event through intrusive recollections, flashbacks, and nightmares (Anxiety and Depression Association of America, 2016). Secondly, the individual may emotionally numb the pain and trauma while avoiding certain places and people that can be triggers and reminders of the trauma (Anxiety and Depression Association of America, 2016). Numbing can be in the form of unhealthy alcohol consumption, feeling detached, having diminished interest or willingness to participate in any activities, and the inability to experience positive emotions (Anxiety and Depression Association of America, 2016). Lastly, the individual can face increased arousal such as difficulty sleeping, concentrating, feeling on edge, and easily irritated or angered (Anxiety and Depression Association of America, 2016). The individual can engage in self-destructive or reckless behaviour, become hypervigilant, and have an exaggerated startle response. (Anxiety and Depression Association of America, 2016). The overall health and wellbeing of persons living with PTSD is diminished and can cause other negative health symptoms such as nausea, constipation, angina, shortness of breath, dizziness, fatigue, headaches, heart disease, and fibromyalgia (Pacella, Hruska, & Delahanty, 2013).

Direct Exposure. Direct exposure to at least one traumatic event has been the focus of PTSD in research. It has been examined that experiencing multiple forms of trauma imposes a greater risk of the development of PTSD (American Psychiatric Association, 2013; May & Wisco, 2015). A higher cumulative trauma exposure throughout one's life is also associated with the risk of PTSD (May & Wisco, 2015). Not only can experiencing the trauma firsthand lead to PTSD, there is a clear link that directly witnessing trauma occurring to others also has impacts on the development of PTSD (May & Wisco, 2015).

Secondary Trauma. PTSD is composed of both direct and indirect exposure to traumatic events. The DSM defines the "repeated or extreme exposure to aversive details" of said event is known as secondary trauma (May & Wisco, 2015, p. 234). Secondary traumatisation is the stress

associated when a person experiences a traumatic event indirectly (May & Wisco, 2015). This can be in the form of hearing and or viewing it through narrative accounts (May & Wisco, 2015). Many researchers have found secondary trauma to be most commonly experienced by professionals who provide services to vulnerable and traumatised communities, such as mental health professionals (Bride, 2007; Elwood et al., 2011; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Shoji et al., 2014, as cited in May & Wisco, 2015) telecommunicators (Pierce & Lilly, 2012) medical professionals (Peltzer, Matsek, & Louw, 2014) and police officers (Brady, 2008). This type of traumatic stress can also be referred to as *compassion fatigue* (Figley, 2002, p. 1435) or “*vicarious traumatization*” (McCann & Pearlman, 1990, as cited in May & Wisco, 2015, p. 236). A study conducted by Bride (2007) on effects of secondary trauma faced by those individuals in a work related environment showed that out of the 282 social workers that were studied, 70.2% of them experienced at least one symptom of PTSD in a week (Bride, 2007, p.67). Bride’s (2007) research has shown that professionals who are frequently exposed to secondary trauma may experience PTSD symptoms or distress.

PTSD and First Responders. Traumatic situations and events can often be a feature of police work (Carleton et al, 2018; Rees & Smith, 2007; Royal Canadian Mounted Police, 2020). The nature of their role to interact with an assortment of personalities, and violent, threatening and horrific situations make operational policing much more inclined and liable to traumatic stress (Carleton et al, 2018; Rees & Smith, 2007). Researchers have argued that at times police officers experience traumatic events, and these events are not handled effectively (Rees & Smith, 2007). The ineffective responses can ‘lock’ officers into a traumatic cycle (Rees & Smith, 2007, p. 272). The lack of response can be attributed to the ‘police culture’ prevalent among many policing organisations (Loftus, 2012). A study conducted by Smith (2009) looked at statements made during his time researching police officers in the UK. He looked for connections between statements made about trauma and police culture. Focusing on sudden death, death of infants, fatal car accidents, victims of crime, firearm matches, and other public disorder incidents, he found that indeed officers are faced with traumatic incidents, and culture does in fact play a role in further traumatization (Rees & Smith, 2007; Smith, 2009). Heavily relying

on one another can benefit officers in many ways; however, Walker (1994) has argued that this cohesiveness has the potential for negatives, and it results in solidarity and insularity (Walker, 1994, as cited in Rees & Smith, 2007). In Smith's (2009) study, the officers had commonly expressed copious amounts of peer pressure, resistance to change and cynicism (Smith, 2009). Interviews with police officers disclosed the difficulties one faced, which would generally lead to emotional black mail, taunts, and remarks from fellow officers (Smith, 2009). The officer also stated that it was dangerous to show any weakness and to be honest. Interviewed officers also revealed change within a policing organisation was either disastrous or met with backlash as officers viewed it to be loads of trash (Rees & Smith, 2007; Smith, 2009). Reaching out is seen as a sign of weakness and incompetence, therefore ignoring these symptoms seems to be their only options, however, doing exactly that is what allows them to fall prey to PTSD (Smith, 2009; Violanti & Hackett, 2003; Waters & Ussery, 2007).

Stigma

Understanding the term stigma, as well as the role it plays with those suffering and dealing with mental illness is paramount. Mental illness has, and continues to be, one of the most stigmatised topics in our society (Byrne, 1997; Byrne, 2000; Chronister, Chou & Liao, 2013; Corrigan & Penn, 1999). As the literature will suggest, persons with mental illnesses (PWMI) face insurmountable challenges and hurdles in their lives, and the addition of stigma only further adds stress (Corrigan & Watson, 2002; Markowitz, 1998). The American Psychological Association (2020) defines stigma as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency" (American Psychological Association, 2020). The negative stereotypes attached to these persons can also lead to discriminatory behaviours directed at the individuals (American Psychological Association, 2020). One study, while looking at the impact stigma plays with those living with mental illness, suggests that stigma can be evident in one of two ways: "public stigma" and "self-stigma," which, respectively, are the reactions of the populations towards PWMI, and secondly, is the prejudice towards oneself, while coping with their mental

illness (Canadian Mental Health Association, 2016; Corrigan & Watson, 2002; Hack, et al., 2019). These forms of stigmas are an additional and oftentimes detrimental barrier to seeking and receiving assistance (Corrigan & Watson, 2002; Hack, et al., 2019; Markowitz, 1998). Link et al. (1997) suggests that the labelling effect on a person living with mental illness is quite strong and has adverse effects (Link et al., 1997; Markowitz, 1998). The negative stereotypes attached to individuals living with mental illnesses become their reality, which then allows the person to feel devalued and expect to be subjected to discrimination (Link et al., 1997; Markowitz, 1998).

The Effects of Stigma. The negative effects of stigma are seen to be destructive and harmful (Hack et al., 2019). There is substantial evidence that indicates the relation between the negative stigma faced and its impact of seeking help (Clement et al., 2015). The effects are so harmful, the World Health Organisation, in their World Health Report have stated stigma to be one of the remaining obstacles towards seeking treatment for mental illness (Chronister, Chou & Liao, 2013; Oral, 2007). Effects associated with stigma can, potentially, cause feelings of lower self-esteem, feelings of being misunderstood, depression, reduced help seeking, few social interactions, and an overall lower quality of life (Hack, et al., 2019); (Harris, et al., 1992; Lawrie, 1999; Link et al., 1989, as cited in Chronister, Chou & Liao, 2013; Link, Mirotznik & Cullen, 1991). These negative effects are commonly understood to be detrimental to an already vulnerable person, and thus in turn creates additional stressors for the individual. Discussing the role stigma plays is important, as we can connect how stigma in the workplace, the police culture, impacts those officers suffering in silence.

METHOD

This project aims to determine the connections between police culture and PTSD by examining contemporary newspaper articles and government reports. The authors chose to analyse newspaper articles as well as reports, as they provided a medium to hear officers' narratives, without structural and organisational barriers. For example, in an article, by Erlingsson and Brysiewicz (2017), they highlight that a content analysis provides not only a means to contextualise information, but also provides a conduit for

inducing narrative. Social science research has utilised content analysis to deepen arguments, identify themes, and build connections that other methodological approaches cannot illicit (Erlingsson & Brysiewicz 2017; Hsieh & Shannon, 2005). Furthermore, a qualitative content analysis was used, as it is ideal for textual data and allows for the interpretation and meaning of text (Hsieh & Shannon, 2005). Using this methodology proved superior, as it allowed the classification of large amounts of text into categories that represented similar meanings (Weber, 1990, as cited in Hsieh & Shannon, 2005). The goal for a content analysis is to help provide “knowledge” and to understand the phenomena being explored in greater detail, through the process of coding and identifying patterns within the literature (Hsieh & Shannon, 2005; Reid, Greaves & Kirby, 2017). Thus, it was considered that a content analysis was the most appropriate research method to utilise and to analyse our data.

Newspaper articles and government reports were drawn upon for this research project. We identified that newspaper articles offered us the accessibility to gain fruitful information, and access to interviews conducted with officers, both current and retired, which then allowed the analysis of those narratives and accounts of those conversations. Murdoch et al. (2019) followed a similar methodological approach, for example, they coded newspaper articles as a means to identify attributes within a population. Additionally, government reports provided us official accounts and perspectives of police culture. Drawing on these reports furthered our understanding of police culture being connected to PTSD, such as the impact of masculinity and toxicity as discussed. The inclusion of these government reports signifies that policing organisations acknowledge policing culture can be problematic. Therefore, we concluded these two sources of knowledge are not only empirically validated but offer tone, understanding, and context.

The primary resources for this study were retrieved online, consisting of sources from large news media outlets to smaller ones across Canada. The news media articles were searched and obtained by using key terms to synthesize relevant hits, through the platform *Google*. The initial search terms of “PTSD” and “Police” in “Canada” resulted in media articles all relevant to PTSD and police officers. The next search looked

for the terms “Police”, “Canada”, “PTSD” this also resulted in a large amount of resources – however the selection process to picking the articles looked at the relevance by the date published, and whether the article referenced the keywords searched. The third search used the key terms: “Police” “Canada”, “trauma” and “culture”; this search resulted in a few articles that would prove to be useful. The fourth and final search conducted used the terms “Canada”, “trauma”, “policing” and “culture”. This last search also tailored results to articles relating to police culture and trauma in policing. Having gone through the various articles, 41 news articles were selected to represent the sample of newspaper articles. The secondary and supplemental resources included were government reports and investigations (see Appendix B) that discussed the importance of police culture and PTSD within the workplace. The articles chosen were analysed only for their written content - content such as images, and comments sections were excluded from this analysis. After review of the articles key themes emerged and were subjectively coded for. These major themes that arose from the articles were then used later on for the coding process.

Using a multi-step color coding process specific themes were identified within the articles, such as trauma experienced by officers, stigma faced when receiving help, and police culture cultivating the stigma. For the government documents and reports, a spreadsheet was created outlining the passages referring, directly or indirectly, to police culture. The researchers looked at what the government documents identified as it’s “sources” “features” and “implications”. The researchers also searched for passages that identified the “sources,” “scope,” and “implications” of trauma, and lastly searched for the passages that discussed “reforms,” in regard to policing, trauma, and culture. The findings within the government reports showed that there was a direct link between trauma and culture.

FINDINGS AND ANALYSIS

Findings from a Review of Government Reports

From the aggregate data of government reports of policing and police culture, we can see a common theme overtly being discussed that indicates

police culture is a catalyst for trauma (see Rees & Smith, 2007). This theme was apparent from the years of 2007 through 2016. In Murphy & McKenna (2007), they argue that the police culture cultivates a negative work environment, where stigma is present towards officers experiencing difficulties on the job. This relationship, of stigma, making the job more difficult, makes these stigmatised officers hesitate to seek help (Murphy & McKenna, 2007). Moreover, the *Task Force on Governance and Change* identified policing to be stressful, dangerous, and a complex profession, where officers often rely on each other to ensure their safety (Murphy & McKenna, 2007). The police culture has also been described as a culture of “fear and intimidation” (Black et al., 2007). Officers do not speak about topics that may undermine their physical strength, such as mental health, as the culture within policing communities looks down upon weakness (Black et al., 2007). Therefore, speaking out about issues, such as PTSD, is faced with stigma and officers are then deterred from identifying with PTSD (Oliphant, 2016). Thus, inherently, it can casually be deduced that the police culture is a catalyst for trauma, which then prevents officers to seek out assistance.

“Trauma is the rule rather than the exception”. The report from the *Standing Committee on Public Safety and National Security* had indicated that the unique nature of their work puts police officers at risk for developing PTSD, specifically saying, “trauma is the rule rather than the exception” (Oliphant, 2016, p.3). Perhaps, as police officers internalise themselves representing a profession that embodies strength and mental fortitude, it puts pressure on the officers trying to maintain their reputation and their mental health, through means not in line with the established masculine traits (Loftus, 2012; Oliphant, 2016; Skolnick 1966). For example, the reports such as the final report of the *Standing Senate Committee on National Security and Defence* and the *Task Force on Governance and Change in the RCMP* have commonly expressed that policing organisations as a whole must undergo a “cultural transformation,” as many systemic barriers exist including a lack of leadership and training (Black et al., 2007; Lang & Dallaire, 2013).

Representations of PTSD and Occupational Stress in News Media Articles

Many of the articles express it's "about time" that we look into the impact of PTSD and police culture (Cowan, 2018^{*}). The Commissioner of the Royal Canadian Mounted Police, Brenda Lucki, stated, "we are actually talking about mental health in a loud voice and not a whisper" (Lucki, 2018, as cited in Cowan, 2018, para. 11). The media used the voices of many officers who have faced traumatic events and deal with PTSD to shine a light on how prevalent and important this issue is. The Executive Director of Wounded Warriors Scott Maxwell told CBC "As a nation we're losing, time and time again" (Bartlett, 2017, para. 5[†]). Maxwell also expressed how we are losing "too many of our [police officers] to the invisible injuries of mental health" at a rate too fast (Bartlett, 2017, para. 5).

"Suck it up, be a man". The features of the police culture can make it impossible, at times, for one to reach out for help. The dominant male culture that emphasises "macho problem solving and the denial of distress" (The Conversation, 2017, para. 4[‡]) accompanied with the prevalence of fear or career repercussions, all add to the unlikeliness of an active police officer seeking help (Carleton et al., 2018; Rees & Smith, 2007; The Conversation, 2017). It is apparent in the news media articles reviewed that police officers are reluctant to seek help when it comes to their dealings with PTSD and mental health issues, as there still seems to be stigma surrounding this topic within the occupation (Gollom, 2014[§]). Vince Savoia, the Executive Director of Team Counter Memorial Trust, has said the "old suck it up, be a man" attitude is still very predominant within policing organisations (Gollom, 2014). He further adds that stigma surrounding mental health issues continues to be a barrier for seeking help (Gollom, 2014). Further, Ontario Ombudsman, Andre Marin, adds that the "police culture today treats mental illness as a weakness...officers who

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suffer from workplace stress are told to “suck it up” or are ostracised” (Rash & Casey, 2012, para. 5*).

“To Serve and Protect their Mental Health”[†]. Officers are at a higher risk to commit suicide and experience symptoms of PTSD and depression (Carleton et al., 2018). In a study conducted by University of Regina’s Canadian Institute for Public Safety and Treatment, Director Nick Carleton reported on the rates of suicide committed by first responders. He found that, on average 50 percent of male Mounties are more likely to contemplate suicide due to traumas they’ve experienced on the job (Freeze, 2018[‡]; see Carleton et al., 2018 for a more comprehensive review and analysis). In Freeze (2018), Carleton stated, it is evident that we need to attend to our public safety personnel as they are exposed to a “daily tempo” of “high stress situations”. The witnessing of trauma, such as “desperate dying people” and internalizing it due to the “suck it up” culture takes a toll on first responders (Carleton et al., 2018). Those who do seek help for their work-related traumas are often ostracized and/or thrown under the bus, suggests Violanti (Lorinc, 2016[§]). John Violanti, professor of public health and epidemiology at the University of Buffalo has said there is “institutional pushback, and bullying” directed to those who voice their mental health concerns (Lorinc, 2016). Violanti goes on to say that admitting you have a problem should be the first step to recovery, however many first responders avoid seeking treatment for PTSD, due to the fear of being labelled as “weak or damaged” (Lorinc, 2016).

Being unable to find the support within their organisations due to these factors, officers either deny they have a problem, or suffer in silence until they retire (Lorinc, 2016). Such was the case for Detective Kruger of the Ontario Provincial Police (OPP) (see Lorinc, 2016). While on duty as an active police officer, he was forced to take a life (Lorinc, 2016). This resulted in him suffering from anxiety and PTSD for years, until he mustered courage to seek support at the OPP, however was told his meetings would be relayed back to his supervisor, and from that day he

* Listed in Appendix A

† Listed in Appendix A, No. 13

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§ Listed in Appendix A

“shut his mouth, until he retired” all to avoid the stigma and repercussions he would face (Lorinc, 2016). It is events such as these that continue to repress and stifle healthy conversations regarding mental health and PTSD, therefore, further adding to the mental and emotional struggles the officers are already experiencing. This also highlights how the stigma surrounding PTSD faced on the job deters officers’ willingness to seek assistance. Thus, creating additional stressors to an already vulnerable officer.

DISCUSSION

This paper found the police culture is a detrimental, negative, and impeding factor when officers are wanting to seek help with their mental illness. The features of police culture continue to promote an environment of silence and fear, and, if an officer is brave enough to speak up about their struggles, they are ostracized. Through a content analysis of news media articles and government reports, it was identified that the police culture plays a significant role when officers experience PTSD and try to seek assistance. The media articles, through interviews with officers, indicates that officers were frightened and hesitant to speak about their issues and were continuously struggling in silence. Thus, this paper aimed to discuss that police culture impacts an officers’ mental health relating to PTSD and exacerbating its effects. The culture and stigma surrounding mental health issues, such as PTSD, remain a constant barrier for officers. Thus, we can infer that the existing PTSD symptoms are then further aggravated through the toxic, masculine, and negative police culture (Black et al., 2007). The negative aspects of the police culture continue to manifest a cycle of trauma that officers, who in turn feel the need to suffer in silence than be faced with the negative effects of stigma produced by the culture (Rees & Smith, 2007; Waters & Ussery, 2007).

Policing organisations in recent years are now looking to raise awareness by promoting positive mental health conversations at work, as well as advertising races and fundraisers in support of seeking assistance with PTSD (CTV News, 2018^{*}; Sawachuk, 2018[†]; Stolz, 2018[‡]). However, a change in police culture discourse needs to occur in order to break the

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[‡] Listed in Appendix A

causational impact of the police culture. This can only be done through a systematic approach, such as police recruitment training, as indicated by Black and colleagues (2007). Top down training must also occur where managers, supervisors, and officers are trained with understanding empathy, sympathy, as well as acceptance. Police organisations must undergo a “cultural transformation” in order for there to be any success and acceptance to change (Lang & Dallaire, 2013). The development of a dependable support system, improved communication skills, and being able to ventilate feelings comfortably would provide officers the opportunity to heal and understand their experiences with PTSD (Waters & Ussery, 2007, p. 184). Waters & Ussery, (2007) identify some necessary changes and additions that would aid in restructuring previous rooted thought and culture towards mental health. Realistic job-related training that indicates trauma is a part of policing (Royal Canadian Mounted Police, 2020) as well as establishing open communication and conversation between officers and their supervisors is deemed necessary for change (Waters & Ussery, 2007, p.184). The addition of workshops that continue to promote mental wellness, and training for supervisors, as well as all levels of officers, to manage the emergence of those experiencing PTSD, and allowing for opportunities to debrief would also aid in the rehabilitation process (Waters & Ussery, 2007, p.184). Having programs in place that offer peer support can also be beneficial as it can deconstruct the notion that officers must remain emotionally tough with their colleagues (Carleton et al., 2018; Waters & Ussery, 2007). Employing strategies such as these may enable organisations to continue to move towards an open and positive environment that sees the emergence of conversations surrounding the struggles being experienced by officers.

CONCLUSION

This study was concerned with the ways that the police occupational culture continues to repress and stifle conversations regarding officers' mental health, and their ability and willingness to seek help. It examined elements of the police culture, as well as identified and defined the concept of police culture by examining previous explanations. The aim of this paper was to identify the connection between police culture exacerbating effects of PTSD and trauma within the workforce. By way of a content

analysis of news media articles and governmental reports, this study found a connection between the negative effects and features of the police culture stigmatising and ostracising officers dealing with mental health concerns. This in turn, may make them reluctant to seek help further adding to their stress. Only when we understand that some police occupational cultures are toxic and unsupportive environments, can we aim to implement force wide policies and training to educate officers on topics such as stigma intensifying PTSD symptoms.

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Appendix A

Selection of News Media Articles Reviewed

No.	Search String	Publication/ Author	Date	Title	URL
1	"police" "canada" "PTSD"	The Globe and Mail/ Colin Freeze	February 20th 2018	Paramedics face suicidal thoughts more frequently than other emergency responders, study finds	https://www.theglobeandmail.com/news/national/paramedics-in-canada-more-likely-to-experience-suicidal-ideation-study-finds/article38045978/
2	"police" "canada" "PTSD"	The St. Catharines Standard/ Bill Sawchuk	March 16 2018	Scars you can't see are the deepest	https://www.stcatharinesstandard.ca/news-story/8331221-scars-you-can-t-see-are-the-deepest/
3	"police" "canada" "PTSD"	CBC/ CBC News	March 16 2018	WorkplaceNL beefs up coverage for people in stressful jobs	http://www.cbc.ca/news/canada/newfoundland-labrador/workplace-nl-workers-compensation-ptsd-rnc-depression-anxiety-1.4580012

4	“police” “canada” “PTSD”	CTV/ CTV News	February 21 2018	Roasting for a cause: Alberta coffee startup aims to help first responders	https://www.ctvnews.ca/canada/roasting-for-a-cause-alberta-coffee-startup-aims-to-help-first-responders-1.3813971
5	“police” “canada” “PTSD”	CBC/ Dean Stolz	February 21 2018	Wounded Warriors Run raising money to help those with PTSD	https://www.cheeknews.ca/wounded-warriors-run-raising-money-help-ptsd-421426/
6	“police” “canada” “PTSD”	Regina Post/ Cowan	Leader Pamela March 2nd 2018	Millions in federal funding for post-traumatic stress injury research	http://leaderpost.com/news/local-news/millions-in-federal-funding-for-post-traumatic-stress-injury-research
7	“police” “canada” “PTSD”	CBC/ Brett Ruskin	September 19 2017	Human rights probe launched into police officer's pay cut after PTSD diagnosis	http://www.cbc.ca/news/canada/nova-scotia/halifax-police-officer-ptsd-diagnosis-pay-cut-benefits-human-rights-commission-complaint-1.4283565
8	“police” “canada” “PTSD”	CBC/ Yvonne Colbert	October 4th 2017	He's the 'poster boy' for PTSD, but Halifax police chief is now accused of hypocrisy	http://www.cbc.ca/news/canada/nova-scotia/halifax-police-chief-ptsd-hypocrisy-

					officers-1.4319292
9	“police” “canada” “PTSD”	CBC/ Alison Crawford	August 30 2017	Researchers find significantly higher rate of mental disorders among first responders	http://www.cbc.ca/news/politics/police-fire-fighters-ptsd-paramedis-1.4266720
10	“police” “canada” “PTSD”	Global News/ Phil Heidenreich	January 18th 2018	Former Edmonton police officer alleges harassment, lack of help with PTSD while with EPS	https://globalnews.ca/news/3974849/former-edmonton-police-officer-alleges-harassment-lack-of-help-with-ptsd-while-with-eps/
11	“police” “canada” “PTSD”	The Leader (Morrisburg)/ The Leader	March 15th 2- 018	Who cares for the Caregivers	http://www.morrisburgleader.ca/2018/03/15/who-cares-for-the-care-givers/
12	“police” “canada” “PTSD”	CBC/ Yvonne Colbert	October 12 2017	In-patient PTSD centre needed in Atlantic Canada, advocate says	http://www.cbc.ca/news/canada/nova-scotia/in-patient-ptsd-centre-needed-atlantic-canada-1.4349974

13	"police" "canada" "PTSD"	CBC/ Geoff Bartlett	September 14 2017	To serve and protect their mental health: The call for more PTSD help for first responders	http://www.cbc.ca/news/canada/newfoundland-labrador/first-responders-ptsd-1.4289095
14	"police" "canada" "PTSD"	OHS Canada - Magazine/ Jeff Cottrill	October 17th 2017	Advocate calls for better availability for PTSD treatment for first responders	https://www.ohs canada.com/advocate-calls-better-availability-ptsd-treatment-first-responders/
15	"police" "canada" "PTSD"	CBC/ Rafferty Baker, Majula Dufresne	September 29th 2017	B.C. government to make it easier for 1st responders to make PTSD claims	http://www.cbc.ca/news/canada/british-columbia/ptsd-presumptive-clause-for-first-responders-1.4312561
16	"police" "canada" "PTSD"	Saultstar.com/ Brian Kelly	January 27th 2018	More police will want PTSD help: Keetch	http://www.saultstar.com/2018/01/27/more-police-will-want-ptsd-help-keetch
17	"police" "canada" "PTSD"	CBC/ CBC News	March 20th 2017	'Traumatic event' claims quintupled among Ottawa police after PTSD law enacted	http://www.cbc.ca/news/canada/ottawa/ptsd-prevention-ottawa-police-1.4032887

18	“police” “canada” “PTSD”	CBC/ Ariana Kelland	September 27 2017	Journey through post-traumatic stress: A story of 2 officers	http://www.cbc.ca/news/canada/newfoundland-labrador/ptsd-rnc-hmp-kelsey-aboud-dave-odea-1.4305316
19	“police” “canada” “PTSD”	Toronto Sun/ Terry Davidson	March 12 2017	Many cops shy away from PTSD treatment	http://torontosun.com/2017/03/12/many-cops-shy-away-from-ptsd-treatment/wcm/60431bb0-5c15-4e9e-a375-b0ca282b44a8
20	“police” “canada” “PTSD”	CBC/ Alison Crawford	October 14 2017	'How many more lives do we have to lose?': MP urges Senate to pass PTSD bill after Mountie's death	http://www.cbc.ca/news/politics/rcmp-suicide-first-responders-todd-doherty-1.4354280
21	“police” “canada” “PTSD”	Global News/ Maham Abedi	November 26 2017	PTSD, suicide and first responders — A lot of talk, and not much progress	https://globalnews.ca/news/3874975/first-responders-ptsd-mental-health-progress/
22	“police” “canada” “PTSD”	Mississauga News/ Chris Clay	November 16 2017	Higher rates of PTSD in first responders but also afflicts other fields	https://www.mississauga.com/news-story/7767459-higher-rates-of-ptsd-in-first-responders-but-also-afflicts-other-fields/

23	“police” “canada” “PTSD”	Global News/ Kelly Hayes	October 16h 2017	Cops criticize RCMP for how it handles members with PTSD	https://globalnews.ca/news/3807048/cops-criticize-rcmp-for-how-it-handles-members-with-ptsd/
24	“police” “canada” “PTSD”	The Tyee/ Crawford Killian	August 2 2017	Why Is Canada #1 in PTSD?	https://thetyee.ca/Opinion/2016/08/02/Canada-PTSD/
25	“police” “canada” “PTSD”	CBC/ CBC News	February 23 2017	More than 30 per cent of Vancouver police officers have PTSD, says study	http://www.cbc.ca/news/canada/british-columbia/police-vancouver-ptsd-kwantlen-1.3997069
26	“police” “canada” “PTSD”	The Globe and Mail/ Colin Freeze	DECEMBER 18 2016	As police gain awareness of PTSD, Mounties see diagnoses doubling	https://www.theglobeandmail.com/news/national/as-police-gain-awareness-of-ptsd-mounties-see-diagnoses-doubling/article33360812/
27	“police” “canada” “PTSD”	Global News/ Natasha Pace	February 6 2018	Wounded Warriors Canada investing \$300K to create a national PTSD service dog program	https://globalnews.ca/news/4009576/wounded-warriors-canada-ptsd-service-dog-program/

28	"police" "canada" "trauma" "culture"	The Globe and Mail/ Jojn Lorinc	Janusry 15 2016	How do we help the first responders who endure trauma when helping us?	https://www.the-globeandmail.com/news/national/theyre-there-when-trauma-hits-us-but-whos-there-when-it-hits-them-back/article28217514/
29	"police" "canada" "trauma" "culture"	CBC/ Cameron MacLean	December 2 2017	Drunk driving charges against police reveal struggles to deal with trauma, psychologists say	http://www.cbc.ca/news/canada/manitoba/winni-peg-police-service-drunk-driving-therapy-counsellors-1.4429753
30	"police" "canada" "trauma" "culture"	CBC/ Mark Gollom	September 29th 2017	Why emergency services need a 'culture change' to deal with PTSD	http://www.cbc.ca/news/canada/why-emergency-services-need-a-culture-change-to-deal-with-ptsd-1.2781733
31	"police" "canada" "trauma" "culture"	The Star/ Graham Slaughter	Septmeber 8th 2014	Lives of Ontario LGBT cops revealed in new study	https://www.the-star.com/news/gta/2014/09/08/lives_of_ontario_lgbt_cops_revealed_in_new_study.html

32	"police" "canada" "trauma" "culture"	The Globe and Mail/ Andrea Woo	November 20th 2017	Abbotsford, B.C. police chief praised for mental-health advocacy after deadly shooting	https://www.the-globeandmail.com/news/british-columbia/abbotsford-bc-police-chief-praised-for-mental-health-advocacy-after-deadly-shooting/article37035929/
33	"canada" "trauma" "police culture"	The Conversation/ The Conversation	March 2nd 2017	Police officer's suicide: it's not just about workplace stress, but culture too	http://theconversation.com/police-officer-suicide-its-not-just-about-workplace-stress-but-culture-too-76710
34	"canada" "trauma" "police culture"	The Record/ Liz Monteiro	January 20 2017	Waterloo Regional Police face gender-discrimination suit	https://www.the-record.com/news-story/7347554-waterloo-regional-police-face-gender-discrimination-suit/
35	"canada" "trauma" "police culture"	Police One/ Troy Kneebone	December 1 2017	The 7 layers of police grief after a line-of-duty death	https://www.policeone.com/health-fitness/articles/463467006-The-7-layers-of-police-grief-after-a-line-of-duty-death/

36	“canada” “trauma” “police culture”	The Star/ Curtis Rash & Liam Casey	October 5th 2017	How the Ontario Provincial Police deals with officers’ PTSD	https://www.thestar.com/news/crime/2012/10/05/how-the-ontario-provincial-police-deals-with-officers-ptsd.html
37	“canada” “trauma” “police culture”	Ottawa Citizen/ Robert Sibley	September 29th 2014	The unspoken toll: Police suffering in silence	http://ottawacitizen.com/news/local-news/the-unspoken-toll-police-suffering-in-silence
38	“canada” “trauma” “police culture”	The Hamilton Spectator/ Susan Claremont	January 18 2014	Mental health, police officers and suicide	https://www.thepec.com/news-story/4322554-mental-health-police-officers-and-suicide/
39	“canada” “trauma” “police culture”	Global News/ Anna Mehler Paperny and James Armstrong	July 29th 2014	Should we be hiring more compassionate cops?	https://globalnews.ca/news/1479598/should-we-be-hiring-more-compassionate-cops/
40	“canada” “trauma” “police culture”	The Star/ Curtis Rash	October 24th 2012	Ombudsman slams OPP and government for lack of action on PTSD among officers	https://www.thestar.com/news/canada/2012/10/24/ombudsman-slams-opp-and-government-for-lack-of-action-on-ptsd-among-officers.html

41	“canada” “trauma” “police culture”	Global News/ Kendra Slugoski	March 16th 2015	Unique EPS program helps treat ‘working wounded’ and reintegrate work	https://globalnews.ca/news/1885489/unique-eps-program-helps-treat-working-wounded-and-bring-them-back-to-work/
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Appendix B

Selection of Government Reports

Title	Organization	Date	Author/s
“Action Plan: The Way Forward. Modernizing Community Safety in Toronto”	Toronto Police Service: Final Report Transformation Task Force	2017	Toronto Police Service
“Healthy Minds, Safe Communities: Supporting our Public Safety Officers through a National Strategy for Operational Stress Injuries”	Canadian Public Safety and National Security: Report of the Standing Committee on Public Safety and National Security	2016	Robert Oliphant
“Rebuilding the Trust”	Royal Canadian Mounted Police: Task Force on Governance and Change in the RCMP.	2007	Linda Black David A. Brown Richard Drouin Norman D. Inkster Larry Murray

“Conduct Becoming: Why the Royal Canadian Mounted Police must Transform its Culture”	Report for the Standing Senate Committee on Canadian National Security and Defense	2013	Hon. Daniel Lang Hon. Roméo A. Dallaire
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ABOUT THE AUTHORS

Salehah Hakik recently graduated and successfully obtained her Bachelor of Arts (Honours) in Criminology with Co-op Distinction at Kwantlen Polytechnic University in British Columbia, Canada. Salehah received honourable recognition at the provincial level from the *Association of Cooperative Education and Work Integrated Learning* for her achievements as co-op student of the year. She has extensive experience working with at risk youth and families in her role as a Youth Support Worker. She is actively engaged in social justice, and human rights issues and strives to advocate for and provide voices to the voiceless within the criminal justice system. She aims to continue her passion for advocacy through a career in law as well as pursuing further research opportunities at a graduate level. Salehah can be reached at salehahhakik33@gmail.com.

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Book Review

Mental Health and Offending: Care, Coercion and Control

Julie D. Trebilcock and Samantha K. Weston

Routledge

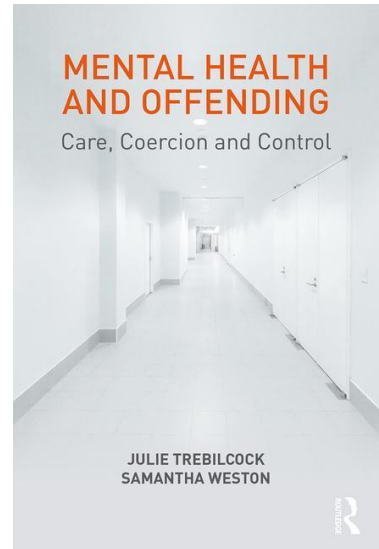
2019, 296 pages

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Reviewed by Piero Moraro

A person is as likely to be killed by a stranger with schizophrenia as she is to be killed by a lightning; and yet, as Julie Trebilcock and Samantha Weston note in the opening chapter, Western societies (specifically the UK, which is the focus of their book) are deeply worried by the dangerousness of people with mental health problems. This striking disproportionality between the threat posed by mentally disordered people, on the one hand, and the response to it by the UK Government, on the other, constitutes one of the major themes underlying this book. The authors illustrate how UK mental health legislation seemingly treats offenders with a mental health disorder on a par with terrorists: “the power to constrain, without trial, those posing a putative future risk is only found in mental health services and in statutes to pre-empt terrorism” (4).

This is even more troubling since people suffering from poor mental health are among the most vulnerable members of society, and governments should abide by requirements of proportionality and necessity when legislating on mental health. As the book’s title reveals, the challenge for any democratic society, with reference to mental health, involves balancing three seemingly conflicting goals: care, coercion and control.



The imperative of ‘care’ should be given priority, since people suffering from mental health disorders are significantly more *at risk from* the community than they are *a risk to* the community: they are disproportionately more likely to be victims themselves rather than offenders. Yet, as the authors explain in chapter 3, politicians have a tendency to pay more attention to community’s volatile feelings than to the advice of experts; hence, they are more likely to (appear to) manage a perceived risk than to heed the pleas of service user activists.

The “anti-psychiatry” movement in the second half of the 20th century played a major role in promoting the *deinstitutionalisation* of mentally disordered people. In the 1960s, Michel Foucault, Erving Goffman and Thomas Szasz highlighted the coercive, abusive and stigmatising nature of the mental asylum which, far from playing a ‘humanitarian’ role, was a site for the exercise of *power*. Similarly, David Rosenhan’s famous experiment (in which he feigned a mental disorder and, once admitted to hospital, returned to acting ‘normally’, yet was not released for another 6 weeks) sought to highlight the unreliability of psychiatric diagnoses. Others have stressed the risk of stigmatisation and prejudices against patients, whose subjective experience is often ignored by the medical account of their condition.

Thus, the shift from mental asylums to community care was a welcome development of this debate in the 1980 (though significantly sped up by financial considerations, as community-based facilities were much cheaper than large asylums). Yet, as the authors explain, this shift led to what Stan Cohen labelled the “dispersal of control”, whereby mentally disordered people fell under the “disciplinary gaze of the state”. The process of deinstitutionalisation turned into one of *trans-institutionalisation*, whereby the criminal justice system became the *de facto* mental health care provider.

It is an unfortunate coincidence that, together with the closure of mental asylums, the 1990s also witnessed the emergence of a “new penology”, focused on risk-management rather than on justice. The ensuing mass incarceration in the 1990s and 2000s (the UK prison population almost doubled from 1993 to 2012) meant that a larger number of offenders with mental health issues were sent to prison rather than to community care

institutions. The authors contend this resulted in the “arranged marriage” of two very different ideologies, that of the NHS, based on healing and wellbeing, and that of the prison system, based on security and deprivation of liberty – with security playing a dominating role over healing (197).

The authors further highlight the chronic underfunding of the mental health sector over the past 10 years. The latter has not only hampered attempts to help mentally disordered individuals but has also placed the police force “between a rock and a hard place”. The UK police force is the only body which is available 24/7 to manage mental health-related emergencies; as the authors reveal, there have been situations where police officers have even had to act as first responders, due to lack of ambulances. Similarly, despite legislative reform in 2017 stressing the need to detain mentally disordered individuals in HBPOS (Health-Based Places of Safety) rather than in prison cells, the latter have turned out to be the only option available to house those individuals, due to lack of available HBPOS. In this sense, this book offers yet another reminder of austerity’s toxic effects not only on the health of the most vulnerable citizens, but also on the institutions designed to serve and protect the community.

ABOUT THE REVIEWER

Dr. Piero Moraro is a Lecturer at the Centre for Law and Justice, Charles Sturt University. His research focuses on issues in philosophy, law and political theory. He is the author of *Civil Disobedience: A Philosophical Overview* (2019, Rowman and Littlefield International).

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