Mentalization-based treatment for antisocial personality disorder: Evaluating the implementation of a randomised controlled trial in the UK criminal justice system

Jessica Wood Yakeley

Division of Psychology and Language Sciences

University College London

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Thesis declaration:

I, Jessica Yakeley, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Name: Jessica Wood Yakeley

Date: 11.2.2023

Abstract

Background

In contrast to the health care sector, there is a paucity of randomised controlled studies (RCTs) conducted within criminal justice settings due to cultural, ethical, methodological, and practical challenges, such that many interventions aimed at reducing risk or improving the health of offenders lack a robust evidence base.

Aims

The aims of this thesis are firstly, to identify the barriers to implementing a multi-site RCT of mentalization based treatment for violent offenders with a diagnosis of antisocial personality disorder under the supervision of the UK National Probation Service; and secondly, to explore which theoretical frameworks might offer the best conceptualisation and understanding of the nature, meaning and origins of these barriers to identify preventative or mitigating interventions.

Methods

Semi-structured interviews with a total of 64 staff were conducted via focus groups and individual interviews. All had roles in implementing the trial as therapists, research assistants, coordinating assistant psychologists, probation officers, experts by experience and commissioners. Transcripts were analysed using thematic analysis.

Findings

5 predominant themes were generated for each group. The most cited obstacle to implementing the trial was the emotional impact of researching in criminal justice settings, a finding not previously reported in the literature. Other predominant themes included systemic issues, attrition of participants, and trial methodology and delivery. Experts by experience highlighted challenges in taking up research roles in forming an identity, maintaining boundaries, continuity, and effecting change. Distinct, but complimentary, theoretical models of emotionality from the fields of psychoanalysis, sociology, and criminology were helpful in interpreting these results and in identifying solutions to such challenges.

Conclusion

Challenges to implementing trials in criminal justice settings should be anticipated at the outset. Strategies to prevent or minimise these should be integral to trial design and methodology, and include interventions, such as reflective practice, aimed at reducing emotional pressures.

Impact Statement

Despite its limitations, the RCT remains the gold standard methodology for studying causal relationships between an intervention and its outcome, and as such is essential in demonstrating that interventions used within the criminal justice system are effective. It is therefore essential that obstacles to carrying out such trials be identified and interventions to prevent or ameliorate these are developed. Although there is a growing literature on the challenges of implementing RCTs in criminal justice settings, studies are mostly descriptive, and do not base suggestions on empirical studies aimed at investigating these difficulties. This thesis addressed this gap and identified and applied theoretical models to improve understanding of barriers to RCTs for prevention or treatment interventions.

Several findings of this thesis replicate those of previous studies in identifying significant obstacles to implementing trials in the criminal justice system: systemic issues, resistance to randomisation, attrition of trial participants and lack of research expertise. However, to the author's knowledge, this research has produced findings not previously described concerning the emotional impact on the staff of conducting trials, and the personality traits and behaviours of the trial participants which resulted in particular difficulties in recruitment, randomisation, engagement and retention. Furthermore, in identifying theoretical models to better understand these barriers and identify preventative or mitigating interventions, this thesis offers further contribution to research by integrating psychological and sociological concepts pertaining to emotions in criminal justice settings.

The findings of this thesis are of relevance to all those involved in implementing and conducting RCTs in criminal justice settings. For the academic community, the results support researchers to anticipate challenges to implementation at the outset and offers strategies to prevent or minimise these arguing that addressing the resistances should be included at the trial planning phase and remain integral to its design, methodology and delivery. The emotional risks of doing research trials in criminology, especially with high-risk offenders, should be considered as important as physical risks, and consideration of these risks, as well as measures to be put in place to mitigate them,

should be included in applications for ethical approval boards. The researchers, and others involved in the trial such as the clinicians delivering an intervention, should be able to access sources of support, such as regular supervision, or reflective practice, to process the psychological and emotional effects of the work.

More generally, this thesis has exposed the lack of collaboration in criminal justice studies between researchers in the psychological field, and those within academic criminology. Research involving emotionality in criminology researchers could be enhanced by the linking of these different disciplines.

Policy makers, commissioners and grant-giving bodies should also be aware of the challenges of implementing trials, particularly in systems undergoing organisational changes that may result in problems in communication, poor staff morale, staff shortages and high staff turnover.

Finally, this thesis provides evidence that ex-offenders with lived experience of the criminal justice system may be helpful in criminological research and their participation should be facilitated in future studies.

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Chapter 1: Introduction and context for the study

1.1 Introduction

This introductory chapter provides the background and context of this thesis, the research aims and hypotheses, the methodology, the significance of the study in addressing gaps in the field, and the limitations of the research, and concludes with an outline of its chapters.

1.2 Background to the thesis

Since its introduction in the 1990s (Eddy, 1990a; 1990b) evidence based medicine – the use of the current best scientific evidence in making decisions about the care of individual patients – has become increasingly required practice in the field of health care, with the publication of guidelines such as the National Institute for Health and Care Excellence (NICE) evidence-based recommendations for health and care in England, and the demand for services to provide empirical evidence of the effectiveness of their interventions. Although evidence-based practices have spread from the health care sector to other fields such as the allied health professions, education, management, architecture and law, their uptake within the criminal justice system has been slower (Johnson et al., 2018), resulting in a paucity of published methodologically sound trials such that many of the interventions to reduce risk or improve the health of offenders lack a robust evidence base.

This state of affairs may be attributed to the many challenges in implementing trials - particularly those which are randomised controlled and offer the best evidence for an intervention's effectiveness - within criminal justice settings. Over the past 20 years, criminological researchers have investigated the manifold resistances and barriers to the uptake of randomised controlled experiments. These include differences in the relative cultures between medical science and criminology; ethical issues such as withholding a potentially effective treatment from half of the participants in a randomised controlled trial (RCT); practical challenges, for example, engaging partner agencies, delays in obtaining ethical approval, and the problems of recruiting and randomising participants in busy environments undergoing frequent reorganisations, high staff turnover and low staff morale; and methodological issues such as small

sample sizes, attrition of participants, contamination between treatment and control participants and difficulties in blinding of participants and professionals implementing the intervention (Asscher et al., 2007; Boruch, 2000; Di Paola et al., 2014; Farrington and Jolliffe, 2002; Labriola et al., 2010; Pearson et al., 2010; 2016; Shepherd, 2003; Weisburd, 2000; 2003).

The ideas which developed into this thesis arose from its author's experience of being part of the team involved in conducting an RCT which took place in the UK criminal justice system within the Offender Personality Disorder (OPD) pathway Programme, a government funded initiative jointly commissioned by the Department of Health and the Ministry of Justice that aims to provide a pathway of psychologically informed services to identify, manage and treat offenders who are likely to be diagnosed with a severe personality disorder and who pose a high risk of harm to others. As noted above, few of the available treatment interventions for offenders have been subject to robust evaluation for their effectiveness, and the commissioners of the OPD pathway were keen to facilitate an RCT of a psychological therapy, mentalization-based treatment (MBT), that had shown some promise in reducing violence in individuals with a diagnosis of antisocial personality disorder (ASPD). In 2014, these commissioners provided funding for the development of MBT services within 13 probation offices across England and Wales which would constitute the treatment arm of the RCT, which was aimed at evaluating the effectiveness and cost-effectiveness of MBT in violent offenders under the supervision of the National Probation Service. A research grant from the National Institute of Health Research was subsequently obtained to fund the research component of implementing the RCT, and recruitment of participants commenced in 2016.

However, from the outset, obstacles to all aspects of the RCT's implementation - initially the recruitment, assessment, and randomisation of participants, followed by delivery of the intervention, data collection, retention of participants and their follow-up - were encountered, which were similar to the challenges involved in conducting RCTs in criminal justice settings described in the literature. It therefore seemed pressing to attempt to identify the factors which were impeding the trial as these might interfere with and bias its results. For example, if it was found that there was no difference in the reduction of violence in participants between the intervention and the

treatment arms, this might be due to failure to retain participants in the MBT groups rather than failure of MBT to effect change in offenders' behaviour.

1.3 Aims of the thesis

The aims of this thesis are twofold: firstly, to identify the barriers to implementing this RCT; and secondly, to explore which theoretical frameworks might offer the best conceptualisation and understanding of the nature, meaning and origins of these barriers in order to identify preventative or mitigating interventions. Two particular theoretical frameworks were initially identified as being potentially informative in interpreting the results: firstly, a mentalizing framework, which forms the theoretical underpinning to the psychological intervention, MBT, which is being evaluated by the RCT; and secondly a psychoanalytic framework, from which mentalizing theory developed. The hypothesis is that systemic factors would be one of the main obstacles to conducting the trial, which could be understood within these two different, albeit related, theoretical frameworks: 1. within a mentalizing framework, the criminal justice system can be thought of as a non-mentalizing system in which non-mentalizing factors, such as psychic equivalence or teleological ways of thinking, will be barriers to the implementation of this RCT; and 2. within a psychoanalytic framework, unconscious factors, including pathological defence mechanisms such as projection and projective identification, may systemically create and perpetuate a hostile environment that hinders the delivery of the RCT. If this hypothesis is correct, interventions that increase mentalizing and/ or address pathological unconscious processes within the system may be effective in addressing obstacles to the implementation of such trials.

1.4 Methodology of the study

Most of the publications exploring the challenges of implementing trials in the criminal justice system as mentioned above consist of descriptive accounts and there is a lack of studies which use a more empirical approach to investigate this issue. Moreover, there are no studies, to my knowledge, which attempt to interpret the difficulties in conducting trials in criminology within a wider conceptual framework. This thesis attempts to address these gaps in the literature by carrying out a methodologically robust qualitative study of the challenges to implementing an RCT evaluating a

psychological treatment for offenders within the UK criminal justice system. The study involves carrying out semi-structured interviews with the staff who were currently involved in conducting the trial, which were subsequently systematically subjected to thematic analysis, a well-established qualitative method of analysis used to identify, analyse, and report patterns or themes within sets of data. This study therefore adds to the literature on the challenges in conducting RCTs in the criminal justice system in the UK in its robust methodological design and empirically derived findings, which are then submitted to systematic reviews motivated by different meta-analytic theoretical frameworks.

1.5 Limitations to the research

As with any research, there are limitations, and several potential ones could be identified from the outset with this study. One limitation is that the thesis' author both conducted and analysed the qualitative interviews and had also been involved in the trial in being the lead for the development of the MBT community services which formed its intervention arm. Interviewing the staff and analysis of the interviews, therefore, may have been unconsciously influenced by the selection of themes to fit with her pre-existing experiences in her involvement in the trial, which may have then biased the findings. Similarly, another limitation may be that the author's fields of expertise are psychoanalysis and mentalizing which may have led to these two theories being chosen at the expense of others which might provide as useful or a better conceptualisation of the data. This indeed proved to be the case in that whilst psychoanalytic and mentalizing theories showed value in understanding some aspects of the study's findings, certain limitations were identified which led the author to explore other theoretical frameworks outside of the psychological field.

1.6 Structure of the thesis

Following this introductory chapter, the next three chapters of the thesis describe the setting for this study and its theoretical underpinnings. Chapter 2 provides the context for the implementation of the RCT. It summarises the overall structure and functions of the criminal justice system in the UK, and then reviews in detail the historical development of probation services and how this has been shaped by cultural and political influences. The chapter then describes the diagnosis of ASPD and the

empirical evidence for its aetiology and treatment; and concludes with outlining the psychological therapy – MBT- which is being evaluated in the trial for the treatment of ASPD, and the theory on which this intervention is based.

Chapter 3 reviews the two theoretical frameworks, the psychoanalytic study of organisational dynamics and mentalizing social systems, which are proposed as having the most potential in interpreting the factors identified as causing obstacles to the implementation of the RCT. The psychoanalytic approach stems from the theory of social defences, which integrates the sociological ideas of Eliot Jacques (1955) and the psychoanalytic ideas of Isobel Menzies Lyth (1960a, 1960b) to explore how institutions defend against anxieties by using unconscious defence mechanisms. Menzies Lyth's application of these concepts to examining the nursing system in a malfunctioning medical teaching hospital led to the development of the Tavistock model of organisational consultancy, and the subsequent psychoanalytic study of organisations within mental health and more recently criminal justice settings. Central to psychoanalytic organisational theory is the concept of countertransference - the emotional responses generated in staff by the work - which is utilised to understand and explore the anxieties and defences in the organisation. The chapter goes on to review how mentalizing theory has been applied to the study of social systems, how effective mentalizing is necessary for social systems to be supportive for and generate epistemic trust for the individuals within them, and how ineffective mentalizing within institutions and organisations, including the criminal justice system, can cause such systems to become inflexible, unresponsive and hostile to the needs and mental states of the individuals – the staff and those they are tasked to manage or care for - within them.

Chapter 4 describes the Offender Personality Disorder pathway programme, which is the setting in which the RCT is embedded. The chapter goes on to describe the MBT services developed within the OPD programme which support the delivery of the RCT, and the design and delivery of the Mentalizing for Offending Adult Males (MOAM) RCT conducted within these services.

Chapter 5 investigates the existing literature on the challenges of implementing trials in criminal justice settings. It consists of a systematic literature review of all RCTs

conducted within the UK criminal justice system, establishing their type (e.g., cluster trial, block randomisation, step-wedged design), setting (prison, probation, police, courts and juvenile offending services), outcomes (including health and risk related) and risk of bias, and specifically any reported difficulties encountered in the implementation of each trial. The findings of this review orientate the research aims of the subsequent study specific to the MBT RCT and provide a baseline against which to compare its findings.

The next three chapters comprise the body of the thesis' empirical investigations in describing in detail the design, execution and results of the qualitative study that constitutes the central point of this thesis. This study is an exploration of the obstacles encountered by the staff involved in the implementation of the MBT RCT. Chapter 6 describes the methodology of the study, which involved the design and application of semi-structured interviews, which were subsequently subjected to thematic analysis. Chapter 6 then focusses on the interviews with the different members of the team – the MBT clinicians and assistant psychologists delivering the treatment arm of the RCT, the probation officers who facilitated recruitment and retention of participants, and the research assistants who were responsible for interviewing and data collection - and the themes that emerged from these interviews, which are discussed in relation to the obstacles to implementation identified in the literature review. Chapter 7 details the interviews with the commissioners within the OPD programme who funded the clinical services which provided the RCT's treatment under evaluation; and chapter 8 describes the interviews with the experts by experience – the ex-offenders who formed part of the MBT team and helped deliver the treatment arm by co-facilitating groups and providing additional support to those offenders allocated to treatment. This latter chapter discusses the experiences of these experts by experience in relation to peer support and service user involvement in mental health services and criminal justice settings.

Chapter 9 explores the most significant finding from the thematic analysis of the interviews, which was that the main challenge to the trial's implementation identified by the staff in carrying out the RCT was its emotional impact on them. The meaning of this outcome is investigated within five different theoretical frameworks to explore which one might provide the best conceptual fit in interpreting these results. As

mentioned above, the first two frameworks under consideration - the psychoanalytic organisational and mentalizing models respectively - had been hypothesised at the start of this thesis as being the most relevant in understanding the trial's findings. However, the finding that the emotional burden on staff was the main impediment was unexpected, and although both models were found to offer value in understanding the dynamic emotional relationships between the staff and offenders and non-mentalizing factors within the system, they were also found to have some limitations. This led to identifying alternative theoretical models of emotionality within criminal justice settings that have been developed within the fields of sociology and criminology, which may add to the interpretation of the study's results. Three such models, which are inter-related, are introduced: emotional labour, emotional literacy, and affective and moral climate, respectively. The literature pertaining to the theory and application within health and criminal justice systems of each of these models is summarised, and the findings of this specific study and their implications are then explored within each conceptual framework, and the areas of overlap and difference between these models and the psychoanalytic and mentalizing models are elucidated.

Chapter 10 brings together these models in exploring various ways in which the emotional pressures on staff implementing trials in the criminal justice system may be reduced or prevented at the outset. Although the psychoanalytic/mentalizing models and criminological models of emotionality rarely refer to each other in the literature, there is significant commonality in the solutions or interventions put forward by each of these models to alleviate the negative effects of emotional responses in relation to the work.

The final part of the thesis, chapter 11, brings together the key findings of the study in relation to the original research aims and hypotheses, discusses how these add to the field of implementation science and suggests areas of future research. It also identifies the limitations of this study and concludes with some personal reflections of the experience of conducting this research and writing the thesis.

Chapter 2: Evaluating the implementation of a randomised controlled trial of mentalization-based treatment for antisocial personality disorder in the criminal justice system in England and Wales: Background and context

2.1 Introduction

This chapter details the historical, political, and scientific contexts and theories which inform this research: its setting within the National Probation Service of England and Wales; the nature, aetiology and evidence base for the treatment of the mental disorder - ASPD - targeted by the RCT; and the nature of mentalizing and the mentalizing intervention - MBT. This chapter does not offer any critical analysis of these topics but sets the scene for the thesis and informs the analysis of the results of the studies described in the subsequent chapters.

2.2 The criminal justice system in England and Wales

A criminal justice system is a system of law enforcement in a given jurisdiction that is directly involved in apprehending, prosecuting, defending, sentencing, and punishing, those who are suspected or convicted of criminal offenses. The criminal justice system which provides the setting for this study is that of England and Wales. The purpose of the Criminal Justice System in England and Wales (CJSEW) is to deliver justice by investigating, trying, punishing and rehabilitating people who are convicted or suspected of committing a crime, while protecting the public; detecting crime and bringing it to justice; and carrying out the orders of court, such as supervising community and custodial punishments.

The core agencies that comprise the CJSEW are the Police, the Crown Prosecution Service, the Courts, Her Majesty's Prison and Probation Service (HMPPS) (which covers HM Prison Service and the National Probation Service), the Youth Justice Board (which oversees Youth Offending Teams) and victims and witness services. The system as a whole is co-ordinated through a national Criminal Justice Board, which is chaired by the Lord Chancellor and Secretary of State for Justice and brings

together senior leaders from across the criminal justice system. The Criminal Justice Board is supported by Local Criminal Justice Boards, which bring together the chief officers of the criminal justice agencies to co-ordinate activity and share responsibility for delivering criminal justice at a local level.

Three ministerial departments are jointly responsible for the criminal justice system and its agencies in England and Wales: The Ministry of Justice, which oversees the Magistrates' Courts, the Crown Court, the Appeals Courts, the Legal Services Commission, and HMPPS; the Home Office, which oversees the Police; and the Attorney General's Office, which oversees the Crown Prosecution Service, the Serious Fraud Office and the Revenue and Customs Prosecutions Office. Other services within the criminal justice service are run by voluntary groups and charities such as Victim Support, and the National Association for the Care and Resettlement of Offenders.

2.2.1 The National Probation Service

The National Probation Service (NPS) is a statutory criminal justice agency that supervises high-risk offenders released into the community. Its stated aims are to protect the public by the effective rehabilitation of high-risk offenders and tackling the causes of offending and enabling offenders to turn their lives around. The NPS is currently responsible for preparing pre-sentence reports for courts; managing approved premises for offenders with a residence requirement on their sentence; assessing offenders in prison to prepare them for release on licence to the community and supervision by the NPS; managing offenders serving sentences in the community to meet the requirements ordered by the courts; and communicating with and prioritising the wellbeing of victims of serious sexual and violent offences when the offender has received a prison sentence of 12 months or more, or is detained as a mental health patient (National Probation Service website, accessed 4.1.20).

2.2.2 Early history

Probation services in England and Wales have evolved considerably and undergone several major structural reorganisations, shifts in culture and policy changes since their early origins in the mid to late 19th century. The early history of the probation services has been well described; the accounts of McWilliams (1985, 1986, 1987), Nellis (2007) and Vanstone (2004) are particularly noteworthy.

The practice of an offender being supervised in the community in Britain can be traced back to a philanthropist, Matthew Davenport Hill (1792-1872), a Recorder in the Birmingham court, who in the 1840s started imposing 'token sentences of one day' on the condition that the defendant was under supervision in the community of a responsible adult with the aim of rehabilitation rather than punishment (Phillips, 2010). Hill's work was continued under the banner of Christianity with the appointment of missionaries by the Church of England Temperance Society in 1876 (Vanstone, 2004). Offenders were believed to have lost their religious beliefs and fallen from grace and the task of probation was to restore their souls by divine intervention.

In the UK, the Probation of First Offenders Bill (1886) gave formal recognition to the work of the missionaries, but the development and provision of probation services were not consistent throughout the country until the Probation of Offenders Act (1907), which marked the beginnings of a formal national service and professionalisation of probation work. This was in the context of liberalism and positivistic reform, with the creation of the welfare state and the idea that criminality could be eliminated through reformation (Garland, 1985; Phillips, 2010). Courts were now able to impose community orders instead of punishment via incarceration and also considered the offender's age and character before making an order. Probation officers were employed by the courts to help, support, and befriend offenders (Robinson, 2014).

2.2.3 Probation as social care

The links between probation and social work were strengthened from the 1930s onwards when probation officers became concerned with the offender's welfare and intervening in the personal and social circumstances thought to be underlying offending behaviour (Chui & Nellis, 2003). Probation work was underpinned by American social casework theory, which included some of Freud's ideas on social work as a form of therapy, and the idea that delinquency was due to unconscious drives and conflicts within the family (Raynor, 2006). The importance of the probation officer developing a positive and trusting relationship was perceived as central to the offender's capacity to change, and this therapeutic emphasis was reinforced by including childcare and mental health training in the training of probation officers in the late 1960s (Chui & Nellis, 2003). This focus on rehabilitation and therapeutic optimism

continued in the 1960s and 1970s during which time probation services had an increasingly recognised professional role in the criminal justice system, probation officers were able to operate with a high degree of autonomy (Raynor, 2006), and this period being widely thought of as the heyday of probation practice (Chui & Nellis, 2003).

2.2.4 'Nothing works'

However, the late 1970s heralded a reversal of penological optimism in an undermining of the notion of rehabilitation and challenges to the assumed effectiveness of probation supervision. This started in the US with an influential review of evidence of the effectiveness of correctional intervention programs (Martinson, 1974), which concluded that rehabilitation interventions, with very few exceptions, had no effect on recidivism. Similar research was conducted in other countries, including the UK (Brody, 1976; Folkard, Smith & Smith, 1976) which led to an international consensus amongst the public, media and policy makers that 'nothing works'. With the decline of the treatment model the role of probation was now under scrutiny and shifted from a focus on rehabilitation to diverting offenders from custody, the provision of help (rather than treatment) for offenders, the statutory supervision of offenders and the reduction of crime (Bottoms & McWilliams, 1979). The remit of the probation service had begun to move away from its social work foundation to an organisation the purpose of which was enforcement, corrective punishment, and public protection.

During the 1980s and 1990s the organisation and administration of the service became more managerialist with the imposition of national standards and key performance indicators based on private sector practices (Annison, 2013). Despite objections that probation officers on the ground had not been adequately consulted, the after care of offenders was marginalised and the Home Office issued its first national guidance on 'objectives and priorities' (Hansard, 1984) and provided management training for senior probation officers and funding for management consultants to advise individual services on ways to improve management practices (National Audit Office, 1989).

2.2.5 Penal authoritarianism

The 1991 Criminal Justice Act offered hope with its aim of prioritising 'punishment in the community' and concomitant promise of an increased number of probation officers

to supervise more offenders sentenced to community orders. However, this optimism was short-lived as these legislative goals were reversed in the 1993 Criminal Justice Act. The greatest threat to the future of the probation service now came from John Major's conservative government of 1990-1997 with the harshly punitive 'law and order' stance of the then Home Secretary, Michael Howard, who questioned the very existence of probation (Raynor, 2006). The political rhetoric now was that 'prison works' (Howard, 1993), criminal sanctions increased with more offenders being incarcerated, the principle of consent to a community sentence was abolished, resources within probation were cut, and probation lost its central place within the criminal justice system. Training for probation officers no longer included social work courses, and the government's aim was to recruit ex-police and armed forces personnel into probation (Annison, 2013). The negative impact on probation officers in this era of penal authoritarianism, with its increased emphasis on efficiency, risk assessment and management of offenders, control and surveillance, was compounded by falling staffing levels, increasing workloads and new practice responsibilities (Harding, 1999).

2.2.6 'What works'

Paradoxically, at the same time, the academic world of criminology was becoming more optimistic with the emergence of evidence from more methodologically robust research studies that originated in Canada in the late 1980s and early 1990s based on social learning theory and cognitive-behavioural approaches that challenged the dogma of 'nothing works' (McGuire, 1995). The criminal justice system became interested in developing evidence-based treatment programmes to reduce re-offending with a new 'what works' agenda, and in 1998 the probation inspectorate commissioned a report (Underdown, 1998) which found that of 267 treatment programmes running in probation services only four had been subjected to any form of robust evaluation (Deering, 2008). The New Labour government which came into power in 1997, in line with their political agenda of 'modernisation', enthusiastically took up the issue by setting up pilot cognitive behavioural programmes, for the most part group-based, which led to the Effective Practice Initiative (Home Office, 1998), an attempt to introduce systematic change in the Probation Service so that its practices were based on the best evidence of what works with offenders (Furness & Nutley, 2010).

This was followed in 1999 by the wider-reaching Crime Reduction Programme in what has been described as a rare 'window of opportunity' (Kingdon, 1995) in which politicians, administrators, practitioners, and researchers were willing to collaborate and invest significant resources in an unprecedented ambitious 10-year programme of pilot projects of a wide variety of interventions and their evaluation in all agencies of the criminal justice system (Maguire, 2004). An independent non-departmental public body, initially known as the Joint Prison/Probation Services Accreditation Panel, later renamed the Correctional Services Accreditation Panel (CSAP) of England and Wales, was set up in 1999 to assist in development and approve programme designs. The CSAP assumed a central role in the government's plan to create and accredit a suite of 'gold standard' interventions for adult offenders which would significantly reduce reconviction rates (Maguire et al., 2010). However, the programme was beset with numerous problems as the political climate changed, including unrealistic timescales, cultural resistance amongst practitioners, slow-moving bureaucracy, and fundamental differences in the understanding of research between researchers and policy makers resulting in the latter's aims of achieving crime reduction targets taking precedence over research. 2004).ogramme was ended prematurely in 2002 (Maguire,

For the probation service other significant changes interfered with the envisaged large-scale delivery of evidence-based programmes. Interventions were not perceived to be effective in reducing crime unless they were linked to enforcement procedures and a stricter approach to improve enforcement rates in relation to breaches of community penalty requirements was introduced by new National Standards in 2000 (Home Office, 2000). Moreover, case management and supportive supervision became neglected with the narrow focus on programmes, which may have contributed to the latter's high attrition rates of offenders and several high-profile failures of supervision (Raynor, 2006). However, arguably the most disruptive influence was the major restructuring and nationalisation of probation services in 2001.

2.2.7 Nationalisation

The National Probation Service (NPS) for England and Wales was created in 2001 (Home Office, 2001) in the Criminal Justice and Court Services Act 2000, replacing 54

locally based Probation Services, and centrally run from the Home Office by a National Probation Directorate. Prior to 2001, the Probation Services had been independent bodies corporate, with probation officers appointed by their local courts. Local Probation Committees, which included representation by local authorities, were responsible for policy and direction. In the newly nationalised service, the number of probation areas was reduced from 54 to 42, to make all services co-terminus with the newly aligned Police, Crown Prosecution and Magistrates' Courts Services. One of the main incentives behind the formation of the new NPS was to improve consistency and rigour in policy and practice and there was greater emphasis in the criminal justice system as a whole on 'joined-up' working between different government departments and public sector agencies, as well as involving private and voluntary organizations (Macguire, 2004). Formal partnership working between probation, prison and the police were encouraged through the Crime and Disorder Act 1998, and the Multi-Agency Public Protection Arrangements (MAPPAs), which were established by the Criminal Justice and Court Services Act 2000 to manage high risk violent and sexual offenders in the community. These closer relationships between agencies were not always easy, exposing differences and conflicts in information sharing, objectives, ways of working, attitudes towards offenders and organisational culture (Mawby & Worrall, 2011).

2.2.8 The National Offender Management Service (NOMS)

The relationship between the Probation Services and Prison Services was formalised in 2004 when the two agencies were brought together to form the National Offender Management Service (NOMS). This followed a report by Patrick Carter, a successful businessman turned Downing Street advisor (Raynor, 2006), commissioned by the then Government in 2002, with little wider consultation, to review correctional services in England and Wales. His report, *Managing Offenders, Reducing Crime - the Correctional Services Review* (Carter, 2003), had three main proposals: to 'break down the silos of prison and probation and ensure a better focus on managing offenders' (Carter, 2003, p. 1); to introduce 'greater contestability, using providers of prison and probation from across the public, private and voluntary sectors' (Carter, 2003, p.34); to ensure more effective delivery of services and the need for the 'end-to-end management' of offenders, in which offender management should be a single process that spans the whole of an offender's sentence. This vision of a seamless

movement of offenders from custody to community has been described as a ‘penal imaginary’ (Carr, 2017; Worrall, 2008: 113).

The newly created post of Director-General of NOMS assumed responsibility for both the National Probation Service as well as HM Prison Service and the management of contracts for the private sector operation of prisons and prisoner escorting.

NOMS introduced the Offender Management Model (Home Office, 2006) which was described as an evidence-based, offender-focussed approach to work with individual offenders, emphasising the personal relationships developed with an offender in a one-to-one manager structure delivering a single, end-to-end process. Resources and interventions were commissioned and purchased by Regional Offender Managers using a brokerage approach. However, despite the emphasis on being a ‘human’ model involving an individualised and collaborative approach to working with offenders, it was experienced by some as a rebranding of case workers as offender managers who were required to access interventions via a brokerage approach, which prevented offender managers meeting offenders’ needs themselves through one-to-one supervision (Robinson, 2014). High rates of staff sickness and staff turnover, high caseloads, and shorter supervision sessions were also reported (Turley et al., 2011). There was also criticism of the government’s decision to allow ‘contestability’ (Dobson, 2004) amongst providers and open the service to competition via the marketisation of its functions. These widening commissioning conditions were consolidated in the Offender Management Act 2007 which allowed for a privatised, market led system requiring probation to provide only limited services to the courts and allowing all other functions to be commissioned by the Secretary of State from ‘any other person’ (Deering & Feilzer, 2019).

Further major structural changes affecting the probation service followed. In 2007, the then Labour government instigated a major Machinery of Government change which split the Home Office into two separate departments responsible for justice and security: a new Ministry of Justice which took over the responsibilities of the Department for Constitutional Affairs and the criminal justice functions of the Home Office and its agencies — mainly the National Offender Management Service, which was designated as an executive agency within the Ministry of Justice; and the Home

Office, the responsibilities of which were now concentrated on counter-terrorism, policing and asylum and immigration (House of Commons Constitutional Affairs Committee, 2007).

In 2010, within the probation service, the 42 existing Probation Boards were amalgamated into 35 Probation Trusts in 2010 and service delivery organised into 150 local delivery units which were largely synonymous with local authorities (House of Commons Justice Committee, 2011).

2.29 Transforming Rehabilitation

Transforming Rehabilitation (TR) has been described as the most dramatic and significant change to probation structure, including, the part-privatisation of probation work, which affected over 16,000 probation staff and over 200,000 people under probation supervision in one form or another (Deering & Feilzer, 2019; Ministry of Justice, 2013). It involved major reforms to the probation services, proposing to reduce reoffending by opening the market to a range of rehabilitation suppliers from the private and voluntary sectors; paying providers by results for reducing reoffending; and extending statutory rehabilitation to those serving sentences of less than 12 months (Ministry of Justice, 2013). In 2013 the Ministry of Justice dissolved the 35 self-governing probation trusts and created 21 Community Rehabilitation Companies (CRCs) to manage offenders who posed a low or medium risk of harm, and a new public sector National Probation Service to manage offenders who pose higher risks. In February 2015, the CRCs were transferred to eight, mainly private sector, suppliers working under contracts, that were to run to 2021-22.

Concerns were voiced from the outset from Napo (the trade union for probation), academics, former probation staff, reform groups such as the Howard League for Penal Reform, User Voice (a charity of ex-offenders working to reduce reoffending), Clinks (a charity representing the voluntary sector working with people in the criminal justice system and their families) and some journalists (Deering & Feilzer 2019), which were raised by the House of Commons Justice Committee (2014) about the scale, architecture, detail and consequences of the reforms and the pace at which the Government was seeking to implement them without adequate road testing. Particular concern was expressed about the bifurcated risk model and how this split would be

likely to cause problems in the delivery of probation services as the risk of an offender can change throughout their time on probation.

Since its implementation several reports by HM Inspectorate of Probation (HM Inspectorate of Probation 2016(a); 2016 (b); 2016 (c)) have highlighted the negative impact on probation practice and staff morale in both the NPS and CRCs, including staff exodus, reduction in qualified probation practitioners, poor working conditions, inadequate IT structures, poor pay and benefits, and shortfalls in 'through-the-gate' rehabilitation provision. These reports led to an inquiry by the House of Commons Justice Committee, which published a very negative review (House of Commons Justice Committee, 2018) citing a number of serious concerns including poor performance of the CRCs, the NPS-CRC split creating a two-tier system, failure to open up the probation market to the voluntary sector, staff morale being at an 'all-time low' with high caseloads and inadequate training, low confidence in community alternatives to short custodial sentences, 'wholly inadequate' through the gate (continuous support from custody into the community) provision, inappropriate telephone supervision of offenders by the CRCs, and lack of attention to the specific needs of offenders. The committee concluded that they were unconvinced that the TR model could ever deliver an effective or viable probation service.

Following this review, the Ministry of Justice announced that the contracts with the CRCs would be terminated two years earlier than initially contracted and would lead to a complete reorganisation and reduction of the CRC contracts from 21 to 10 covering England. Offender management on low and medium risk offenders was to be transferred to the National Probation Service in Wales.

The negative findings regarding TR were confirmed by a Progress Review by the National Audit Office in March 2019 which reported that the Ministry of Justice had set itself up to fail with its rushed implementation and commercial approach which had far-reaching consequences. The CRCs were found to have underinvested in probation services and underperformed on a range of measures. Although the number of reoffenders had reduced, the average number of reoffences they committed had increased significantly. The CRCs also showed ineffective support for transition from prison to the community; a significant increase in the number of people being recalled

to prison; little evidence of hoped-for innovation; and patchy third-sector involvement with CRCs. The NPS had performed better in establishing a consistent national structure for delivering its services but was constrained by severe staff shortfalls and high workloads. The review concluded that Transforming Rehabilitation has achieved poor value for money for the taxpayer (National Audit Office, 2019).

A further Progress Review by the House of Commons Committee of Public Accounts in May 2019 concluded that 'In its haste to rush through its reforms at breakneck speed the Ministry of Justice not only failed to deliver its 'rehabilitation revolution' but left probation services underfunded, fragile, and lacking the confidence of the courts. Inexcusably, probation services have been left in a worse position than they were in before the Ministry embarked on its reforms.' (House of Commons Committee of Public Accounts, 2019, p.3).

In June 2019 the government announced that the CRC contracts would terminate altogether in 2021 and that the NPS would have responsibility for managing all offenders on a community sentence or licence following release from prison (HM Prison & Probation Service, 2019). The private sector would still play a part in the provision of services for rehabilitation services, such as the provision of unpaid work and accredited programmes, but the core function of the service – supervising and managing about 250,000 offenders in the community – would once again be publicly provided. These reforms were put in place in June 2021 under the auspices of the 'Target Operating Model' (HMPPS, 2021), but in March 2022 HM Inspectorate of Probation (2022) found that significant challenges remained for the newly unified Probation Service. Over half of probation staff reported that they were dissatisfied with guidance about how to manage work at the point of unification and that their workload was unmanageable. The quality of supervision had not improved, with concerns that the assessment and management of risk of harm were inadequate. A continuing cultural divide between former CRC and NPS staff who were now part of the unified Probation Service was evident with some former CRC staff feeling that they were perceived by former NPS staff as less skilled and 'second class'. The effects of reunification were compounded by the profound impact of the Covid pandemic on core probation functions where the majority of contacts with offenders on probation were

by telephone rather than face to face and all group-based face-to-face interventions to tackle offending behaviour had ceased.

2.2.10 Her Majesty's Prison and Probation Service

In 2017, NOMS was replaced by Her Majesty's Prison and Probation Service (HMPPS), and with the HM Prison Service, the NPS became one of the two agencies of HMPPS. Responsibility for commissioning services, development of policy and setting standards passed from NOMS to the Ministry of Justice. HMPPS within England and Wales became responsible for running prison and probation services, rehabilitation services for people leaving prison, supporting people to stop reoffending, and contract managing private sector prisons and services such as the prisoner escort service and electronic tagging. The HM Prison Service managed public sector prisons and the contract for private prisons in England and Wales, and the National Probation Service oversaw probation delivery in England and Wales including through the CRCs. HMPPS also has responsibility for strengthening security in prisons, tackling extremism, and building intelligence about criminal gangs. The establishment of HMPPS was linked to prison reforms proposed in a new framework set out in the Prisons and Courts Bill (2017) following reports of a record growth in the prison population since the inception of NOMS (Carr, 2017).

2.3 Antisocial personality disorder

2.3.1 Diagnosis

Antisocial personality disorder is a particular type of personality disorder as defined by the DSM-5 (APA, 2013). It is characterised as a pervasive pattern of disregard for and violation of rights of others since age 15, including failure to conform to social norms, deceitfulness, impulsivity or failure to plan ahead, irritability and aggressiveness, reckless disregard for safety of self and others, consistent irresponsibility, and lack of remorse. A diagnosis of schizophrenia or mania must be excluded as causes of antisocial behaviour. As with other personality disorders, the diagnosis cannot be made before the age of 18; however, unlike other DSM-5 defined personality disorders, to make a diagnosis of ASPD, the person must show evidence of having conduct disorder before the age of 15 years.

The diagnosis has been criticised for its focus on antisocial behaviour and criminality rather than on underlying personality structure and interpersonal deficits (Widiger & Corbitt, 1993), and also does not distinguish between those individuals with mild, moderate, or severe psychopathy, as measured on the Psychopathy Checklist-Revised (PCL-R) (Hare, 2003). Studies show that only one third of individuals with antisocial personality disorder has severe psychopathy, which carries a significantly poorer prognosis than individuals with mild to moderately psychopathic traits (Hare, 1991; 2003).

In this current study, the diagnosis was based on the DSM-IV-R criteria, as measured by the Structured Clinical Interview for DSM-IV axis II personality disorders (SCID-II) (First et al., 1997).

2.3.2 Prevalence and co-morbidity

Estimations of the prevalence of ASPD in the general population varies according to the methodology and countries studied, and range from around 1% (Torgerson et al., 2001; Coid et al., 2006a) to 6.8% (Swanson et al., 1994). All studies show that the prevalence of ASPD is consistently higher in men than in women (NICE guideline, 2009). The prevalence is significantly increased in criminal justice settings, representing up to 80% of the prison population (Moran, 1999; Ogloff, 2006; Singleton et al., 1998). People with ASPD are significantly more likely to commit violent behaviours (Coid et al., 2006b) and the diagnosis is highly predictive of future violence, future reconviction or reincarceration upon release, and recidivism severity (Hodkins et al., 1996; Wormith et al., 2007).

ASPD carries a considerable co-morbidity with other mental disorders, particularly substance misuse (Compton et al., 2005; Robins et al., 1991), anxiety disorders (Goodwin & Hamilton, 2003) and depressive disorders (Lenzenweger et al., 2007). It is also associated with poor physical health (Byrne et al., 2013) and increased mortality, particularly at a young age not only to an increased risk of suicide, but also to reckless behaviour such as drug misuse and aggression (Black et al. 1996). Individuals with the condition also exert a heavy toll on others, with negative impacts on their families and relationships with others, as well as increased involvement with social services, health and the criminal justice system. The financial burden of injury

to victims, damage to property, involvement with the criminal justice system, use of healthcare facilities, lost employment, family disruption, childcare proceedings, gambling, and alcohol and substance misuse is large (Myers et al., 1998; National Research Council, 1999; Home Office & Department of Health, 2002; NICE, 2009).

2.3.3 Aetiology

Although the precise aetiology of ASPD remains unknown, like most mental disorders it is considered to be a multifactorial construct with both a biological and environmental foundation. Its heritability has been estimated as between 40% and 70% (Torgersen et al., 2008; Mason & Frick, 1994; Ferguson 2010; Fu et al., 2002), and is more pronounced in aggressive and antisocial children with callous and unemotional traits, which are considered to be precursors to psychopathy in adulthood, compared to aggressive and antisocial children without such traits (Viding et al., 2005).

Studies looking at genetic abnormalities in the pathogenesis of ASPD are limited and are focussed on antisocial and aggressive behaviours rather than samples of individuals with a diagnosis of ASPD. The gene C-521T, which is involved in the creation of the dopamine 4 receptor, has been implicated in novelty-seeking and impulsivity (Basoglu et al., 2011 which are features of ASPD. An abnormality of the Monoamine Oxidase A (MAO-A) gene, which breaks down monoamine neuro-transmitters such as dopamine and serotonin, has also been correlated with antisocial and aggressive behaviour. (Merriman & Cameron, 2007; Raine, 2006).

However, it is unlikely that such genetic abnormalities work in isolation. Complex gene / environmental interactions are likely to operate in the development of ASPD, where adverse social experiences trigger genetic susceptibility. Antisocial behaviour in males has been linked to gene variants, but only for individuals exposed to stressful early life environments (Caspi et al., 2000; 2002; 2004). Caspi et al. found that low MAO-A activity in children who had been seriously abused were more likely to have conduct disorder and more extreme violent behaviour than children who were not abused and also had low MAO-A activity. This suggests that children who are genetically vulnerable to antisocial behaviour and also experience abuse from their caregivers are more likely to develop antisocial behaviour, which may be exacerbated by provoking negative parental responses (NICE, 2009).

The neurobiology of ASPD is being increasingly investigated. Neuroimaging research suggests that ASPD is linked with abnormal brain anatomy and function. MRI scans of individuals with ASPD have been shown to have significantly reduced prefrontal grey matter compared to controls (Raine et al, 2000, Yang et al, 2010) which correlated with a reduction in autonomic function (Raine et al, 2000). Given the heterogeneity of the population that fulfil criteria for a diagnosis of ASPD, particularly in relation to the presence or absence of psychopathy, some studies have distinguished between 'successful' and 'unsuccessful' psychopaths where the latter show more impulsive and risk behaviour and are incarcerated more frequently than the former group. Significant reductions in both the left and right amygdala have been noted in unsuccessful psychopaths in comparison to the successful psychopaths (Yang et al., 2010). Neuro-developmental abnormalities in the corpus callosum (Raine et al., 2003), and abnormalities in the symmetry of the hippocampus have also been implicated in ASPD (Raine et al., 2004).

These brain abnormalities are thought to be the manifestations of malfunction of the neural threat system, which includes the amygdala, the hypothalamus, and the dorsal half of the periaqueductal gray (PAG) (Gregg & Siegel, 2001). This circuitry is thought to be regulated by regions of the frontal cortex, such as the orbital, medial, and ventrolateral frontal cortices (Blair, 2004). Deficits in the frontal lobe impair threat-response regulation and increase the likelihood of problematic behaviour.

However, it is difficult to disentangle the relative effects of genetic and environmental factors which result in such brain deficits and dysfunction. Chronic adverse psychosocial stressors in childhood have been shown to be associated with a reduction in the volumes of the pre-frontal cortex and hippocampus, increased CRH levels and activation of the HPA axis, and elevation of inflammatory compounds e.g., cytokines (Danese & McEwen, 2012).

Numerous adverse environmental influences including harsh and inconsistent parenting, social adversity, poverty and associating with criminal peers are considered important causative factors for ASPD (NICE, 2009). There is now a wealth of evidence demonstrating that criminal offenders are significantly more likely to experience adverse childhood experiences (ACEs) than those in the general population, and that

offenders with the most serious violent and criminal behaviour are more likely to have a history of cumulative ACEs [Baglivio, 2018; Baglivio et al., 2015; Craig et al., 2017; Fox et al., 2015; Wolff & Baglivio, 2017]. Several studies have focused on ASPD and suggest that ACEs play a significant role in development of the disorder. Physical abuse, sexual abuse, emotional abuse and neglect respectively in childhood have been found to be associated with a diagnosis of ASPD in adulthood (Battle et al, 2004; De Lisi et al, 2019; Douglas et al; Farrington, 2000; Fergusson et al. 2008). However, again these studies do not distinguish between individuals with ASPD with high levels of psychopathy, and those with low levels. There is evidence to suggest that severely psychopathic adults may experience less abuse and neglect as children than moderately psychopathic adults, which also supports the relative increase in biogenic contributions as degree of psychopathy increases (Felthous & Sass, 2007).

2.3.4 Attachment and ASPD

One hypothesis that has been proposed to explain how such adverse experiences, in conjunction with genetic precursors, may contribute to the development of ASPD is that they interfere with the normal development of attachment between the child and his caregivers (McGauley et al., 2011). Stemming from the seminal work of the psychiatrist and psychoanalyst, John Bowlby, attachment theory is a body of knowledge concerned with the emotional bonds and interactions between human beings and the psychopathological difficulties which arise when these processes are disturbed (Bowlby, 1969, 1973, 1977, 1988). It proposes that the need for significant human relationships is universal, which are established at a psychobiological level in early childhood. Attachment theory explores how these relationships are linked to care giving and care-eliciting behaviours and used to manage fear, vulnerability, and threats of loss across the lifespan. Bowlby's work was influenced by the ethological work of Harry Harlow who discovered how raising infant monkeys in social isolation had negative effects on their behaviour and interactions with other primates (Harlow et al., 1965).

Attachment is the normal tendency of the infant and young child to seek close proximity to its primary caregivers, usually initially the mother, for protection and a feeling of security. This develops in the first year of life to provide a safe haven and secure base for exploration, including exploration of the mind of self and others (Bateman &

Fonagy, 2019a). Bowlby proposed that the relationship between the mother and baby led to the latter forming an 'internal working model' of that relationship, which influenced how the baby deals with stress, anxiety, and loss. Bowlby's work was subsequently expanded by Mary Ainsworth (Ainsworth et al., 1978), who observed different patterns of behaviour in children in response to an experimental condition, which she called the 'strange situation', where the mother leaves the infant for a short period with a stranger, and then returns, that could be reliably identified and linked with a distinct attachment pattern. She distinguished secure and insecure patterns of behaviour, with the latter further divided into three identifiable patterns of insecure attachment: avoidant, ambivalent and disorganised. Babies with a secure pattern of attachment were found to manage anxiety and loss better than babies showing insecure models of attachment. Longitudinal follow up studies have found that childhood attachment patterns tend to be stable across time, especially insecure attachment patterns. Insecure attachment is associated with childhood, trauma, separation and neglect, which disrupt the normal development of attachment and can produce long-term pathological effects including impaired affect regulation, impulse control, socialisation and mentalizing, and the development of personality difficulties and mental disorders, including ASPD, in adult life (DeKlyen & Greenberg, 2008; Kobak et al, 2006; Lyons-Ruth et al, 1987; Lyons-Ruth et al, 1993).

Mary Main and others extended Ainsworth's findings to investigate the intergenerational transmission of attachment by measuring adult mental representations of attachment with the Adult Attachment Interview (AAI), a semi-structured interview developed to assess adult- and adolescent-attachment representations based on how their attachment experiences in the past are represented in their adult mental states (Main & Goldwyn, 1994). She showed that such representations may have a significant influence on their children's development and attachment patterns (Main et al., 1985). Subsequent research on pregnant mothers interviewed about their own attachment history with the AAI showed how the mother's security of attachment in relation to her own parents measured before the birth of the child predicted the baby's security of attachment with her at 12 months (Fonagy et al., 1991).

From the outset, attachment theory was concerned with the integration of psychological and biological models of development. Bowlby was interested in how psychological mechanisms affected biological reactions and physiological homeostasis and proposed that attachment was a behavioural system that regulates the effects of external stressors on internal physiological stability by prompting the individual to seek proximity to attachment figures (Bowlby, 1973). There is now considerable evidence that activation of the attachment system is closely linked to arousal and stress regulation (Heinrichs & Domes, 2008; Lieberman, 2007; Mayes, 2006). Contemporary research on the neurobiological underpinnings of attachment and understanding of affective physiological processes have shifted attachment theory towards a more complex and clinically relevant affect regulation model (Schore & Schore, 2008).

ASPD may be conceptualised as a disorder of attachment. Several studies using the AAI have shown higher levels of insecure attachment in violent offenders, most of whom had a personality disorder, than in the normal population (Adshead, 2004; Bogaerts et al., 2005; Frodi et al., 2001; Levinson & Fonagy, 2004; van IJzendoorn 1997). All these studies showed an over-representation of individuals with dismissive attachment states of mind, and one study of incarcerated offenders showed that dismissive states of mind were statistically more likely in the violent prisoners compared to a matched non-violent group of patients with a personality disorder (Levinson & Fonagy, 2004). However, the small sample sizes of the studies and the heterogeneity of the study groups mean that these finding may not be robust. Nevertheless, other studies have shown that psychopathic tendencies in children have been linked with maladaptive interactive patterns in families (Dadds et al., 2012) and severe institutional deprivation (Sonuga-Barke et al., 2010). This suggests that at least in some cases apparent callous and unemotional traits exhibited in children are rooted in disrupted attachment relationships, and as such do not result in adult psychopathy but are defence against early anxiety (Frick & Viding, 2009). A recent meta-analysis of 12 studies with a total of 1876 participants looking at the relationship between attachment styles and psychopathic traits showed a positive association between psychopathy and insecure and disorganised attachment. The strongest associations were found in forensic and prison samples (van der Zouwen et al, 2018) which is consistent with evidence that offenders detained or supervised within criminal justice

systems are more likely to report having experienced disruptions in attachment due to separations, abuse and neglect from their early caregivers than in the general population (Coid 1992; Heads 1997; Weeks 1998).

2.3.5 Violence and ASPD

Violence is recognised by the World Health Organisation violence as a major public health priority (WHO, 2012) and the UK's Department of Health has endorsed a public health approach to violence prevention (Bellis et al., 2012). Although ASPD is a very broad diagnostic category which encompasses people who never commit offences or violent crimes, it is nevertheless highly predictive of violent behaviour, future reconviction or reincarceration upon release, and recidivism severity (Wormith et al., 2007). The impact on society of individuals whose ASPD manifests in the form of violent criminal behaviour include direct physical and emotional damage to victims, damage to property, police time, involvement with the criminal justice system, and increased use of healthcare facilities (Home Office and Department of Health, 2002). Hence the target of treatment programmes for ASPD is frequently focussed on the reduction of aggressive acts.

Originally based on animal physiology research (McEllistrem, 2004; Weinshenker & Siegel, 2002), a widely accepted bimodal model of violence has been empirically supported in numerous studies in which aggression is divided into two behaviourally distinct categories: affective or reactive aggression (reacting to a threat) and predatory, proactive, or instrumental aggression (using aggression for personal gain). Affective violence is a primal response to a real or perceived immediate threat and is characterised by raised heart rate, elevated blood pressure, increased awareness other indices of autonomic arousal, the presence of anxiety, fear and/or anger, and the cessation of such violence soon after the threat is no longer perceived (Meloy, 2000; 2006). By contrast, predatory violence occurs in the absence of emotion and autonomic arousal, and is purposeful and goal directed (Meloy, 2006). Physiological (Stanford et al., 2003), neuropsychological (Houston et al., 2003), psychopharmacological (Eichelman**,** 1988; Barratt et al., 1997), and neuroimaging (Raine et al., 1998) studies have provided empirical evidence for the existence of these two modes of violence in humans.

The evolutionary basis of affective violence may be seen as survival against an imminent threat, whereas the evolutionary basis of predatory violence is hunting (food gathering), which also promotes survival and genetic reproduction (Yakeley & Meloy, 2012).

Individuals with ASPD who are more emotionally dysregulated are more likely to engage in affective violence, whereas psychopathic criminals are three to five times more violent than non-psychopathic criminals (Hare, 2003), and more likely to engage in both predatory and affective violence than non-psychopathic criminals (Cornell et al., 1996). These differences may be due to differences in activity in threat circuitry mentioned above, where increased activity in this circuit is more likely to lead to reactive aggression (Blair, 2010), whereas individuals with psychopathy show deficits in this type of response and are more able to control their violent actions. Studies of children and adolescents show that those who engage in proactive violence are more likely to show callous and unemotional traits and develop psychopathy as adults (Crick & Dodge, 1996).

Hodgins and colleagues emphasize the importance of co-occurring anxiety in subtyping ASPD (De Brito and Hodgins 2009). Based on studies of children and adults, they propose that around half of individuals in the ASPD population are characterized by anxiety as well as persistent antisocial behaviour and have low levels of callous unemotional traits as children and low levels of psychopathic traits as adults. This group is more likely to have experienced physical abuse as children and resort to violence as a compensatory response to underlying emotional conflict and distress. The other half have normal to low levels of anxiety and varying levels of psychopathy but include a subgroup with high levels of psychopathy. This group shows marked callous and unemotional traits as children, low levels of anxiety, more predatory (instrumental) violence, and less amenability to treatment.

Based on observation and clinical work with violent offenders, many authors have emphasised the role of anxiety and other negatively experienced affects, particularly shame and humiliation, in precipitating interpersonal aggression and violence. In his work with high-security inmates, Gilligan (1996; 2002) proposed that early experiences of abuse, neglect and rejection predisposed them as adults to be sensitised to feeling

ostracised, bullied or ignored, leading to unbearable feelings of shame and humiliation which need to be defended against by violent means. Within the shame literature, empirical studies have revealed the prominent role of shame and social exclusion in triggering anger and aggression, which may be seen as coping strategies, emotional regulation and evolutionary adaptations to social pain (Elison et al., 2014). Research on the affective science of social pain suggests that aggression and violence may be an adaptive response to physical pain, which, through evolutionary processes, became associated with social pain, including feelings of shame, humiliation, inferiority and rejection, which trigger an aggressive response which is now maladaptive.

2.3.6 Treatment of ASPD

The belief that ASPD is untreatable remains widespread and individuals with the diagnosis are frequently rejected from mental health services due to the difficulties in engaging them in treatment, their chaotic lifestyles, drug and alcohol misuse and risk of violence to themselves or others (Crawford et al., 2009; Yakeley & Andrews, 2014).

The evidence base for the treatment and management of the condition is limited and only a small number of high quality treatment trials of specific psychological therapies have been conducted among people with antisocial personality disorder (Gibbon et al., 2010; NICE, 2009). Most studies have been conducted on offenders in general rather than specifically on samples of individuals with a diagnosis of ASPD, and moreover outcome criteria are usually restricted to the presence or absence of re-offending (NICE 2009).

Following an early review (Vennard *et* al., 1997) which gave some evidence that cognitive behavioural therapy (CBT) methods combined with training in social skills and problem solving reduced recidivism in both juvenile and adult offenders, most treatment programmes for offenders have been based on cognitive-behavioural principles. Programmes found to have the largest effect size adhere to the 'risk-needs-responsivity' (RNR) model (Andrews, 1995; Simon, 1998). These focus on risk (targeting those individuals at greatest risk of reoffending), need (focussing on dynamic criminogenic risk factors such as criminal attitudes, substance abuse and impulsivity), and responsivity (delivering interventions that maximizes offender engagement in treatment).

An early review of the treatment of psychopathic and ASPD (Dolan & Coid, 1993) concluded that the evidence base for such treatments was poor, with only a small number of studies, which were limited by poor methodology and lack of long-term follow-up. Subsequent meta-analyses have highlighted the limited evidence base for effective treatments for ASPD (Duggan et al., 2007; Warren et al., 2003; NICE 2009; Gibbon et al., 2010) and the difficulties in comparing interventions due to differences in defining and measuring outcome, a focus on treating incarcerated offenders rather than those in the community, a focus on behavioural and symptomatic rather than structural personality change, and diagnostic inconsistencies with most outcome studies failing to differentiate offenders with psychopathy from those without (De Brito et al., 2009). A Cochrane review of psychological interventions for antisocial personality disorder (Gibbon et al., 2010) considered 11 studies, of which several looked at treatments to reduce drug or alcohol misuse in people with antisocial personality disorder, but few focussing on treating ASPD specifically. They found some evidence that contingency management (which provides rewards for progress in treatment) could help people with ASPD to reduce their misuse of drugs or alcohol, no firm conclusions regarding the treatment of ASPD were found from the evidence available.

There is emerging evidence for the efficacy of democratic therapeutic approaches for the treatment of forensic patients and offenders. Such approaches were discredited following a series of studies in the 1990s showing that group interventions in therapeutic community settings for psychopaths not only had a poorer treatment response and greater drop-out rate than non-psychopaths (Ogloff, Wong & Greenwood, 1990), but actually increased violent recidivism in the psychopathic population studied (Harris, Rice and Cormier, 1991; 1994). The majority of outcome studies of therapeutic communities in both health and forensic settings are hampered by poor methodology and small sample sizes but did show some improvement in interpersonal outcomes and reducing reoffending, particularly for individuals with personality disorder (Capone et al., 2016; Lees et al., 1999, 2004; Newbury, 2010; Skett & Lewis, 2019).

There are very few studies evaluating the treatment of patients with ASPD in general mental health services. Most randomised controlled trials of specific psychological therapies for the treatment of personality disorder are for borderline personality disorder and exclude ASPD. One pilot randomised controlled trial of individual CBT for men with ASPD suggested that psychological treatments may help to reduce the likelihood of re-offending, but the study was limited by its small sample size (Davidson et al., 2008).

The evidence base for the pharmacological treatment of ASPD is equally limited. Two large meta-analyses of trials for pharmacological interventions for ASPD (NICE, 2009; Khalifa et al., 2010) concluded that there was no consistent evidence that supported the use of any pharmacological intervention to treat the disorder. It is recommended that pharmacological interventions should be limited to the treatment of co-morbid mental disorders and not be routinely used for treating the primary traits or associated behaviours of ASPD (NICE, 2009).

2.4 Mentalizing and ASPD

2.4.1Mentalizing

In recent years mentalizing has become one of the most widely used terms in the areas of developmental psychology, mental health, and psychological therapies. However, its very ubiquity has contributed to it being used loosely or indiscriminately with overlapping terms such as reflective function, mindfulness, or psychological mindedness, risking confusion and concerns regarding its specificity and usefulness in understanding mental states and psychological processes.

The mentalizing that concerns us here is a concept describing mental activity that has been elaborated and refined by Fonagy and his colleagues (e.g., Fonagy et al., 2002; Bateman & Fonagy, 2019a) over the past 25 years from its roots in psychoanalytic theory and attachment theory within the crucible of developmental psychopathology. In its exploration of psychological processes, mentalizing has had wide-reaching influence in clinical practice, particularly in the understanding of personality disorders and other mental disorders and the development of tailored psychological treatments for these conditions, and its scientific credentials continue to be affirmed by new

research findings in developmental psychology, psychopathology and neuroscience. Moreover, not only may the process of mentalizing be the most common psychotherapeutic factor accounting for the effectiveness of all psychological therapies, and that plays a role in all mental disorders so that an understanding of its principles and practical implications would be of benefit for all clinicians, but it has wider relevance in being a fundamental developmental achievement necessary for all of us to attain a sense of self and identity, to experience oneself as an individual with agency, to sustain meaningful and mutually intimate interpersonal relationships, and to negotiate the complexities of the social world.

2.4.2 What is mentalizing?

Mentalizing is an essential and uniquely human psychological process which involves the capacity to reflect and understand the contents and processes of one's own and other people's mental states, including thoughts, beliefs, desires, affects, wishes and intentions, and to be able to interpret the actions of oneself and others as meaningful and based on intentional mental states. Crucially, mentalizing entails the awareness that mental states, even if they are not fully conscious, influence and explain behaviour - understanding that the actions of others and oneself are not solely phenomena in themselves but are governed by psychological processes within the mind. Mentalizing therefore includes the ability to appraise behaviour in terms of mental activity, to perceive and interpret behaviour as conjoined with intentional mental states. Intentional here means representational, that mental states are about something, they represent an aspect of reality in a particular way, in contrast to physical objects and materials which are not representations, but reality in itself. Mentalizing is not only about understanding the representational nature of the mind, but about understanding our understanding of the mind. Phrases in common parlance which capture the overall essence of mentalizing include 'holding mind in mind', 'giving a mental quality to', or 'cultivating mentally'.

Mentalizing is mostly a preconscious activity, taking place out of conscious awareness. It may be thought of as imaginative in that it necessitates the ability to imagine or envisage what is in other people's minds, to 'put oneself in the shoes of the other'. This sometimes requires an imaginative leap to conceive of what might be in our own minds, let alone others, particularly if we are dealing with emotionally laden issues

which cloud our minds and make us more prone to irrational thinking. However, although mentalizing involves an attitude of curiosity, allowing ideas to be played with and new theories generated, its imaginative activity does not extend to invention, but requires some awareness that mental states are representations of reality, albeit from one of many possible perspectives.

Mentalizing underpins our everyday interactions with others and as a psychological process it is as essential to our mental health as it is to our mental ill-health. Psychological well-being entails enjoying secure and mutually enriching relationships with other people. Homo Sapiens evolved from other primates that live and function in social groups, and optimal psychological functioning across the life span has been found to be associated with group affiliation of some sort (Vaillant, 2012). Mentalizing skills have evolved in humans that allow group members to anticipate and reflect on the intentions of others, particularly in relation to threat, sexual pair bonding and care giving. Mentalizing can be seen as a form of social cognition that necessitates a knowledge and appreciation of the cognitive and emotional processes that mediate social relationships.

To be able to function in social groups requires not only the skills needed to mentalize oneself but also those needed to mentalize others. Being able to represent our own mental states allows us to experience a sense of self which has psychological coherence and boundaries. This secure sense of our own identity enables us to differentiate ourselves psychologically from others, and to recognise that our own mental states are different and can be distinguished from those of other people. The ability to appraise the motives that underlie other people's actions towards us is important in informing how we choose to react and relate to them.

Our interpretation of other people's behaviour is often based on our understanding of the states of mind that underlie our own behaviour, and we often equate what we think or feel in particular circumstances with how we think other people might think or feel in the same situation. Mentalizing, however, requires the recognition that other people's feelings, beliefs and intentions regarding particular issues may not be identical to one's own. A central tenet of mentalizing is that the internal states of others are opaque – that although we may have a pretty good idea about what the person

might be thinking or feeling based on our analysis of the circumstances of their actions and their prior patterns of behaviour, ultimately our judgement is based on inferences, which are prone to error as mental states are more changeable than aspects about the physical world that are immutable. Having the aptitude to acknowledge that other people may have different perspectives from ourselves allows us the flexibility to negotiate relationships with other people whose thoughts, feelings, desires and motivations may not only diverge from our own but fluctuate and evolve according to circumstance.

Mentalizing is not a unitary concept but involves a range of complex cognitive and affective processes. Moreover, the capacity to mentalize is not fixed, but varies according to the person's current physical and mental state. Lapses and fluctuations in mentalizing may occur due to physical illness, stress, and anxiety, or in certain affectively charged interpersonal situations when the person feels overwhelmed with their emotional state, and their capacity to mentalize is compromised, leading to misunderstandings and misattributions of other people's behaviour. People also differ in their overall capability to mentalize due to differences in innate predisposition and early environmental influences, particularly in the context of attachment experiences. Individuals with personality disorders may find it particularly difficult to conceive of their behaviours as coherently organized by mental states, predominantly when they experience interpersonal difficulties and ruptures in their attachment relationships.

2.4.3 The developmental origins of mentalizing

Fonagy and his colleagues have developed the concept of mentalizing to bridge psychoanalysis and attachment theory and have designed mentalizing-based therapeutic interventions that link clinical practice with an understanding of developmental psychopathology. In this model, mentalizing is essentially a social cognition that develops in a relational context - importantly, but not exclusively, in the early attachment relationships with primary caregivers - and which is necessary for human beings to operate within a social world and to meaningfully relate to others.

The normal development of mentalizing is dependent on the intersubjective process of emerging psychological awareness between the child and his primary caregivers in the context of a secure attachment. The child becomes increasingly aware of his own

mind through his growing awareness of the mind of his mother, or trusted other, through her capacity to demonstrate to him, via her empathic mirroring, that she experiences him as a separate person with his own distinct intentions, beliefs and desires. The quality of affective mirroring, particularly the capacity for contingent emotional responsiveness by the caregiver ('marking' the affect), is critical for the normal development of affect regulation, impulse control, attentional mechanisms, and mentalizing. Disruptions in attachment, including abuse and trauma, combined with constitutional vulnerabilities, can lead to impairments in the capacity for mentalizing. This can lead to personality pathology in adulthood, in which the capacity for mentalizing is fragile and developmentally earlier modes of thinking about subjective experience are triggered in the context of emotionally intense attachment relationships.

Fonagy and Target (Fonagy & Target, 1996; 2000; 2007; Target & Fonagy, 1996) have identified several primitive modes of thinking that predate the emergence of mentalizing, which are present in the normal early childhood development in of all of us but are more likely to persist and re-emerge in people with certain personality disorders when the attachment system is reactivated and mentalizing fails. These pre-mentalistic or non-mentalizing modes of organising subjective experience include what they call 'psychic equivalence', 'pretend mode', and 'teleological thinking'. Psychic equivalence is a state of concrete thinking, in which internal and external reality are experienced as isomorphic where thoughts are felt to be real, there is no tolerance of differing points of view, a suspension of doubt, and thoughts cannot be symbolised. In extreme cases, a disturbed subjective state of mind is experienced as pseudo-psychotic symptoms, or as flashbacks in post-traumatic stress disorder. In pretend mode, sometimes referred to as hyper mentalizing or pseudo mentalizing, thoughts and feelings are dissociated from reality to point of meaninglessness, so that a person may appear to be talking about important internal experiences, but these are disconnected from any meaningful context. The person shows cognitive understanding of mental states but little affective understanding. In states of extreme pretend mode, the person may experience states of dissociation or derealisation. Teleological mode refers to a mode of thinking in which the motivations of others are interpreted according to the presence of physical actions and where changes in mental states are only felt to be real when confirmed by physically observable action. Teleological

mode may be expressed by 'acting out' in dramatic or destructive actions, for example, behaviours such as self-harm or violence which are felt to be the only method of communicating with others.

Early traumatic experiences can also lead to impairments in the development of a stable sense of self. The mother (or alternative caregiver) who is not attuned to her baby's experience will provide inadequate mirroring of the infant's behaviour, so that the child is unable to develop a representation of his own experience, and instead internalises the image of the caregiver. Where the primary caregiver has been neglectful or frankly malevolent towards the child, this internalised representation will be experienced as foreign or bad and will never be fully integrated into his overall schema of self-representations. Fonagy and colleagues (Fonagy et al., 2002) have called this discontinuity within the self the 'alien self' and suggest that this internalised self-representation is subject to the pressure of projection into others to maintain the illusion of a self that does not contain unacceptable aspects. This results in a disorganised self-structure involving the continual re-externalization of intolerably painful self-states, particularly negative affects associated with vulnerability, shame, and humiliation.

2.4.4 Dimensions of mentalizing

Mentalizing is a multi-dimensional construct containing several underlying polarities which are most likely related to relatively distinct neural systems (Fonagy et al., 2012). Mentalizing can be considered as four intersecting dimensions or functional polarities: automatic/ controlled (or implicit/ explicit); internally/ externally based; self/other orientated; and cognitive/affective process. Successful mentalizing involves integrating of all these dimensions into a coherent whole: this is difficult for all of us, but people with personality pathology may show particular impairments in one or more of these polarities (Fonagy & Luyten, 2009).

The automatic (implicit) and controlled (explicit) dimension is the most fundamental polarity underlying mentalizing. Implicit mentalizing is a non-conscious, non-reflexive, procedural function that requires little effort or attention, whereas explicit mentalizing is a much slower process which is more conscious, usually verbal, and requires effort, attention and reflection. In our normal daily interactions and interpersonal situations,

we predominantly use implicit mentalizing, especially in the context of secure attachment relationships, and it is only when something unexpected or unusual occurs that we may need to consciously slow down, reflect and explicitly think about what has happened.

The external/ internal mentalizing dimension refers to the target of mentalizing. Internal mentalizing is a focus on one's own or others' internal states, i.e., their thoughts, feelings, intentions, and desires; external mentalizing implies a reliance on the external world or external features of others such as facial expression and non-verbal behaviours in interpreting intentions and making sense of interpersonal situations.

The external/ internal mentalizing dimension differs from the self/other mentalizing dimension which refers to the object of focus of mentalizing (i.e., the self or others). Impairments in mentalizing may manifest similarly in both the self and others (e.g., they may be primarily internally oriented in both) or there may be marked imbalances in mentalizing about the self and others. For example, the mentalizing of patients with narcissistic personality disorder is primarily focused on the self, whereas people with antisocial and psychopathic traits may be expert at reading other people's internal states – at least at a cognitive level – with little understanding of their own (Bateman & Fonagy, 2019a).

The final dimension of mentalizing relates to cognitive and affective processing. Cognitive processing encompasses belief-desire reasoning and perspective taking, whereas affective processing includes emotional empathy, subjective self-experience, and mentalized affectivity (Fonagy et al, 2002; Jurist, 2005). Full mentalizing requires the integration of both cognitive and affective processes.

Imbalances within these dimensions may generate non-mentalizing modes of subjectivity. In psychic equivalence there is dominance of affect over cognition. In pretend mode explicit mentalizing is lost and the person is dominated by implicit mentalizing with little capacity for reflection. Teleological mode occurs where there is too much focus on external events to the neglect of internal experience.

It is not possible to completely mentalize all the time and all of us will oscillate between understanding our own motives and those of others according to consideration of what

is in the mind, to explanations based on the physical environment. Mentalizing is context dependent, and we are all prone to temporarily lose the capacity to mentalize and revert to non-mentalizing modes of thinking under the influence of powerful affective states which trigger the attachment system, disrupt normal cognitive processes and shift the focus of interpretation of interpersonal interactions away from the uncertainty of human minds to more readily understandable and stable physical attributes. Personality psychopathology, however, does not arise solely from a lack of mentalizing but from other disturbances in the capacity to mentalize, including how easily mentalizing is lost and regained, the degree of rigidity or flexibility of mentalizing, and distortions and disruptions in the balance of the components or dimensions of mentalizing. Similarly, although we may all sometimes experience the world in non-mentalizing or pre-mentalistic modes of thinking such as psychic equivalence, pretend mode, and teleological thinking, these modes of primitive psychic functioning occur more frequently in people with personality disorders, especially when their attachment systems are triggered by emotionally charged interpersonal interactions.

2.4.5 Epistemic trust

In recent years Fonagy and his colleagues have introduced the notion of epistemic trust into the conceptual framework of mentalizing (Luyten, 2020). These theoretical developments build on the work of Gergely and Csibra (Gergely, 2013) in their proposal that human infants' capacity for learning from their caregivers is of evolutionary importance. Epistemic trust refers to a social and cognitive adaptation of communication that has developed uniquely in humans, to ensure the efficient transfer of relevant social and cultural knowledge between caregiver and child. To have the ability to do this, a particular sensitivity has evolved in the human species to forms of communication that provide opportunities for this form of teaching and learning. These opportunities are provided by what is called 'ostensive cues' which are interpersonal behaviours acting as signals that occur between caregiver and infant, such as eye contact, turn-taking contingent communications, and a particular tone of voice used by the caregiver which has been nicknamed 'motherese'. Human infants are particularly attuned to these cues, whose function is to indicate to the child that the caregiver thinks of him as a separate individual with his own mind, and to allow him to develop a sense of agency. This facilitates the child in opening his mind to receive and recognise information that is relevant and to modify his emerging beliefs and actions

accordingly. The caregiver is experienced as a reliable source of knowledge and as the child grows up this trust may then be extended to other significant people from whom he may learn from, and eventually generalise in their personal and social relationships so that the adult is open to receiving new information from others, which can be retained in memory, and which is necessary to effectively navigate the social world.

Epistemic trust is more likely to be generated in securely attached children; insecurely attached children who have experienced their primary caregivers as malign due to early experiences of trauma, abuse or neglect, are more likely to develop epistemic mistrust. These individuals find it difficult to accept knowledge and information from others, who are viewed with suspicion and doubt. Their previous traumatic experiences, which have caused ruptures of epistemic trust, predisposes them to misinterpreting others' intentions and communications as malevolent, causing high levels of 'epistemic hypervigilance', a form of hypermentalizing in which other people's motives are overinterpreted, and the person is constantly in a state of uncertainty and anxiety. Such individuals, due to their insecurities in interpersonal and social relationships, may be hungry for validation from others, but any affirmation or reassurance is rejected. Their inability to modify their beliefs due to their resistance to receiving new information engenders a rigidity in their thinking and interactions with others, who may then react negatively, confirming the person's belief that others are not to be trusted, and creating a vicious circle of paranoia and rejection.

2.4.6 Mentalizing in antisocial personality disorder

As adults, people with ASPD are dependent on relationships with others into whom they can project these alien aspects of themselves in order to stabilize their minds and feel a sense of self-coherence. Relationships in individuals with ASPD tend to be rigid, hierarchical, and controlling, as exemplified in dismissive attitudes towards women who are viewed as inferior, or in the 'gang culture' of organised crime. Notions of recognition and respect assume a special importance in their interpersonal relationships. If, however, such relationships are challenged by the other person refusing to be the recipient of malign projections, as in the subjugated wife who talks back to her abusive husband, the return of the alien self threatens the person's fragile

stability of mind, leading to unbearable feelings of shame and humiliation which may trigger violence in an attempt to regain control and sense of integrity.

Violence can be understood in particular relation to such primitive thinking. Bateman and Fonagy (2008) propose that reactive or affective violence, as described above, arises where there is a failure or inhibition of the capacity for mentalizing. The person with ASPD experiences psychic stability so long as projection of the alien self remains successful, but when this fails, pre-mentalistic types of thinking emerge, especially teleological thinking. A person with a limited capacity to mentalize is not able to manage negative emotions such as normal anger, hatred and wishes to hurt, but instead may become highly aroused very quickly, and experience themselves as unable to think and overwhelmed with negative affects. The person with ASPD, who is already highly sensitive to threats to his self-worth or 'respect', cannot tolerate internal emotional states of shame and humiliation at all, which are experienced as threatening his very psychic survival. These unbearable feelings cannot be managed by representational means within his mind but are experienced very concretely in psychic equivalence mode as feelings that the person needs to expel in violent action i.e., teleogically. The expression of aggression is further potentiated by the reduced capacity of the individual to mentalize – if he is unable to see others as having mental states as different from himself, this will reduce the inhibition of his aggression and violence towards others as he is unable to empathize or appreciate another person's suffering. Moreover, the onset of pretend mode creates an illusory sense of safety in which the violent person is detached from reality and hence the danger and consequences of his actions. Mentalizing therefore protects against violence and individuals whose capacity for mentalizing is reduced are more likely to be violent.

Individuals with ASPD show imbalances in the dimensions of mentalizing (Bateman, et al., 2019). They find it difficult to explicitly mentalize themselves and others due to their lack of interest in what other people think and feel. They therefore tend to overuse automatic mentalizing, which is compromised because their assumptions about themselves and others are not informed or challenged. In relation to the cognitive-affective dimension of mentalizing, they may demonstrate a good cognitive understanding of mental states but lack a capacity to connect with the affective core of others. This is evident in the absence of compassion of empathy for others.

Moreover, their cognitive capacities become distorted in self-serving ways such that they become convinced of their own convictions, rather than being able to consider and incorporate the views of others. These deficits within the cognitive-affective axis are reflected in asymmetry and fixations at one or other poles of the self-other axis of mentalizing. They fail to see aspects of themselves in the other person, and vice versa, which facilitates their disregard for the rights of others and permits antisocial and violent behaviour, as their experience of the other person's reaction and feelings do not constrain them. Their excessive focus on either self or other means that their relationships tend to be one-sided, and their social interaction is impaired. Finally, in general, individuals with ASPD find it difficult to differentiate internal from external states and tend to find it difficult to reflect on their own internal states and explore their current experiences. They also tend to misinterpret other people's expressed facial or other external emotions, which results in difficulties and delays in gaining information about others' mental states, particularly in relation to affect.

The neurobiological irregularities and deficits observed in people with ASPD as described above may underpin some of their impairments in mentalizing. Studies of adult psychopaths (Blair, 2010) show that they are impaired on tasks that rely on a functional amygdala, including specific deficits in recognizing fearful expressions, which is an external component of mentalizing. Hypoactivation of the amygdala has also been observed in youths with conduct problems in response to pictures considered emotionally arousing, particularly those depicting a potentially painful aggressive act (Jones et al., 2009). A reduced responsiveness of the amygdala to fearful faces and consequent difficulties in picking up on distress cues in others are likely to be contributory factors to their lack of empathy, and consequently recognition and empathic identification of distress in others (affective/other mentalizing) which would normally inhibit aggressive behaviour is lacking.

Other studies have shown hyper-responsiveness of the amygdala in conduct disordered youths to images of injuries inflicted on others such as seeing a foot being stamped on, and their responses correlated with parents' ratings of impulsive behaviour and sadism (Decety et al., 2009). This increased amygdala reactivity may therefore result in excitement or enjoyment of others' pain, rather than empathetic concern. Psychopaths have also been shown to have a reduced facility for aversive

conditioning and passive avoidance learning, forms of learning that are dependent on normal amygdala activity. These deficits also contribute to their lack of empathy because they are unable to invest memories and experiences with emotional salience (Blair, 2010).

There is also evidence to suggest that individuals with psychopathy may find it difficult to recognise affects in general in others, rather than just impairments in identifying fear. In a study of adolescents, it was found that those with high psychopathic traits showed a diminution in attention to other peoples' eyes in computer generated images of faces, compared to controls with low psychopathic traits (Dadds et al., 2008). Further studies showed that these results were replicated in real life situations, where children with antisocial behaviour and callous unemotional traits showed consistent impairment of eye contact with their parents. Their levels of eye contact were also associated with independent measures of fear recognition, and general empathy in the boys (Dadd et al., 2011). Moreover, these impairments were independent of their mothers' behaviour, who did not show significant impairments in eye contact with their sons (Dadd et al., 2012).

These findings are consistent with the problems that many people with ASPD and psychopathy have in external mentalizing and their lack of interest in internal mental states. Not being able to attend to socially relevant cues such as scanning the eyes may result in a reduction in ability to recognise or misread emotions generally, leading to extensive difficulties in being able to negotiate social and interpersonal relationships or understand others' perspectives due to their lack of empathy and emotional responsiveness. This substantiates Baren-Cohen's salient description of psychopathy in that it exemplifies a partial but fundamental impairment of mentalizing – i.e., mindreading without empathising (Baron-Cohen, 2003; 2005).

From the perspective of epistemic trust, personality disorders may be understood as arising from the person being unable to access cultural communication that is relevant to the self from the social context. This is at variance with traditional models of personality disorder which emphasize the abnormality of the person's character, i.e., the disorder of their personality; by contrast, within the model of epistemic trust, personality disorder is conceptualized as a failure of communication in which learning

from others is disordered. This accounts for the clinical experience of such patients as being difficult to engage in treatment or 'hard to reach'.

2.5 Mentalizing-based treatment for antisocial personality disorder

Mentalizing-based treatment (MBT) is a structured, time-limited, evidence-based psychological therapy that was originally developed in the 1990s to treat patients with borderline personality disorder in a partial (day) hospital setting. It is a psychodynamic therapy that incorporates relational and cognitive elements, and its theoretical frame of reference includes developmental psychology, attachment theory and a theory about the mechanism of therapeutic action (Bateman & Fonagy, 2019a). MBT is specifically focussed on increasing the capacity to mentalize. As described above, individuals with ASPD show marked deficits in mentalizing which negatively impact on their relationships with others and increases their capacity for violence. Thus, a reasonable hypothesis is that MBT would be an effective treatment for individuals with a diagnosis of ASPD.

2.5.1 Structure of MBT-ASPD

Mentalizing-based treatment for antisocial personality disorders (MBT-ASPD) is comprised of weekly group sessions lasting 75 minutes for the duration of one year. Individual sessions are offered on request to discuss issues that they are reluctant or ashamed to talk about in the group, e.g., difficulties in their personal relationships, depressed or suicidal feelings, but are primarily used to support the client in the group.

2.5.2 Aims of MBT-ASPD

The overall aims of MBT-ASPD are to stimulate robust mentalizing in all dimensions in the context of hierarchical interpersonal interactions and intimate relationships, and to reduce aggression as the primary pathway of expression of problematic internal states. Given the specific difficulties in mentalizing of individuals with ASPD described above, treatment is specifically focussed on understanding emotional cues - external mentalizing and its link to internal states; recognition of emotions in others – other/affective mentalizing; exploration of sensitivity to hierarchy and authority – self/cognitive; generation of an interpersonal process to understand subtleties of others' experience in relation to ones' own – self/other mentalizing; and explication of

threats to loss of mentalizing which lead to teleological understanding of motivation – self/other mentalizing and self/affective mentalizing.

2.5.3 Group work

Group work is essential for people with ASPD to address their disorganized and violent behaviour in their social and personal relationships for several reasons. The treatment group provides a peer group who are more likely to be influenced by each other rather than therapists who they believe have no understanding of the violent culture of the communities in which they live where the use of violence is seen as normal and necessary for survival. Group work stimulates a hierarchical process which replicates the hierarchical structure of their relationships in the external world, and which can be used in the group to explore their sensitivity to authority and control. Moreover, their interactions with each other in the group expose their attempts to overcontrol their emotions within well-structured attachment relationships by avoiding interaction or behaving in anxious or ambivalent ways. Furthermore, the relative absence in individuals with ASPD of more emotional capacities such as guilt, love, and empathy for others which normally inhibit violence, and their difficulties in recognizing others' affects, are best addressed in a group which can focus on mentalizing emotional states in self and others.

2.5.4 Focus of treatment

The first few group sessions are organised as an introduction and an engagement phase (MBT-I) which offers psychoeducation about mentalizing and ASPD, including an introduction to mentalizing, understanding attachment processes and mapping of relationship patterns, and addressing problems that are likely to occur in treatment.

Following the sessions of MBT-I, the group becomes focussed on interpersonal processes, specifically increasing affective understanding of self and others and identification of attachment and relational patterns.

2.5.4.1 Increasing affective understanding of self and others

To address the difficulties that people with ASPD have in identifying, expressing, and avoiding emotions, the clinician asks the client to describe their current subjective experience, for example whether they feel comfortable or uncomfortable in the group.

Inquiring about the patient's subjective experience is not identical to asking the patient how they feel, which in itself may make them feel humiliated when they cannot describe specific feelings. It is only after validation and some exploration of the cause of their current experiences can they start to identify specific feelings such as worry, irritation, or hurt and relate these to experiences in their life, or as they become more confident with each other in the group, although clinicians should be sensitive to any shame or embarrassment evoked in the group, as these feelings are often the triggers to aggression and violent behaviour.

In order to build a capacity for compassion and empathy, clients are also asked what they think other group members might be thinking and feeling, and how they came to that conclusion. Their answers are checked out with the participant in question so that different understandings of how someone feels can be explored, and the interpersonal relationships in the group may be strengthened.

2.5.4.2 Identification of relational patterns—increasing constructive interaction and decreasing destructive interaction

This work focusses on clients' attachment patterns, and their representations in relationships, that have been identified during their assessment and the early phase of treatment. Participants are asked to present their understanding of their relationship style and how this links with their problems in their external life, and as the group progresses, to begin to see how their relational patterns and attachment strategies play out in their affective interactions with each other. The clinician facilitates this process by identifying and validating constructive interactions as much as problematic interactions. Despite their predominantly dismissive attachment patterns of relating, people with ASPD can be surprisingly supportive of and form bonds with each other in the group, often through discussion of shared experiences, for example being victimized by the criminal justice system. Although harnessing these shared experiences are important to create a cohesive and functioning group, the participants often carry out such conversations in pretend mode, where any real affective connection to the events described is lacking. Moreover, attributing their difficulties to external agencies is an example of activation of the alien self where their relationships are characterized by rigidity and their representations of others are schematic or stereotypical. These discussions and interactions with each other in the group must

eventually be challenged by asking clients to reflect on their own part on their difficulties in order to promote a more balanced self-other mentalizing. Highlighting and exploring their difficulties in mentalizing within the group leads to a greater understanding of how these mentalizing impairments interfere with the development of healthy relationships in their external lives.

2.5.5 Evidence for the effectiveness of MBT for ASPD

MBT was initially shown to be effective in a randomised controlled trial in patients with borderline personality disorder (Bateman & Fonagy, 1999) where it diminished suicidal and self-injurious behaviours, significantly improved interpersonal functioning and reduced the number of hospitalisations and use of medication compared to the control group; follow-up studies (Bateman & Fonagy, 2001; 2009) reported that these gains were maintained post treatment. MBT has subsequently been adapted for other disorders, including ASPD (Bateman & Fonagy, 2008; 2016), with increasing interest in applying MBT to patients in forensic in-patient settings.

Although to date there have been no RCTs evaluating the effectiveness of MBT for ASPD, preliminary evidence that MBT might be effective in treating patients with ASPD emerged from a trial comparing MBT with structured clinical management (SCM) which included problem solving and social skills. In this study MBT was found to be more effective than SCM in patients in reducing self-harm, suicidality, hospital admissions, depression, and general symptom distress in BPD patients comorbid with ASPD, although the effectiveness of both was reduced when compared with BPD patients without ASPD (Bateman & Fonagy, 2009). This subsample of patients with co-morbid BPD and ASPD was further investigated and was found to show improvements in symptoms related to aggression including the reduction of anger, hostility, paranoia, and frequency of self-harm and suicide attempts, as well as the improvement of negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment than those offered a structured protocol of similar intensity but excluding MBT components (Bateman et al., 2016).

Chapter 3: Psychoanalytic and mentalizing models of organisational dynamics

3.1 Introduction

As mentioned at the outset, the secondary aim of this thesis is to investigate whether a mentalizing framework and/or a psychoanalytic organisational framework are helpful in understanding the main barriers and facilitating factors to the implementation of the RCT evaluating the effectiveness of MBT for offenders with a diagnosis of ASPD within the criminal justice system in England and Wales.

This chapter describes in detail the theories, backed by empirical research where present, that underpin these two broad frameworks. Psychoanalytic models of organisational dynamics are described first in that their historical origins precede those of a mentalizing understanding of social and organisational systems.

3.2 Psychoanalytic approaches to the understanding of organisations

3.2.1 Social defences

The dynamics of organisations and institutions, including those within the criminal justice system, have been explored from a psychoanalytic perspective in a body of literature stemming from the work of the sociologist Eliot Jaques (1951; 1955) and that of the psychoanalyst Isobel Menzies Lyth (1960a; 1960b). Both used Kleinian psychoanalytic ideas to understand social practices within institutions, specifically focussing on unconscious anxieties and defences against anxiety within work settings, and the formulation of social defences against anxiety. Jaques' original study was of a consultation to a factory going through significant organisational change. He located anxieties between managers, workers and union representatives of both paranoid-schizoid and depressive types. Menzies Lyth's study was of the nursing system in a malfunctioning medical teaching hospital and saw the primary source of anxiety as being due to the mental pain and distress evoked by the task of nursing sick and dying patients in the context of the hospital's authoritarian and managerial culture. She observed that nurses experienced a range of conflicting feelings towards their patients:

‘The work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of patients who arouse these strong feelings; envy of the care given to the patient.’ (Menzies Lyth, 1960b, p. 98). Such feelings, she proposed, were the result of the reactivation of infantile persecutory anxieties which the nurses counteracted by deploying the unconscious primitive defence mechanisms of projection, splitting and denial. In her model of the ‘social defence system’ these defensive reactions and countertherapeutic behaviours developed and were expressed in the organisation’s bureaucratic rules and procedures, hierarchies, rosters, paperwork, and task lists, which served as supports to distance themselves from personal contact and emotional engagement with patients.

The main difference between Jaques’ and Menzies Lyth’s formulations was that Jaques thought that the defences against anxiety were the result of projections of the individuals’ internal conflicts onto the social organisation structure which offered containment in more or less constructive ways, and that certain individuals with particular characters or difficulties were attracted to similar sorts of organisation. On the other hand, Menzies Lyth saw the anxieties as emanating from the working task, and the unconscious defensive structures as being determined by the organisation. The differences between these two positions regarding the source of the anxiety encapsulate the tension between ‘internal’ and ‘external’ forces in attempts to link psychological and sociological perspectives (Rustin & Armstrong, 2019). A third source of anxiety originates in the wider external environment, for example, the centrally-imposed government financial cuts to the NHS in recent years in the UK and introduction of a market economy and target driven culture which presents pressures on managerial staff who push their unconscious survival anxieties into the clinical staff who are sandwiched between the demands of the managers and those of the patients (Blacker, et al., 2017; Evans, 2015). The anxieties caused by relentless organisational changes may increase risk and uncertainty (Rizq, 2011) and keep at bay the existential anxieties of staff associated with infirmity, pain and mortality (Ballatt & Campling, 2014). At an even wider level, Obholzer has suggested that social institutions represent containers for society’s anxieties regarding life and death, where the NHS ‘is used as a receptacle for the nation’s projections of death, and as a collective

unconscious system to shield us from the anxieties arising from an awareness of illness and mortality' (Obholzer, 1994, p. 171).

Jaques and Menzies Lyth's ideas were further developed into the field of organisational consultancy by theorists associated with the Tavistock Clinic and the Tavistock Institute of Human Relations in London such as Trist (Trist et al., 1963), Miller (Miller & Rose, 1988), Rice (1958), Armstrong (2005; 2012) and Rustin (Rustin & Armstrong, 2019), and were also adopted in the US, for example in the work of Gould (1993), Krantz (1989), Diamond (1985,1993), and Hirschhorn (1988, 1989). This work has been informed by the psychoanalytic observational method, a research methodology pioneered by Bick (1964) in her observations of babies on a neonatal ward, where the researcher carefully observes and studies over time the emotional atmosphere and nature of the relationships and interpersonal interactions within a given setting, making particular use of their feeling states, or countertransference, to make emotional sense of their observations (Blacker et al., 2017). Hinshelwood and Skogstad (2000) adapted this method for use in organisational contexts and suggest that it has five perspectives akin to the task of a psychoanalyst in their treatment of patients: a way of observing with 'evenly hovering attention' and without premature judgement; the careful employment of the observer's subjective experience; the capacity to reflect and think about the experience as a whole; the recognition of the unconscious dimension; and the formulation of interpretations which afford a means of verifying or falsifying the conclusions the psychoanalyst has arrived at through this process. This method of data collection bears affinity with ethnographic observation traditionally used by anthropologists in the use of research subjectivity. However, it has been criticised as failing to give research participants an active voice, in contrast to other studies of organisational dynamics which have involved qualitative interviews of staff.

The concept of social defences has been widely applied within the mental health field where patients with mental disorders may arouse particular anxieties related to vulnerability, dependence, fragility, fears of madness and loss of control (Rizq, 2011). Bott (1976) first applied Menzies Lyth's thinking to a psychiatric setting in her observational study of a long stay psychiatric hospital, using an anthropological fieldwork method. She found that staff were profoundly uneasy about the conflicting

tasks they were asked to perform: on the one hand to protect society from patients' madness, and on the other hand to offer treatment to these patients, who might improve but would not then be welcomed back into society. Moreover, staff were confused as to whether patients needed long-term care or active treatment. In contrast to staff in medical wards who were looking after patients with damaged and dying bodies, staff in psychiatric institutions were forced into contact with patients who could not recover from their mental illness, who had lost their personal identities and whose minds had died. Donati (1989) observed nurses' relationships with patients on a chronic psychiatric ward and how they kept the patients at arms' length as a defence against the fear of losing their minds themselves. She described the atmosphere of chronic boredom of patients and staff, the occasional bursts of activity when others visited the ward briefly but then left again, leaving it disappointed and hopeless. Goodwin and Gore (2000) also observed nurses on a long-stay psychiatric ward and noted that the overall environment was lifeless with occasionally bursts of manic activity, where staff appeared disinterested in patients to the point where they barely referred to a patient committing a violent assault.

Hinshelwood and Skogstad (2000) suggested that fears of insanity and violence may be fuelled by an unconscious assumption that any liveliness between patients might result in madness, resulting in a culture of deadness and that talking to patients may be experienced as dangerous. Similarly, Evans (2010) proposed that the concrete communications and lack of affectivity of psychotic patients inhibited meaningful dialogue and deadened the responses of mental health professionals tasked with looking after them, whose responses may become as concrete (e.g., form filling, administering medication) as those of their patients. By contrast, defensive reactions to tension and anxiety by staff may become over excited: Hinshelwood and Skogstad (2002) observed staff in a mental health hostel and medical ward who related to each other in a flirtatious way to distract them from the pain and suffering of their clients.

Other researchers have studied the operation of collective social defences in mental health settings. In a ward for eating disorders, Morante (2005) observed nurses engage in more functional and practical tasks such as serving meals and weighing patients to divert them from becoming involved in the more therapeutic and emotive role of individual key working. Rizq (2011; 2012a; 2012b; 2013) proposed that IAPT

(Improving Access to Psychological Therapies) services systematically deny feelings of loss and vulnerability in both staff and patients through the promotion of a consumerist ethos and patient choice agenda, and bureaucratic systems monitoring staff and clinical activity and that preoccupations with regulation, surveillance and governance in mental health institutions were symbolic attempts to obtain mastery over feelings of disgust and fear associated with caring for mentally ill patients. Similarly, in a study exploring the impact of organisational change on professionals working within a community mental health team Hanley et al. (2017) found that financial constraints, increased regulation, accountability and 'industrialising therapy' challenged a culture of care and trust and resulted in low staff morale, burnout, and increased risk to patient safety. Primitive collective defence mechanisms of splitting and denial were elicited in the clinicians who perceived themselves as caring and management as cut off and neglecting the needs of patients.

3.2.2 Criminal justice and forensic mental health settings

Criminal justice and forensic mental health settings are particularly susceptible to the development of pathological organisational dynamics given the anxieties generated by the risk to others that their clients or patients pose. For example, Kurtz (2001) studied staff organisational defences in a regional secure unit and a community forensic mental health service and found that staff were anxious not only in response to the real threat of danger from patients but also due to fears of survival in these forensic services which had been criticised by the government in blaming incompetent staff and poor governance. In another study of experiences of staff in a secure unit for men with learning disabilities, Isherwood et al. (2006) found that staff were preoccupied with anxiety about risk, with a practice of passing difficult decisions up the professional hierarchy rather than allowing frontline staff to take responsibility for risk assessment themselves. Adshead (2009) also drew attention to how the long-term nature of forensic secure care, where many forensic patients have lengthy admissions, makes particular demands on staff, upon whom patients may become dependent or treat in destructive ways.

There has been a growing literature about the traumatising impact of these pathological dynamics within forensic and criminal justice institutions (e.g., Aiyegbusi & Kelly, 2012; Armstrong, 2005; Gordon & Kirkchuk, 2008). Similar to the recent

revelations regarding the maltreatment of patients by staff in care homes, there have been a number of high-profile cases of institutional corruption and abuse in forensic residential care in the UK, which have prompted public inquiries. These include two inquiries into staff practices at Ashworth High Secure Hospital – the first revealing evidence that staff had been physically abusive to patients (Blom Cooper, 1992), and the second involving sexual boundary violations in which members of staff were caught smuggling children into the hospital to be abused by paedophile patients (Fallon, 1999). In 2009, evidence of neglectful care was found at Broadmoor High Secure Hospital where there had been a homicide and multiple patient suicides. In such cases, the prevailing regime within the institution has often been described as a 'toxic culture' (Davies, 2004) where management perpetuate and endorse a persecutory and bullying ethos and/or turn a blind eye to the pressures on staff and the corrosive effects of daily contact with highly disturbed patients.

Often the structure of institutions is compartmentalised into separate functioning (or non-functioning) units composed of different professional groups, with different trainings, sub-cultures, and work practices (Yakeley, 2010). Within a secure hospital, there might be separate departments or professional groupings of nursing, psychiatry, occupational therapy, psychology, and psychotherapy, the representatives of each delivering their own treatment practices and programmes, often with minimal liaison with each other. Within criminal justice settings, such as prisons or probation, rifts may be particularly pronounced between health staff and custodial staff reflecting the lack of integration between the therapeutic and custodial aspects of the work and conflict as to whether the primary task is to reduce risk to others or to improve the health and wellbeing of the offenders. Thus, Kurtz and Jeffcote (2011) investigated the extent to which staff from a range of disciplines in a mainstream NHS medium secure unit (MSU), and a personality disorder unit in an MSU experienced therapeutic and public protection tasks as mutually enhancing or in conflict with each other and found that different groups of staff had contradictory ideas about the nature of the work in these respects. Another study in a secure forensic mental health service found that perceived power differences between staff and patients on the one hand and medical and non-medical staff on the other interfered with effective multi-disciplinary team working (Shaw, 2007).

Such splintering of professional groups and the resulting fragmentation of the institution may be explained as being due to the unconscious projection of the patients' or offenders' own chaotic and fragmented minds into the institution as a whole. Thus, the individuals who are being cared for or managed within the institutions represent a fourth source of anxiety which trigger pathological social defences. From a Kleinian and object relations psychoanalytic perspective, violent and antisocial individuals, especially those with personality disorders, may be the result of the person's underlying unconscious states of mind where primitive defences, such as projection, splitting, projective identification, omnipotence, and denial; and primitive affects, such as paranoid anxiety, aggression, envy, shame, humiliation and excitement predominate. These unwanted affects, which cannot be tolerated and processed and feel unbearable to the patient's conscious mind are projected into the staff and institution, who react in kind via collective and destructive primitive defence mechanisms, in particular, projective identification, mirroring those of the patient. Projective identification, first described by Klein (1946), is a defence mechanism in which the person projects or externalises their internal feelings and object relationships, which they cannot bear to recognise as internal to themselves and therefore attribute them to others. The person who has been invested with these unwanted aspects may unconsciously identify with what has been projected into them and may feel unconsciously pressurised to act out in some way (Yakeley, 2010).

How the patient's disturbance is acted out within the institution has been explored within the psychodynamic literature on therapeutic communities (e.g., Jones, 1968; Main, 1983) but also has been noted by cognitive behavioural therapists treating offenders and has become incorporated into the concept of 'offence paralleling'. This is where the relationships between offenders and staff resemble previous offending patterns (Daffern, Jones, & Shine, 2010). In psychodynamic terms, offence paralleling is where the patient's deeply engrained relational patterns stemming from their early traumatic experiences and enacted in their offence behaviour are unconsciously transferred into and played out in the here and now of the forensic institution (Scanlon, 2012).

3.2.3 Countertransference

The role of emotions in these unconscious dynamics comes to the fore and may be understood via the psychoanalytic concept of countertransference. Countertransference refers to the emotional responses that the therapist or clinician has towards the patient. This reflects the individual therapist's own internal conflicts but is also a reflection of what the patient feels, or is 'doing to', the therapist consciously or unconsciously. Freud (1910; 1912) originally saw countertransference as a manifestation of unresolved conflicts in the analyst, which acted as an impediment to the work of analysing the patient. However since the 1950s, influenced by the ideas of Klein (1946) and Bion (1962) on projective identification, and the work of Heimann (1950), Racker (1953; 1957) and others, there has been a shift in psychoanalytical theorising towards an appreciation of the patient's contribution to shaping the analyst's countertransference via projective identification - the projection of the patient's own unwanted emotional states into the therapist who identifies with the projected affects to produce unexpected or unwanted feelings, experiences and behaviours. The countertransference can be a valuable tool in providing clues to the patient's unconscious and internal world, and awareness of and reflection on the therapist's countertransference is now an essential part of the process and technique of psychoanalytic therapy and is used to inform the therapist's therapeutic interventions and interpretations.

Due to the disturbing nature of their criminal activities and offending behaviours, forensic patients and offenders may evoke particularly extreme emotional reactions in staff tasked with their management or care. A systematic literature review of the impact on staff of working with personality disordered offenders suggested that working with this population is associated with negative attitudes, burnout, stress, and negative countertransferential experiences (Freestone et al., 2015). Common countertransference reactions towards offender patients include moral outrage; disgust; excessive fear, and its counterpart, the denial of real dangerousness; devaluation and loss of professional identity; feelings of hopelessness and guilt when therapeutic change does not occur; excessively punitive and sadistic responses, such as overestimating a patient's risk; and sexual excitement which is rarely admitted or spoken about, but can lead to boundary violations (Meloy & Yakeley, 2013). Sometimes these emotional responses, for example disgust and other strange or disconcerting experiences, may be more felt in the body than in the mind, representing

physiological responses. Menzies Lyth (1960b) described countertransference feelings in nurses as reactions to medically ill patients' bodies. In forensic patients and offending individuals, unpleasant visceral reactions in staff may be understood as direct physiological responses to what their clients have done to other people's bodies, or their own in the case of self-harm, which are too disturbing to think about consciously.

For example, in a large survey study of 584 mental health and criminal justice professionals, Meloy and Meloy (2002) found that over three quarters of those who had interviewed an adult psychopath reported a physiological reaction that the authors attributed to sympathetic activation of their autonomic nervous system. Dermatological responses were common such 'my skin was crawling' or 'he made the hair stand up on my neck'. Other reactions included perceptual, 'felt outside myself . . . numb'; gastrointestinal, 'stomach felt like I swallowed cement'; muscular, 'frozen with fear'; pulmonary, 'I couldn't catch my breath'; and cardiovascular, 'my heart was pounding'. Meloy proposes that these are all primitive atavistic responses that signal danger, and that their presence may indicate particular risk to the professional.

Inadequate analysis of the countertransference of staff members may lead them to unconsciously enact unhelpful individual and collective behaviours, which may result in faulty risk assessment that may in itself increase risk (Yakeley, 2010). For example, where patients or offenders' actions provoke anger, fear, or disgust, this may elicit unconscious punitive or sadistic responses in professionals, so that their risk is overestimated and inappropriate interventions such as prolonged incarceration or physical restraint are implemented. The patient's subsequent anger and resentment at feeling punished and mistreated may then lead to an actual increased risk of behaving dangerously. Other offenders may elicit sympathy and present themselves as innocent victims who are not responsible for their actions, which may resonate with a clinician's 'rescue fantasies' in their desire to treat patients whom they perceive have been misunderstood and mistreated by other professionals, so that the risk here is underestimated. In a study looking at the relative contribution of actuarial and emotive information in determining risk ratings of violence, Blumenthal et al. (2010) demonstrated that experienced forensic mental health professionals, despite being well trained in the use of actuarial risk assessment tools, tended to unwittingly

disregard actuarial information about the patient and were disproportionately influenced by their emotive responses to the clinical information given to them about the patient, leading them to make significant errors in risk prediction.

Negative countertransference reactions may be elicited in staff not only as a reaction to the disturbing nature of the patient's or offender's criminal offences, but also due to their client's disordered relationship to caregiving. Many antisocial or violent individuals have experienced abuse, trauma or neglect from their parents or other primary caregivers, which has left them wary, distrustful, or paranoid of others, especially those who profess care or concern for them. Due to their early childhood experiences of feeling rejected, humiliated, shamed or ignored, and consequent wish to defend themselves from future experiences of being vulnerable and dependent on others who may abuse them, they tend to reject care from others, including professionals. This may set up, consciously or unconsciously, a negative response in the professional, who, feeling rejected themselves despite their wishes to help the patient, may counteract by rejecting the patient, for example, not following up or prematurely withdrawing treatment altogether from patients who fail to engage. Thus, the staff group or forensic institution in its entirety may behave in ways which reflect the problematic dynamics of the patients' or offenders' families of origin. Adshead (2012) situates the understanding of the relationships between staff and patients within an attachment framework. As described in chapter 2, some patients or offenders within forensic settings have insecure attachments (Frodi et al., 2001; Levinson & Fonagy, 2004; van IJzendoorn et al., 1997) resulting in a range of abnormal behaviours when distressed making it hard for them to develop therapeutic relationships with professional carers; but at the same time, research shows that people who have a history of insecure attachments may negatively impact on their ability to give, as well as receive, care (Goldberg et al., 2003; van IJzendoorn, 1995), which substantiates Bowlby's (1960) speculation that children with insecure attachments would grow up to be 'compulsive care-givers' in adulthood. This means that there may be a sub-group of staff in forensic settings with insecure attachment histories who may be more likely to become involved in toxic relationships with patients with similar histories, resulting in boundary violations and other abuses of care.

3.3 Mentalizing social systems

The dynamics of organisations, including those within the criminal justice system, have also been explored from a mentalizing perspective, within a wider literature on mentalizing social systems. Mentalizing is essentially a relational process and is intimately connected with how we interpret the mind in relation to the social world around us. Mentalizing is developed and sustained by the social system in which we live (Bateman & Fonagy, 2016). Personality disorders may be conceptualised as (mal) adaptations to the adverse social environments that the individual was originally exposed to and learnt from.

Gains from therapeutic interventions aimed at the individual are unlikely to be sustained if that person's social environment does not support mentalizing. Bateman & Fonagy (2016) propose that effective therapeutic treatments act on three types of communication system to produce change. The first communication system is an implicit mentalizing process which provides the individual patient with a model of thinking about his own mind and others'. This involves the therapist communicating in such a way as to make the patient feel understood and taken seriously, and that their sense of self and agency has been recognised. This increases epistemic trust and their acceptance and acquisition of knowledge from others which brings forth the second communication system, in which they can start to engage in social exchanges, initially with the clinician, to allow their mind to be changed by engaging with another mind. However, mentalizing can only be maintained in the long term via the involvement of the third communication system, when the patient's epistemic trust and social learning can be extended beyond the current therapeutic relationship with the clinician to interpersonal interactions in wider social situations. If the patient can constructively mentalize themselves and others in their social world this will lead to a virtuous circle of the ongoing creation and sustainability of more positive, robust, and meaningful relationships in general. However, this final communication system can only be effective if the patient's social environment is benign enough for mentalizing to be applied constructively. If the person's external world does not support mentalizing or the generation and maintenance of epistemic trust therapeutic progress will be more difficult to sustain.

Applying the theory of mentalizing to social systems may be particularly useful in relation to thinking about the criminal justice system and how its non-mentalizing nature fosters an aggressive, competitive, and hostile culture that hinders interventions aimed at reducing violence and undermines the creation of safe and supportive working conditions.

3.3.1 Effective mentalizing social systems

For social systems to be supportive socialising structures for the individuals within them they need to have a capacity for effective mentalizing and the potential to generate epistemic trust. The relational strengths of a mentalizing social system comprise all the important components of effective mentalizing: curiosity, an ability to tolerate anxiety and uncertainty, a capacity for reflection, perspective-taking, an awareness of the impact on others of one's behaviours, humility and forgiveness, playfulness and humour, and non-paranoid attitudes. Thus, an effective mentalizing social system needs to be flexible and not limited to propagating a particular viewpoint or dogma. It needs to be continuously interested in and curious about the different perspectives and experiences of individuals, including different cultural attitudes, values, traditions and customs, which need to be heard and respected rather than being autocratically defined by one-sided beliefs and intentions. A mentalizing system also encourages people to have agency and take responsibility for their actions and behaviours rather than experiencing them as the result of external forces. A mentalizing system needs to have the capacity to constructively adapt to changing circumstances and allow modifications of convention, at least temporarily (Asen, 2020; Bateman & Fonagy, 2016).

A mentalizing social system improves the health and well-being of an individual by mentalizing them - making that person feel that others in the system are curious about them or take their states of mind seriously by recognising their needs and wishes. Thus, the person is more likely to accept the communications and rules of the system and see them as relevant to organising their future social behaviour. This empowers the individual by increasing their sense of agency and openness to the views and preferences of others, creating a virtuous circle in which a well-mentalizing system fosters mentalizing within the individual, who in turn exerts a positive impact on the mentalizing of others who make up the system.

Di Stefano et al. (2017) applied a mentalizing model of organisations to the workplace, arguing that if individuals can feel psychologically supported by a mentalizing organisation which acknowledges their specific identities and their anxieties related to work, workers are more likely to feel securely attached to the workplace. Moreover, understanding the meaning of the individual's feelings and emotions about the work environment can lesser anxieties by making them more accessible and understandable. This is an elaboration of the anxiety/defence paradigm of psychodynamic approaches to organisations stemming from the work of Jaques (1955) and Menzies Lyth (1960a, 1960b) by relating protection from anxiety not solely to notions of the containment of projections, but to the capacity of the system to reflect upon, symbolise and attribute meaning to anxiety.

3.3.2 Ineffective mentalizing social systems

In contrast to mentalizing systems, non-mentalizing systems disrespect human subjectivity and agency, close down social attention to others' mental states and communications, and generate an environment of epistemic mistrust. Such systems are inflexible and unresponsive to the differing needs and mental states of individuals such that they consider communications as not relevant to them beyond the context of the particular situation. Non-mentalizing systems annihilate thinking and reflection, stifle creativity and negate human collaboration by generating fear and hyperactive attachments which push the system back to pre-mentalizing modes of thinking. Fonagy and Bateman (2016) delineate three types of non-mentalizing social systems: pretend mode systems, psychic equivalence mode systems and teleological mode systems.

Pretend mode systems are disorganized, confused and inchoate; thoughts and feelings are felt to be disconnected from reality and have no consequence for others; experience becomes empty and meaningless. Lack of consideration of others fosters selfishness and egocentricity, permitting interpersonal aggression as other minds are not felt to exist.

Psychic equivalent systems promote mind world isomorphism where inner thoughts and feelings are indistinguishable from the power and importance of the external world. Black and white thinking predominates and solutions to social problems are

singular and restrictive. Different perspectives are not tolerated which creates conditions ripe for prejudice, discrimination, and bullying. Coercive power dynamics may proliferate where one individual or group of individuals repeatedly and relentlessly intimidate and force others to think and do things against their will (Twemlow et al., 2005a). The inseparability of inner experience and the material world means that any negative ideas or threats to the mind become terrifyingly real and must be defended against by physical action. Thoughts become real and have to be controlled.

In teleological systems only what is material or behavioural is socially meaningful – internal mental states are unimagined or disregarded and only the observable actions of others, rather than the motivations behind them, have significance. The intentions of others are only believed if they are demonstrable in physical gestures. Violence becomes legitimate as it is felt that the only way to have an impact on others' mental states is via physical acts of harm.

In non-mentalizing organisations which do not allow spaces for reflection, anxieties related to work experiences cannot be contained, elaborated, or understood, and workers will consider the organisation as threatening and unreliable, are more likely to resist institutional demands, and attachment to the workplace is diminished. Employees may become locked into relationships of conflict, and a paradigm of power and control, where one person is repressed at the expense of the other, predominates (Di Stefano, 2017). The distrust of leaders of non-mentalizing institutions may extend to distrust of representatives of social institutions in general, such teachers, judges, doctors, or the police (Asen, 2020).

The criminal justice system is a good example of an organisation that is susceptible to non-mentalizing processes (Asen, 2020). Its binary model of people being found either guilty or not guilty of committing a crime fosters psychic equivalence thinking where people are defined by their actions and deemed good or bad accordingly. The polarised positions of prosecuting and defending lawyers who present opposing versions of what 'really' happened, within a fixed paradigm of perpetrators and victims, do not allow for a more nuanced understanding of why offences are committed. Curiosity and interest in the person's mental states that motivate their behaviours is limited. Such non-mentalizing attitudes of the system support non-mentalizing thinking

in the offender, who may have some interest in the intents and agency of the victim, but these are formulated in teleological terms, for example, protection against hostility must be through physical violence, and the penance of others for their crimes is only believed if they are demonstrated in physical gestures such as payment, acts of subservience, and retribution.

3.4 Conclusion

This chapter has introduced two theoretical frameworks, namely psychoanalytic and mentalizing, that are hypothesized to provide the best conceptual fits to explore and comprehend the barriers to the implementation of the RCT that is the focus of this thesis. In the following chapters these barriers will be identified via thematic analysis of interviews carried out with the different staffing groups – clinicians, researchers, experts by experience and commissioners – involved in carrying out the RCT. The next chapter describes the setting for the RCT, the development and implementation of MBT services; and the design and delivery of the RCT conducted within these services; and the following chapter sets the scene in examining the barriers which have been identified to date in the existing literature on the implementation of randomised experiments within the UK criminal justice system.

Chapter 4: Evaluating the implementation of a randomised controlled trial of mentalization-based treatment for antisocial personality disorder in the criminal justice system in England and Wales: The Mentalizing for Offending Adult Males Trial (MOAM)

This chapter describes the specific setting for the mentalizing RCT - the Offender Personality Disorder (OPD) pathway programme, the development and implementation of MBT services within the OPD pathway, and the design and delivery of the Mentalizing for Offending Adult Males (MOAM) RCT conducted within these services.

4.1 The Offender Personality Disorder (OPD) pathway programme

The Offender Personality Disorder (OPD) pathway programme, introduced in 2011, is a jointly commissioned initiative by the Department of Health and the Ministry of Justice that aims to provide a pathway of psychologically informed services for a group of offenders who are likely to be diagnosed with a severe personality disorder and who pose a high risk of harm to others.

4.1.1 The Dangerous and Severe Personality Disorder (DSPD) programme

The OPD pathway programme evolved out of the Dangerous and Severe Personality Disorder (DSPD) Programme, a pilot which was initiated in 1999 by the then Labour government to manage high risk offenders who were likely to be diagnosed with personality disorder or psychopathy. This was a response to the high-profile case of an individual with personality disorder, Michael Stone, who was convicted in 1998 of killing a mother and daughter, and despite being in contact with mental health services and recognised as posing a risk to others, had not been detained as he had been deemed ‘untreatable’ by assessing psychiatrists. The mental health legislation for England and Wales at that time included a ‘treatability test’, which only permitted the detention of people with personality disorder if treatment was ‘likely to alleviate or prevent a deterioration of his condition’ (Mental Health Act 1983). This treatability clause was subsequently removed in changes to the Mental Health Act, following

which 4 pilot DSPD services were developed, two within high secure prisons (HMP Whitemoor and HMP Frankland), and two within high secure hospital settings (Rampton Hospital and Broadmoor Hospital). 12 DSPD places for women were subsequently provided in HMP Low Newton.

Although the DSPD programme was a laudable attempt to treat, rather than solely punish, high risk offenders, it was widely criticised on a number of aspects. These included offenders spending little time in direct therapeutic activities, deliberately placing offenders in a DSPD programme knowing that there would be little active treatment given ('warehousing'), poor staffing levels, long waiting lists for treatments, no segregation of sex offenders, the inconsistent application of discipline, and overall poor cost-effectiveness (Tyrer, 2010). Moreover, the decision to allow the implementation of different treatments and different research methodologies in each site resulted in difficulties in their evaluation such that measurable improvements on outcomes regarding specific DSPD treatments were lacking, and the key question as to what treatments were effective for high-risk personality disordered offenders remained unanswered (Vollm, 2012).

Following a review of the DSPD Programme in 2008 (Ministry of Justice, 2008), and the publication of the Bradley Report on people with mental health problems or learning disabilities in the criminal justice system (Department of Health, 2009) which highlighted, amongst other findings, how many offenders in prison had complex mental health problems who could be more effectively treated in the community and would benefit from early identification and assessment of problems, and inform how and where they are most appropriately treated, a decision was taken by the newly elected Coalition government to terminate the DSPD programme and to re-invest in a new strategy, the OPD pathway. Following public consultation with stakeholders (Department of Health and Ministry of Justice, 2011a), the results of which were published in 2011 (Department of Health and Ministry of Justice, 2011b), the Department of Health and the National Offender Management Service launched the new OPD programme, which commenced implementation in 2013.

4.1.2 Aims of the OPD programme

The overall aims and outcomes of the OPD programme are to reduce re-offending and improve public protection, and to improve the psychological health, wellbeing, and relational skills of offenders likely to be diagnosed with a personality disorder (Skett & Lewis, 2019). These aims are achieved via two main approaches: education of the workforce managing high risk offenders with personality disorder to improve their competence, skills, and attitudes; and developing specific interventions targeted at enhancing the management and treatment of these complex offenders in a comprehensive and high-quality pathway of services. The programme is underpinned by a set of principles derived from a wide range of practice and research evidence (Joseph and Benefield, 2012), which have been refined and expanded further by HMPPS and NHS England into the following 12 principles (Skett & Lewis 2019):

- There is shared ownership, joint responsibility and operations, and partnership working (between health and criminal justice).
- There is a whole system, community-to-community pathway.
- Service users (offenders) are primarily managed through the criminal justice system, with the lead role held by offender managers.
- Treatment and management are informed by a bio-psychosocial approach, in which individuals' development is understood.
- All services adopt a relational approach.
- Staff have shared understanding and clarity of approach.
- The pathway is sensitive and responsive to individual needs, including gender, protected and offence characteristics.
- Service users, where directly engaged on the pathway, have clarity of approach.
- There is meaningful service user involvement, in design, delivery, review, performance management and evaluation of services.
- Ruptures and setbacks should be anticipated, understood and responded to as part of a formulation-based approach.
- There is shared learning across the pathway, involving staff and service users.
- Services are be developed in line with the model and using an evidence-based approach, where evaluation continually informs services.

In contrast to the DSPD programme which was focussed on treating personality disordered offenders in high secure settings, the OPD programme encompasses a whole pathway approach including managing offenders within the community.

4.1.3 A formulation-based approach

A unique feature of the OPD programme is that it is underpinned by a formulation-based approach, rather than one which is driven by categorical diagnoses. Case formulation may be thought of as a 'theoretically based concise explanation or conceptualisation of the information obtained from diverse sources. It offers a hypothesis about the cause and nature of the presenting problems and provides a framework to developing the most suitable management or treatment approach' (Craissati et al., 2015, p.37).

The principles and aims of the OPD programme are informed by theory and evidence highlighting the centrality of the role of adverse childhood experiences (ACEs) and attachment difficulties in the development of personality disorders, whilst taking into account biological and social factors (Skett & Lewis, 2019). The medical model of diagnosing personality disorders based on the current nosological systems of categorical diagnosis of the DSM-5 or ICD-10 is problematic in that there are symptomatic overlaps with other mental disorders including personality disorders, such that people with personality difficulties often fulfil criteria for more than one personality disorder; as well as differences in symptom presentation within categories of personality disorders, such that two people with the same personality disorder diagnosis may present differently (Tyrer et al., 2015). Moreover, the process of arriving at a diagnosis is based on the phenomenology of the person's overt symptoms and behaviours and takes no account of the aetiology of the person's difficulties. This precludes information that may offer meaningful explanations of an offender's antisocial behaviour, counteract attitudes that offenders are inherently bad people defined by their antisocial behaviour, and contribute to the formation of positive relationships between offenders and those who manage them.

Additionally, being given a diagnosis of personality disorder may carry stigma and exclude the person from being able to access mental health services within both the NHS and criminal justice system. In the OPD programme the offender's complex

presentations and difficulties are understood via a holistic approach encompassing psychological, emotional, social, and biological factors, rather than solely diagnostic categories (Skett & Lewis, 2019). Correspondingly, the programme's services should have a developmental and trauma focus – understanding the offender's current behaviour in the light of his or her previous adverse experiences.

4.1.4 The Core Offender Management Service

Each probation office should have access to a dedicated psychologist and a personality disorder probation officer (PDPO) who are both working in the OPD programme and whose role is to help identify suitable cases and work with offender managers to construct a formulation of the offender's psychological and interpersonal problems and the link with their risky behaviours, to inform sentence and treatment planning. Such case identification, case consultation, formulation and joint working constitutes the Core Offender Management Service (HMPPS & NHS, 2019), which is effectively a 'triage' system aiming to identify and prioritise the most problematic, complex and stuck cases in the system (HMPPS & NHS, 2019).

4.1.4.1 Case identification

As noted above, an important aspect of the OPD programme is that is based on biopsychosocial formulation rather than on a medical model of diagnosis. Eligibility for the OPD pathway therefore does not require an offender to have a formal diagnosis of personality disorder. Offenders are identified as suitable for the OPD programme in the community at the earliest point after sentencing by their offender managers via the Offender Assessment System (OASys), a structured professional judgement risk assessment tool used by HMPPS to assess the risk and risk assessment needs posed by the offender. It is comprised of a combination of actuarial and dynamic risk factors and covers a range of domains which have an empirical association with risk of future offending, including childhood difficulties, history of mental health problems, current risk to staff, and current disruptive behaviour, as well as a 10-item screen for antisocial personality disorder features (Campbell & Craissati, 2018). Individuals scoring on 7 or more of these 10 items are deemed likely to have a personality disorder and are then screened into the programme. The majority of eligible offenders are men, who must present a high likelihood of violent or sexual offence repetition as well as a high or very

high risk of serious harm to others; however, around 6% are women, for whom the criteria are the same except the level of risk is not specified.

4.1.4.2 Consultation and formulation

Consultation involves a recorded discussion between either the PD pathway psychologist or PD probation officer and an offender manager, in relation to a particular offender, on a one-to-one basis, or in a group format. Consultation may encompass advice-giving and signposting or lead to the construction of a more formal formulation. The purpose of the consultation is to progress the pathway for the offender and to develop the workforce by enhancing the offender manager's competencies in working more generally with this client group.

The process of formulating an offender's presentation and difficulties involves developing a coherent and consistent narrative of the problem, by considering the offender's psychosocial and criminogenic needs in relation to the development of their complex psycho-social difficulties, taking into account the influence of childhood adverse experiences. The links between the person's problematic personality features and their risk of harm to self or others are also considered. The primary purpose of the written formulation is to summarise the psychological thinking in order to guide ongoing management and pathway planning. This might include developing insight, motivation and engagement, risk assessment, community case management, and compliance with licence or sentence conditions (NOMS & NHS England, 2015).

There are three levels of formulation of increasing complexity which provide a consistent means of providing flexible formulations in the context of divergent contexts and practitioner needs (Craissati et al., 2015). Level 1 formulations are used in community contexts where the offender is progressing according to the sentence plan and used to train prison officers in order to help them to make sense of difficult behaviours. Level 2 formulations are used in community contexts where there is impasse in terms of the sentence plan, as well as being used in psychologically informed planned environments (see below) and in non-intensive community treatment settings (standard weekly/fortnightly sessions and/or < 12 months). Level 3 formulations are used in all custodial and secure hospital treatment settings (1 year +

duration) as well as in all community intensive treatments (> once weekly treatment packages for > 12 months, which would include MBT).

The Core Offender Management Service is aimed to be of sufficient benefit in improving the management of the majority of offenders in the pathway. However, a proportion of offenders may be referred for more complex interventions such as psychologically informed planned environments in prisons or approved premises (Turley et al. 2013) or specific treatment services.

4.1.5 Psychologically informed planned environments

Psychologically informed planned environments (PIPEs) are specifically designed contained environments where staff have additional training to develop an increased psychological and relational understanding of their work. This facilitates them in creating a safe and supportive environment which can promote the development of those living there. PIPEs are not treatment per se but are settings in which offenders can progress through a pathway of interventions and maintain therapeutic gains they have achieved. In prison, PIPEs are progression units for offenders who have completed high intensity treatment.

4.1.6 Treatment services

Three categories of treatment services are available to offenders on the OPD pathway: OPD treatment interventions designed specifically for offenders with personality disorder (HMPPS & NHS England, 2019); general Offending Behaviour Programmes, which are accredited and commissioned by HMPPS (not the OPD team) to reduce reoffending by addressing the offenders criminogenic needs; and NHS mental health treatments, either in the community or in a secure hospital for those who are detainable under the Mental Health Act.

There are a range of specific prison and community based OPD treatment interventions available which are eclectic in approach and have some evidence base. They are aimed at improving mental and emotional wellbeing, and social circumstances associated with a reduction in risk of sexual or violent reoffending, and are delivered within a safe and supportive environment, employing a range of multi-disciplinary staff. Separate treatment services exist for men and for women.

There are also a wide range of accredited Offending Behaviour Programmes (OBPs) addressing a broad range of offence types covering intimate partner violence, general offending, sexual offending, substance misuse, general violence, and extremism and gang affiliated offending, as well as adapted programmes for those with learning disabilities (Ministry of Justice, 2019). These programmes are accredited by the Correctional Services Accreditation and Advice Panel (CSAAP) on a variety of criteria, including having some evidence of efficacy (although few programmes have been evaluated by RCTs). Most accredited OBPs are potentially suitable for offenders with personality disorder, but preparatory work on engagement may be necessary to avoid attrition or offenders undermining the treatment for themselves or others. Democratic therapeutic communities (DTCs) are accredited as OPBs, and due to the evidence of their efficacy with offenders with personality disorder, they play a key role in the OPD Pathway (NOMS & NHS England, 2015).

4.2 Development of mentalizing-based treatment community services

4.2.1 MBT services

In 2013 the Portman Clinic, Tavistock and Portman NHS Foundation Trust, was commissioned by NHS England and the Ministry of Justice to co-ordinate and project manage the development, implementation and delivery of new clinical community MBT services for offenders with a diagnosis of ASPD within the National Probation Service across 13 sites as an integrated part of the government's OPD pathway programme. The Anna Freud Centre was sub-contracted to provide training and supervision for the staff involved in delivering the services. These clinical services were to be set up with the expectation that they would be part of an RCT evaluating the effectiveness of MBT.

The locations of the 13 sites were intended to cover as much as possible all areas in England and Wales and were equitably distributed in four regions: the North of England, covered by sites in Merseyside, Leeds and Preston (Lancashire); the Midlands, covered by sites in Lincoln, Nottingham and Tamworth (Staffordshire); the South, covered by sites in Bristol, Exeter and Wales; and London, where there were four sites set up to cover all of the capital, based in South London, East London, South East London, and central London respectively.

4.2.2 Target population

The initial target population for the service consisted of male offenders over 21 years old with a DSM-IV-R diagnosis of ASPD, as assessed by the Structured Clinical Interview for DSM IV Axis II Disorders (SCID-II; First et al., 1997), and a history of violent offences. They needed to be subject to statutory supervision by the National Probation Service, have at least six months remaining of their licence or community sentence, assessed as high risk/high harm by the OASys risk assessment tool, and demonstrate some willingness and motivation for treatment to reduce their offending behaviour, including a willingness to participate in group therapy. Exclusion criteria for the service were: a diagnosis of schizophrenia, bipolar disorder or other psychotic illness; substance or alcohol dependence; autistic spectrum disorder; severe learning disability; frequent and serious self-harming behaviours; psychopathy scores above 25 as measured by the Psychopathy Checklist-Revised (PCL-R; Hare, 1991); a history of serious sexual offending; no willingness to participate in treatment; inadequate English to participate in informed consent and group therapy; concurrently participating in another psychological therapy; and concurrently taking antipsychotic medication.

Shortly after the services started being rolled out, the commissioners decided that psychopathy scores should not be assessed by the PCL-R as it was feared that those offenders who would be found to have high scores might be excluded from services in the future due to negative attitudes towards managing and treating such individuals.

It was originally planned that one or two sites would deliver a separate service for women; however, with the formation of the NPS shortly after the MBT services were commissioned, this proved impossible because at that time female offenders were envisioned as being managed solely by the CRCs, not the NPS. As it turned out, the NPS did make a decision to manage high risk female offenders, but this occurred too late for MBT services for women to be included as part of the project.

4.2.3 Staffing

The services were delivered on probation premises in each site jointly by staff from the NPS and the NHS mental health trust in each site as part of the OPD Programme.

The service specification recommended that each site should have the following staff profile to deliver the service: 3 MBT therapists (band 8C, 8A, and band 7), whose role was to conduct clinical assessments and deliver therapy; a specialist offender manager, who was responsible for liaising with probation officers to advertise the service and identify potential participants to the MBT; an assistant psychologist, who was responsible for psychometric data collection from participants, as well the administration and coordination necessary in running the service; and a consultant psychiatrist, who was available to provide psychiatric reviews, prescribing medication, and crisis and risk management where necessary. The MBT therapists were usually clinical or forensic psychologists, although some were mental health nurses, psychiatrists, mental health practitioners or psychotherapists. All staff were trained in MBT and contracted to work one day week, except for the assistant psychologists who worked 2 days on the project, and the consultant psychiatrists who were contracted to work the equivalent of one day per month. In practice, the staff profile varied in according to each site, with the London sites employing fewer staff altogether, and others employing therapists at lower bands, despite being advised not to by the Portman Clinic. Moreover, as the project progressed it was found that the psychiatrist was rarely used by any site and therefore some services decided to no longer employ one as part of their MBT team.

4.2.4 Experts by experience

In addition to the staffing structure described above, each MBT team was funded to include an 'expert by experience' (EbE; sometimes referred to as a peer worker or service user consultant) who was an ex-offender with direct lived experience of personality disorder, experience of benefitting from treatment, past involvement with the criminal justice system, and the skills necessary to carry out their role of engaging, representing and supporting offenders in the MBT services. EbEs were initially recruited from service user organisations such as User Voice, or were ex-offenders already known to members. Once the MBT services were established and had been running for 18 months, some sites encouraged an offender who had successfully completed the year of MBT to become the EbE. Not all sites were able to find or engage an EbE. Training sessions for the EbEs were held three time a year by the Anna Freud Centre, bringing together EbEs and members of the MBT teams from the different sites to learn from each other and evolve the role.

Although initially it was not envisaged that EbEs would be involved directly in the delivery of treatment, once EbEs started working with some of the MBT teams, they requested being present on a regular basis in the group sessions as they felt this would enable them to become more familiar with the treatment model, as well as increase the opportunity to get to know the offenders and their progress, and thus enhance their capacity to engage and maintain them in treatment. EbEs were also permitted to attend the clinical supervision sessions in some sites.

4.2.5 Recruitment and referral

The MBT specialist offender manager was primarily responsible for promoting the MBT service in their local probation offices and liaising with offender managers, alongside the rest of the MBT team members, to identify potential participants to the MBT clinical team for assessment. The MBT team also used screening reports as developed through the OPD pathway to support the identification of potential group members. Prospective participants who were near the end of their sentence were also assessed in prison to start MBT on their release. A number of sites also recruited offenders from their local Category D prison, such that they would commence treatment on day Release on Temporary Licence (ROTL) and continuing treatment post-release.

4.2.6 Assessment for treatment

The clinical assessments were carried out by the MBT therapists and included history taking, ascertaining the offender's ability to engage in the treatment process, establishing confidence in the offender's ability to tolerate a group setting, providing the offender with psychoeducation about the diagnosis and treatment model and programme, and obtaining informed consent to participate in the service. A diagnostic assessment was then carried out by the MBT team's assistant psychologist, to confirm the diagnosis of ASPD through application of the SCID-II questionnaire and interview.

4.2.7 Treatment

Treatment was delivered in probation offices (and at one site in an Approved Premise) and consisted of weekly group therapy for 12 months. At the beginning of the project, offenders were also offered monthly individual sessions alongside the group; however,

a year in, due to frequent non-attendance at these sessions, the model was changed to offering individual sessions only when requested by the offender, although some sites decided to retain the original model.

The group therapy sessions were video recorded for the purpose of supervision to monitor and promote adherence to the MBT model. Due to the high rate of drop out of participants, the group operated on a 'slow-open group' basis with new participants joining as older participants left. The group was limited to having 8 participants at any given time, although in practice, few sites managed to achieve recruiting and maintaining this number of participants in their group at any one time.

In the not infrequent instances when the offender involved in the service was recalled back to prison, or committed further offences triggering a custodial sentence, where possible treatment was recommended to continue, with members of the MBT team visiting the person in prison and on release offenders could re-join the full programme.

Offenders whose license came to an end whilst they were enrolled in the MBT service were encouraged to remain in treatment in sites where the local probation service agreed to an offender continuing to be supervised off-licence. Despite guidance from the Ministry of Justice that this could be permitted, some local probation services involved in the project felt that they were too short staffed and/or supervising an offender who was no longer under statutory obligation to be managed by the NPDS was too risky.

4.2.8 Licence conditions and 'assisted compliance'

The MBT services were originally intended to be a voluntary treatment for offenders, i.e., they would not be mandated to attend by the NPS. However, one of the main hurdles for the MBT programme which presented from the outset was securing the offender's commitment and adherence to the therapy to prevent drop-out, the rate of which was higher than predicted. It was decided that adding in a condition to the offender's licence which outlined a requirement to comply with treatment would be a way to tackle the mixed feelings that some of the offenders had with accessing psychological treatments.

The term ‘assisted compliance’ was chosen rather than the usual term ‘licence condition’. Assisted compliance is a licence condition, however the difference is in how the probation officer enforces this. Assisted compliance reinforces the necessity for regular attendance and engagement but also includes a degree of flexibility around the inevitable difficulties personality disordered offenders have in social situations. The threat of automatic recall on breach of a licence condition around treatment is largely unhelpful to the therapy process and if an offender failed to attend under assisted compliance this did not automatically lead to a warning letter or a recall. The offender needed to be able to show an understanding of assisted compliance and sign up to it prior to its instatement on a licence in order to engage him in responsibility for his treatment from the outset by giving him choice in the matter. In the early phase of therapy assisted compliance was of particular use as it reinforced the period when forming attachments with the therapists and group members was most difficult.

Not all sites used these licence conditions to engage their men in treatment, as they felt that for individuals to engage in effective treatment it should be on a voluntary basis; others used assistant compliance with varying degrees of success.

4.2.9 Training and supervision

Training in MBT was provided for all staff by the Anna Freud Centre, who were also responsible for delivering clinical supervision. The latter consisted in the first 2 years of fortnightly supervision for each site, usually via telephone, and quarterly in-person regional supervision where the three sites of each region would meet with the supervisor to watch video-recordings of the group sessions.

4.2.10 Clinical governance

Clinical governance for delivery of the service rested with the local partner health service provider and the director responsible for the provision of the probation services.

All staff whose role included regular involvement with the MBT project were required to have appropriate access to training and clinical supervision.

Ultimate responsibility for governance on clinical issues (i.e., those relating to this service with an impact on the mental or physical health of the offender) rested with the health service; ultimate responsibility for governance on public protection issues rested with the criminal justice service.

Regarding confidentiality and disclosure, although both the NHS and the NPS have policies and procedures in relation to confidentiality, and all have a duty to protect personal confidentiality and the public where necessary, there may be differences in the thresholds for disclosure between the two agencies. It was therefore deemed necessary for each site to clarify the limits of confidentiality and disclosure for both agencies, as well as the offenders who are offered treatment, at the outset. In line with existing practice in forensic psychological therapies services, participants were told at the start of treatment that staff had a duty to report any incidents that were described with sufficient detail for the victim and/or offence to be identified. Disclosure would also be considered if there was a current significant risk to self or others.

4.3 The Mentalizing for Offending Adult Males (MOAM) Randomised Controlled Trial.

In 2016 the MBT sites became the treatment arm of the Mentalizing for Offending Adult Males (MOAM) multi-site RCT evaluating the effectiveness of MBT with a sample of male offenders under community supervision, and who met DSM-IV-R criteria for ASPD. The trial was led by Professor Peter Fonagy at University College London and funded by the National Institute for Health Research (NIHR).

4.3.1 Primary outcome

This was a multi-site pragmatic randomised controlled superiority trial to investigate whether, in a sample of offenders under community supervision who meet DSM-IV-R criteria for ASPD, probation as usual (PAU) supplemented with MBT is more effective than PAU only for reducing aggressive antisocial behaviour.

The primary outcome was the weighted- frequency of aggressive antisocial behaviour as measured by the interview-based Overt Aggression Scale-Modified (OAS-M). Data

was collected at baseline and every 3 months for two years across the 13 sites in England and Wales.

4.3.2 Secondary outcomes

Secondary aims were centred on improving the management of the mental health needs of offenders with ASPD in the community. A variety of self-report questionnaires were conducted with participants at either 3 or 6 month follow up points for two years exploring violence; health-related quality of life; mental health; alcohol use; drug use; self-harming behaviours; suicidal behaviours; treatment engagement and help-seeking behaviour; personality dysfunction; mentalizing ability; health service use and offending behaviour.

Outcome measures assessments were conducted by research assistants as well as by peer researchers (ex-offenders with experience of service user involvement in research) to optimise engagement of the participants and promote candid responses to self-reported questionnaires. Participants were paid to complete assessments.

4.3.3 Inclusion and exclusion criteria

Inclusion criteria remained the same as those of the original MBT services in that the participants were male, aged 21 years and over, had a DSM-IV-R diagnosis of ASPD (using the SCID-II), showed violence of aggressive acts in the 6 months prior to assessment, and were subject to statutory provision by the NPS with at least 6 months remaining of their license or community sentence. A minimum score of 15 on the OAS-M was added as an inclusion criterion.

The exclusion criteria for the trial were narrower than those of the original MBT services and were the following: convictions for child sexual offences (including child pornography); neurodevelopmental disorder or significant cognitive impairment; diagnosis of a psychotic disorder; unmanaged substance misuse; and inadequate English or cognitive capacities to provide informed consent and participate in group therapy.

4.3.4 Recruitment and assessment

Participants were recruited from the probation services local to each site. Potential participants were screened using a 5-stage multiple gating screening procedure: (1) record identification, (2) explanatory meeting (3) clinical assessment and consent (4) formal diagnostic evaluation, (5) confirmation of consent. Offenders who met all the inclusion criteria and none of the exclusion criteria, and who gave consent to participate in the trial, went on to have baseline measures taken, followed by randomisation.

4.3.5 Randomisation

Randomisation was performed off-site using a dynamic adaptive allocation algorithm accessed by a secure web portal to the system held at NWORTH Clinical Trials Unit and maintained by a statistician independent of the analysis and research teams to ensure blinding. Stratification was by site and age (21-25; 26-39; 40+ years), with additional weak stratification for type of supervision (Community Sentence; On Licence After Prison Release) and length of licence or community sentence (under 12 months; 12 months and over). Participants was randomly allocated in a 1:1 ratio to receive 12 months of either MBT or PAU.

4.3.6 Treatment intervention

As in the original MBT services, participants randomised to MBT received weekly group sessions of MBT for 75 minutes and monthly (or less frequent) individual sessions of MBT for 60 minutes. Each MBT group was run by a minimum of 2 MBT therapists, had a maximum of 8 participants, and was an 'open' rolling entry group taking participants randomised to the MBT arm, with new participants joining as others left.

Training in MBT and supervision to ensure adherence to the model was provided by the Anna Freud Centre.

4.3.7 Control treatment

PAU is a well-specified and monitored standard intervention used in the management of offenders under community supervision, consisting of regular (usually weekly) contact with a designated probation officer for the duration of the offender's licence or sentence; MAPPA cases may have additional monthly reviews.

PAU in this trial included referral for additional interventions as indicated in Ministry of Justice guidance. PAU participants were not to be referred to treatments directly related to addressing personality disorder (e.g., DBT) but were free to be referred by their probation officer for any locally available treatment designed to reduce reoffending by addressing criminological characteristics (e.g., anger management programmes, substance misuse interventions, victim awareness, etc). However, as local treatments were limited participants in some sites found it difficult to access any alternative treatments, and in these cases, contact with the probation officer was thought to provide an important supportive and therapeutic, as well as supervisory, function.

In order to address potential contamination bias, MBT therapists and supervisors were not allowed to have contact with participants in the PAU arm of the trial.

4.3.8 Sample size

The recruitment target was 302 participants; each site was expected to recruit one eligible consenting participant per month. This allowed for 37% attrition, to end up with 95 participants per arm, yielding 90% power. The final number of participants recruited exceeded this target, at 313.

4.3.9 Analysis

The primary outcome was analysed using a hierarchical mixed-effects linear regression. Secondary outcomes were analysed using mixed-effects linear regression, mixed-effects logistic regression models and mixed-effects Poisson models as appropriate. Cost-effectiveness analysis combined data on costs with reoffending outcomes; cost-utility analysis combined data on costs with Quality Adjusted Life Years.

Chapter 5: Randomised controlled trials in the United Kingdom criminal justice system: a systematic literature review

5.1 Introduction

Although the randomised controlled trial (RCT) is widely viewed as being the 'gold standard' of evaluation evidence in offering the highest internal validity i.e., the extent to which causal inferences about outcomes may be drawn from a study, the use of experimental designs in the field of criminology has lagged significantly behind that within the field of health (Shepherd, 2003; Wilson, 2006). In an influential review, Farrington (1983) investigated all randomised experiments conducted within crime and justice settings that had been published in English between 1957 and 1981, and found that of 42 studies identified, only 8 were in the United Kingdom (UK), the majority (31) having been carried out in the United States (US). A further review conducted by Farrington and Welsh (2005) looked at all RCTs with reasonably large sample sizes (at least 50 persons assigned to each condition) and offending outcomes that had been published between 1982 and 2004 and found a total of 83 studies (12 on policing, 13 on prevention, 14 on corrections, 22 on courts, and 22 on community interventions). Again, the majority had been carried out within the US (73), but remarkably, unlike the previous review, there were none that had been implemented in the UK. In a more limited, yet important, paper illustrating the paucity of RCTs within criminology, Petrosino et al. (2005) searched one of the UK's most respected criminological journals, the British Journal of Criminology, and found that it had published only 9 randomised field trials between the journal's inception in 1960, and 2004, of which 8 had been published before 1983.

In his historical review on British randomised experiments in crime and justice, Farrington (2003a) attributes the cessation of RCTs after what he terms the 'golden age' of British randomised experiments investigating the aetiology of offending or interventions designed to reduce offending between 1965 and 1975, to a powerful critique by the criminologists Ron Clarke and Derek Cornish which was influential in ending Home Office funded randomised trials (Nuttall, 2003). Clarke and Cornish

became disillusioned with randomised methodology following the negative results of an experiment in which 173 juvenile offenders at Kingswood Training School in Bristol were randomly allocated to one of two houses, respectively operating a therapeutic community and a traditional paternalistic regime. After two-year follow-up, there was no significant difference in reconviction rates between the two groups. Clarke and Cornish's subsequent objections to the use of RCTs in criminology were multifold, including ethical concerns that offenders would get the wrong or no treatment at all; the problems in producing generalisable findings from specific controlled conditions; the impossibility of evaluating penal interventions using double-blind techniques; the heterogeneity and variability of penal treatments which were more complex than medical treatments, and which made it difficult to identify the active mechanisms of the interventions; and disruptions that implementing the trial caused to the running of the institution or setting under investigation. Highlighting the powerful socio-political forces involved, Farrington suggests that the Clarke-Cornish critique was particularly influential in that it coincided with the prevailing anti-rehabilitation beliefs that offending could not be treated and therefore studies designed to measure the effectiveness of therapeutic interventions were unnecessary. Furthermore, Clarke subsequently argued that crime could more effectively be reduced by changing situational factors, focusing on crime in an area rather than on individual offenders, the former being more difficult to evaluate with randomised experiments.

In the past 20 years there has been a growing literature exploring the resistances and barriers to the uptake of randomised experiments within the field of criminology in the UK and internationally, looking at the reasons why, despite increasing emphasis on evidence-based interventions and policy, the number of published trials remains small.

Shepherd (2003) argued that there were fundamental differences in the relative cultures and structures of the fields of medical science and criminology in the UK which accounted for the preponderance of RCTs being designed and delivered in health rather than criminal justice settings. He proposed that in the former, the evaluation of medical interventions was led by clinical academics and medical science developed in close association with university teaching hospitals. By contrast, in criminal justice academia, theory held a higher status than intervention research, and the links

between legal and criminological study, and legal and criminal justice services, were much weaker.

Others have detailed the many ethical, legal, practical, methodological, cultural and political challenges that have been encountered when implementing randomised trials. Legal and ethical arguments against randomisation may be particularly powerful, especially if it is thought to deprive individuals of the benefits of a potentially effective intervention (Boruch, 2000; Farrington and Jolliffe, 2002; Pearson et al., 2010; 2016; Weisburd, 2003). De Roos, et al. (2007) have argued that it violates three principles - equality, proportionality, and individualization - of criminal sentencing (Bruinsma, 2007). Ethical concerns, however, may be particularly emotive and cloud professional judgement, especially when professionals may hold strong views regarding the superiority of a particular intervention, despite its efficacy having never been tested, and lead to practitioner exclusion of eligible cases (Asscher et al., 2007; Labriola et al., 2010; Weisburd, 2003). There may, of course, be legitimate ethical challenges resulting from withholding treatment to half of the study population, but misunderstandings may occur where the ethical reservations are in fact directed at what are seen as problematic or irreversible interventions, for example castration for sex offenders, rather than at the method of evaluation (Killias, 2006). Confusion may also arise as interventions for offenders are not primarily aimed at improving the person's well-being as in health experiments, but at reducing risk, and therefore may be perceived as being more for the benefit of the public, rather than the individual concerned, so that denying an offender a particular treatment due to randomisation may be perceived as undermining public protection. There may also be ethical questions raised where the intervention(s) under evaluation are withhold altogether from those who refuse to participate in the trial (Asscher et al., 2007). Some studies (e.g., McDougall et al., 2009) have tried to address the concerns that not all trial participants will receive what is perceived to be the effective intervention by employing a waiting-list control group, but this means the long-term effects of the intervention are not possible to evaluate.

The practical challenges of conducting an RCT in a criminal justice setting are numerous. These include logistical difficulties in maintaining the cooperation and participation of partner agencies, delays in obtaining ethical approval for trial protocols

across different sites, impediments in ensuring timely and secure data transfer between different sites, problems of randomising in a busy organization, high staff turnover and loss of momentum, complexities in the referral process, and practical difficulties in reimbursing participants (Asscher et al., 2007; Di Paola et al., 2014; Labriola et al., 2010; Weisburd, 2000). Not paying offenders for their willingness to participate in a study where they may not receive their preferred intervention and which may also place considerable demands on their time in having to attend research appointments, due to political and public opinion that offenders should not be rewarded for their behaviour, may also raise ethical concerns regarding their human rights. Moreover, policy makers, practitioners and managers in the criminal justice system may pose significant barriers to the use of experimental designs in routine practice, not only due to their ideological views, but also due to their attitudes towards research and unfamiliarity with the theory and practice of research in general (McQueen & Bradford, 2017).

Methodological and statistical issues include overestimates of the eligible study population, small sample sizes such that a significant effect of the intervention cannot be reliably determined, participant attrition, failure to implement treatment as intended, contamination between treatment and control participants leading to an underestimation of the treatment effect, and difficulties in blinding of participants and treating professionals to the experimental condition to which they are assigned such that outcomes might be biased (Farrington, 2013; Farrington and Welsh, 2005; Goldcamp et al., 2008; Labriola et al., 2010; Pearson et al., 2016; Sousa et al., 2016). Attrition of participants due to non-engagement in treatment is a frequent problem, which may reduce the desired effect size of a potentially effective intervention or lead to low internal validity and biased results if there is differential attrition from experimental and control groups (Farrington and Welsh, 2005). Goldcamp et al. (2008) highlight the problem of attrition before random assignment in targeted populations, which, although the study may be well conducted, can produce misleading results, undermining construct and external validity (i.e. extent to which the results of a study can be generalized to other relevant populations and contexts different from the more restricted conditions under which it was tested). Attrition from the experimental population prior to randomisation may be due to poor buy-in of the trial by professionals or offenders but may also be due to deliberate decisions by researchers

to exclude otherwise eligible participants due to pressures to prioritise them for urgent treatment, or where they were due to be imminently released from custody (McDougall et al., 2009).

The particular difficulties in implementing RCTs in different settings have also been documented, for example, in the juvenile justice system where there may be complexities of the referral process, and specific legal and ethical concerns raised by clinicians about minors being asked to take part in experimental studies (Asscher et al., 2007); the criminal courts, where there may be a necessity to revise legal procedures, uphold due process for defendants, and seek the participation of judges and lawyers (Labriola et al., 2010); and prison settings where unexpected release or transfer to other prisons of inmates involved in the trial may lead to attrition of data due lack of cooperation of other prisons in sharing data, or participants being lost to follow up (Howells et al., 2002; Maunder et al., 2009; Sheard et al., 2009a; Sleed et al., 2013).

To my knowledge, since the reviews of Farrington and Welsh (2005) and Petrosino (2005) described above, there have been no published systematic reviews investigating RCTs within the UK criminal justice system. This current review aims to address this gap in the literature.

5.2 Objectives

The objectives of this systematic literature review are to ascertain the number, type, setting, outcomes and quality of all RCTs conducted within the UK criminal justice system and explore whether any reported difficulties in the implementation of each trial might be linked to its risk of bias.

5.3 Methods

5.3.1 Criteria for considering studies for this review

All published completed studies using an RCT design that have been conducted in the criminal justice system (including prison, probation, police, court and juvenile offending service settings) in England, Scotland, Wales and/or Northern Ireland were eligible for inclusion in the review. RCTs were not limited to those targeted at reducing offending

but included any RCT evaluating any intervention in the UK criminal justice system. Where there was a published trial protocol but no published outcomes, the study was not included in this review.

5.3.2 Search methods for identification of studies

5.3.2.1 Electronic searches

Relevant randomised trials were identified by searching the following electronic databases from inception to 18th June 2022.

- Ovid Medline
- PsychInfo
- Criminal Justice Database
- Cochrane Database of Clinical Trials

Keywords were used covering all types of settings for adults, adolescents, and children within the criminal justice (prison, police, probation, youth offending services); all terms describing randomised controlled trials (randomised controlled trial, randomised experiment, randomised assignment, random allocation etc.) and the names of all countries within the UK.

The following combination of search terms were used in searching each of the databases:

> "criminal justice" or prison or jail or gaol or correctional or "youth offend*" or penal or probation or parole or custod* or police or policing or court
>
> AND
>
> "random* control* trial*" or "random* study" or "random* experiment*" or "random* assign*" or "random* assort*" or "random* allocat*"
>
> AND
>
> "United Kingdom" or UK or England or Wales or Scotland or "Northern Ireland"

In addition, due to the large number of papers generated using the above search terms for the Criminal Justice Database and Sociological Abstracts database, papers were further filtered by limiting the location as subject to the UK.

5.3.2.2 Searching other resources

- Hand searching: The *Journal of Experimental Criminology* was hand searched from its first issue in 2005 to May 2022 to identify relevant randomised trials.
- Reference lists: The reference lists of papers selected were inspected for further relevant studies.
- Personal contact: Authors of included studies were contacted where appropriate for further information, and these and other experts in the field were contacted for information about additional studies that may have been missed.

5.3.3 Data collection and analysis

5.3.3.1 Study selection

The author screened titles and abstracts retrieved from the searches against the eligibility criteria stated above. For studies that appeared to be eligible RCTs, the full reports were obtained and inspected to assess their relevance against the inclusion criteria. The reviewer was not blinded to the name(s) of the study author(s), their institution(s) or publication sources at any stage of the review.

5.3.3.2 Assessment of risk of bias for included studies

Although many tools have been developed for assessing the quality of evidence of studies for use in the context of a systematic review, the Cochrane Collaboration's tool for assessing risk of bias, as described in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011), was chosen for this review, as it is one of the most widely used tools for assessing the risk of bias of clinical trials. Risk of bias is important to ascertain in RCTs as different biases can lead to underestimation or overestimation of the true intervention effect. The Cochrane tool is a domain-based evaluation, in which critical assessments are made separately for seven different domains and assigned a judgement of low risk, high risk or unclear risk of bias. The domains are sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting and 'other sources of bias'.

5.3.3.3 Identifying challenges and barriers to trial implementation

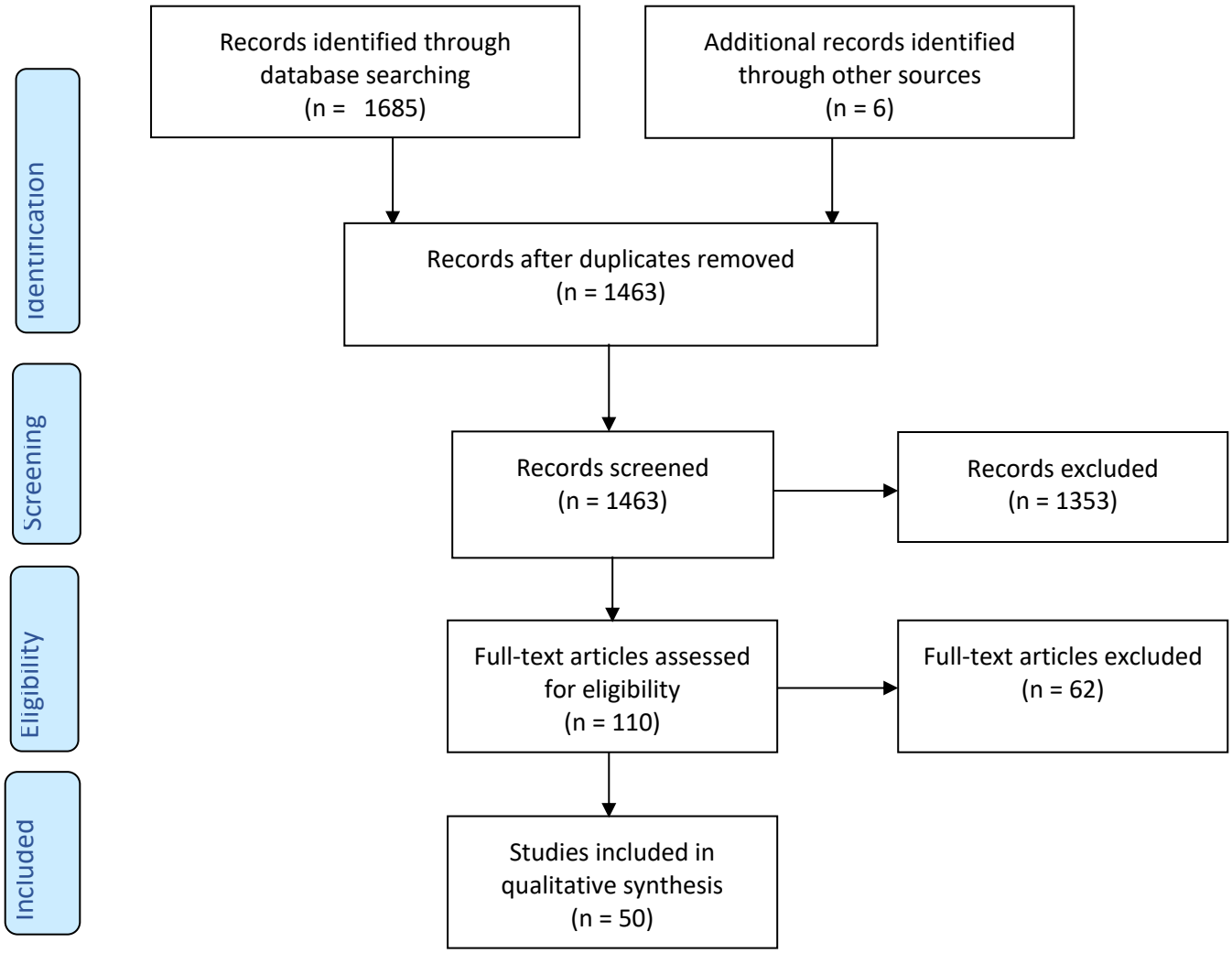
Any difficulties or challenges encountered implementing the RCTs within the criminal justice setting that were documented by the authors of the respective publications were noted and examined for any possible influence on the risks of bias of each respective study.

5.4 Results

5.4.1 Results of searches

Searches yielded 1463 citations after removal of duplicates. The abstracts were screened for eligibility and 1353 were excluded. The remaining 110 full-text papers were assessed, of which 62 were then excluded. The total number of eligible trials was 50. Figure 1 displays the study selection process.

Figure 1 Prisma flow diagram of study selection



5.4.2 Description of trials

Appendix 1 lists all included studies, specifying the type of RCT, the population and intervention(s) being evaluated, the specific setting within the criminal justice system in which the trial was conducted, the trial's primary and secondary outcome measures, the results of the trial, specific concerns regarding the risk of bias of each trial, an overall rating of the risk of bias, and any reported challenges in implementing the trial.

Of the total of 50 RCTs conducted in the UK criminal justice system, there were:

- 16 trials of psychological interventions to reduce risk and/or improve health outcomes in offenders,
- Five drug trials for opiate detoxification or preventing overdose in prisoners,
- Six trials testing screening and/or brief interventions for offenders with alcohol misuse,
- One trial of yoga for prisoners,
- Two trials of dried blood spot testing to improve the uptake of hepatitis C antibody testing within UK prisons,
- Ten trials in police forces evaluating:
    - whether policemen were more accurate at detecting lies using an indirect measure than direct measure,
    - a police intervention to change the perceptions of the public's trust in the police,
    - the effects of police body-worn cameras on the use of force during arrests,
    - policing 'hot spots' (two trials)
    - a training program for police officers in contact with people with mental health problems to reduce the number of incidents resulting in a police response,
    - whether police-led target-hardening crime prevention strategy for recent victims of burglary and their neighbours lowers burglary and increases public satisfaction with police,
    - the effect of reducing barriers to accessing non-police services on the demand for police services in cases of police-reported domestic violence,

    - the effectiveness of an audio-recording panic alarm system provided by the police to domestic abuse victims who are at risk of further victimization,
    - the effect of a cognitive–behavioural stress intervention on the motivation and psychological well-being of senior police personnel,
- Eight linked trials evaluating the effects of restorative justice conferences on offender recidivism and victim satisfaction,
- One trial evaluating whether a behaviour insight intervention using increases witnesses and victims' attendance at trials.

Regarding the specific setting in which the trials were conducted, 20 were in prison, 12 in police forces, three in probation, one in both prison and probation, four in youth offending services, two in a magistrates' court, and the eight linked restorative justice trials were carried out in a range of settings (police, crown and magistrate courts, prison, probation, and youth offending services).

Of the 50 published trials, 32 had authors who were involved in at least one of the other trials in this review, such that there were only 11 groups of researchers responsible for these 32 trials, which highlights how few empirical researchers in the criminal justice system to date are involved in conducting RCTs.

5.4.3 Design of RCTs

For most of the studies, the unit of randomisation was the individual participant involved; however, six studies (Ariel et al., 2016; Hickman et al., 2008; Monnington-Taylor et al., 2019; Newbury-Birch et al., 2009; 2014; Scantlebury et al., 2016; 2017; Sleed et al., 2013) were cluster randomised trials in which groups (clusters) of subjects, as opposed to individual subjects, are randomised. Clusters have equal variability to the overall population, which is too large to randomise every individual subject. The cluster design is commonly used to evaluate non-drug interventions, such as policy and service delivery interventions. However, this design may increase the potential risk of bias of the trial due to recruitment bias and baseline imbalance.

Other studies used block randomisation (Addison et al., 2018; Johnson et al., 2017; MacQueen & Bradford, 2015; 2017). Block randomisation is chosen to reduce variability if there are known variables within the sample population, especially when the sample size is small, that may respond differently to the intervention, for example men and women. Block randomisation uses restricted random allocation to achieve greater equivalence between treatment groups in group sizes and baseline characteristics by randomising participants within blocks such that an equal number are assigned to each treatment. However, small block sizes increase the risk that the allocation process may be predictable, especially if the assignment is open or there is a chance for unmasking of the intervention assignment.

A further two studies (Craine et al. 2014; Pearson et al., 2016) used a stepped wedge cluster design. This design involves a process whereby randomisation occurs at regular intervals (the 'steps') to ensure that one cluster (or a group of clusters) crosses from the control to the intervention group until all clusters have crossed over to be exposed to the intervention. This means that in the initial period no clusters are exposed to the intervention but at the end of the study all clusters are exposed. Data collection continues throughout the study, so that each cluster contributes data under both control and intervention periods (Hemming et al., 2014).

5.4.4 Primary and secondary outcomes

Most of the studies specified both primary and secondary outcomes, although a few did not distinguish between the two. Specific outcomes and how they were measured varied according to the nature of the study. Of the 50 RCTs, 24, which included the eight linked restorative justice trials, had one or more measures of offending, whereas 34 RCTs (again including the eight restorative justice trials) reported outcomes related to offender health or well-being. Most studies had both objective measures of data e.g., reconviction rates obtained from police records, which were assessed as less prone to cause detection assessment bias where researchers were unblinded; and more subjective measures e.g., participant-reported impulsivity questionnaires, or ratings by researchers or other personnel involved in the study of participants' behaviours, which were more likely to cause performance or detection bias where participants or researchers were unblinded.

5.4.5 Results of RCTs

32 of the 50 trials showed evidence of greater efficacy of the respective interventions being evaluated compared to controls on at least one of the outcomes measured.

The eight linked RCTs of restorative justice conferences (RJC) conducted in London, Northumbria and Thames Valley between 2001 and 2004 were part of a seminal research project, the Jerry Lee Program of 12 randomised trials conducted over two decades in Australia and the UK which tested an identical method of restorative justice taught by the same trainers to hundreds of police officers and others who delivered it to 2231 offenders and 1179 victims between 1995 and 2004 (Sherman et al., 2005; 2015). Pooled results of the UK experiments showed significant reductions in repeat offending among offenders assigned to RJCs and significantly fewer post-traumatic stress disorder (PTSD) symptoms in victims in RJC groups compared to controls. Moderator effects across and within experiments showed RJCs worked best for the most frequent and serious offenders for repeat offending outcomes.

A more recent RCT by Monnington-Taylor et al. (2019) evaluated whether an intervention using behavioural insight principles increased witnesses and victims' attendance at trials, measuring the percentage of witnesses/victims that successfully attended at least one hearing at the Magistrates' Court at which they were required to give evidence. However, there was no significant difference in outcomes between treatment and control groups.

Nine of the 17 RCTs evaluating psychological interventions reported positive results in at least some of their measured outcomes. Biggam and Power (2002) conducted an RCT evaluating the effectiveness of time-limited, group-based problem-solving training intervention compared with a no-treatment control for vulnerable, incarcerated young offenders. They reported that the intervention participants experienced significant reductions in levels of anxiety, depression, and hopelessness and improvement in self-assessed social problem-solving abilities which continued to be evident at 3-month follow-up. Maunder et al (2009) did a pilot RCT to investigate the effectiveness of self-help materials for the treatment of anxiety and depression in an adult male prison population and found significant reduction in anxiety in the intervention group compared to the control group.

There were five RCTs evaluating treatments based on a cognitive behavioural model, four of which showed significantly positive results for their effectiveness: the RCT by McDougall et al (2009) testing an Enhanced Thinking Skills Programme in changing self-report of offence-related thinking in adult male prisoners (McDougall et al., 2009); a cognitive-behavioural intervention for suicidal male prisoners (Pratt et al., 2015); a Risk-Need-Responsivity (RNR) evidence-based offender supervision program for reducing reconvictions in a probation population (Pearson et al., 2016); and a motivational interviewing intervention to reduce re-arrests in intimate domestic violence offenders in a police setting (Strang et al., 2017). There were two trials of family therapy for young offenders – an RCT evaluating multisystemic therapy (MST) in reducing youth offending and out-of-home placement for young offenders (Butler et al., 2011); and an RCT of functional family therapy for offending and antisocial behavior in young offenders (Humayun et al., 2017). Both trials showed significant reductions in offending compared to controls over an 18-month period. A trial of an attachment-based intervention for mothers and babies in prison (Sleed et al., 2013) showed that mothers in the control group deteriorated in their level of reflective functioning and behavioural interaction with their babies over time, whereas mothers in intervention group did not, but there were no significant group differences in maternal depression or the mothers' self-reported representations of their babies over time.

Interestingly, a recent study examined the effects of a cognitive-behavioural intervention in the police, not the offenders themselves. Jones et al. (2021) conducted an RCT evaluating the effect of a cognitive–behavioural stress intervention on the motivation and psychological well-being of senior police personnel. As well as administering self-report measures, they also measured hair cortisol, and found that the intervention decreased maladaptive cognitions (irrational beliefs) and increased self-determined motivation, the satisfaction of basic psychological needs (well-being) and the facilitation of stress coping but did not have any significant effect on pre–post cortisol levels.

Other trials of psychological interventions for offenders showed no significant positive effects of the intervention in relation to the control condition. The RCT by Tyrer et al.

(2009) of the effects of early versus late assessment on social functioning, quality of life and aggressive incidents of offenders in the pilot phase of the dangerous and severe personality disorder programme was unable to draw any conclusions due to repeated protocol violations leading to contamination in both of the trial arms. Mitchell et al.'s (2011) RCT evaluating CBT for adolescents with health problems found no significant differences in outcomes between the intervention and control groups. Nathan et al.'s (2019) pilot RCT looked at a similar population of high-risk personality disordered offenders in prison and probation to those in the Tyrer et al. study, evaluating a type of sociotherapy involving social learning, group work and individual therapy, on reducing offending, and also found no evidence for its effectiveness.

The pilot RCT by Walker et al. (2017) to evaluate psychodynamic interpersonal therapy, versus active control, aimed at reducing thoughts and actions of self-harm and suicide risk in female offenders showed improvement from baseline in both intervention and control arms but no significant differences in measures between them. Similarly, Hunter et al. (2021) conducted an RCT evaluating the cost effectiveness of a manualised person-centred intervention, underpinned by a mentalizing-informed approach, aimed at improving psychological and social outcomes for men with common mental health problems in prison, also found no evidence that the intervention was cost-effective compared to usual care.

There were two trials of supportive interventions. A pilot RCT testing the feasibility of a Critical Time Intervention (CTI) on continuity of care for recently released prisoners with mental illness (Jarett et al., 2012) showed a higher proportion of prisoners in the CTI group in contact with services, receiving medication, and registered with a GP at follow-up than those in the control group. However, the Older Prisoner Health and Social Care Assessment and Plan (OHSCAP) trial to improve the ability to meet older male prisoners' health and social care needs (Forsyth et al., 2017) did not reveal any significant differences between the intervention and treatment as usual (TAU) groups.

A small RCT of yoga aimed at increasing behavioural control and decreasing psychological distress in prisoners (Bilderbeck et al., 2015) showed increased self-reported positive affect, and reduced stress and psychological distress, and better performance in the cognitive-behavioural task relative to controls.

Another small trial evaluated the impact of experimentally inducing violence-supportive cognitions on prisoners' aggression and showed some evidence to validate the hypothesis that feeling disrespected is a trigger to violent behaviour (Butler & Maruna, 2009).

None of the four drug trials, however, showed significant differences between intervention and control groups. In an RCT for opiate detoxification in prisoners, Howells et al. (2008) compared lofexidine and methadone but found no significant differences between treatment groups in the severity of withdrawal symptoms; and two related RCTs, comparing dihydrocodeine with buprenorphine (Sheard et al., 2007; 2009), and methadone and buprenorphine (Sheard et al., 2009; Wright et al., 2011) respectively, found no significant difference between the two groups in each study in achieving abstinence. An RCT evaluating the effectiveness of naloxone-on-release in preventing fatality from opioid overdose in prisoners was terminated prematurely due to individuals who were not in the trial being given naloxone by the trial participants.

The six RCTs evaluating interventions for alcohol misuse in offenders showed mixed results. Mann et al. (2004) conducted a small RCT comparing two psychological treatments for relapse prevention – a deliberately positively-focused orientation versus a more traditional approach focusing on avoiding and controlling risk factors. No significant differences were found between treatment groups in relapse prevention, self-esteem, or risk. Watt et al. (2008) assessed the effectiveness of an alcohol brief intervention for violent offenders and showed no significant differences between intervention and control groups in alcohol measures or re-offending, although injury was significantly less likely in the intervention group. At three months, the intervention group were significantly more likely to demonstrate an increase in readiness to change drinking behaviour, but this did not persist at 12-month follow-up. In the RCT by Newbury-Birch et al. (2009; 2014) randomising offender managers to three different screening and brief intervention groups aimed at reducing hazardous and harmful alcohol drinking in offenders, contrary to expectations, there were no significant advantages at follow-up of the more intensive intervention compared to the control groups in terms of reducing harmful alcohol consumption. The same authors did a further pilot RCT of alcohol screening and brief intervention in police custody suites

which achieved target recruitment and intervention delivery but significant attrition of data. The RCT by Bowes et al. (2012; 2014) evaluating the effectiveness of an alcohol related violence intervention showed no differences between groups on reconvictions at the 6-month period, but at 17 months the intervention group had significantly fewer reconvictions. Two more recent studies showed no difference in the effectiveness of the intervention over the control. A pilot RCT evaluating the feasibility and acceptability of delivering alcohol brief Interventions by Orr et al. (2017) was unable to demonstrate any conclusions due to the lack of follow up data resulting from the attrition of offenders. Similarly, the trial by Taylor et al. (2020) assessing the effect of a clinical psychologist-facilitated group intervention on male prisoners' locus of control of drinking behaviour showed no statistically significant effect of the intervention on sense of control of drinking behaviour compared to the control.

There were two cluster trials evaluating whether the uptake of hepatitis C virus testing in injecting drug users in prisons was increased by the use of dried blood spots for diagnostic testing. The first (Hickman et al., 2014) showed that introducing dried blood spot testing was associated with a positive effect on diagnostic HCV testing, but the second (Craine et al., 2014) was not, indicating that this intervention was insufficient to increase HCV diagnosis within UK prison settings.

Of the eight remaining trials in police settings, MacQueen & Bradford (2015; 2017) found that contrary to expectations, their 'procedurally just' intervention comprised of a checklist of key messages to include in routine roadside vehicle stops, and a leaflet for officers to give to drivers, did not improve trust in the police and police legitimacy in the public; whereas the other seven RCTs achieved at least some of their intended outcomes. Thus the trial by Scantlebury et al. (2016; 2017) evaluating the effectiveness of a training program for police officers in contact with people with mental health problems in reducing the number of incidents resulting in police response, found no difference in the number of incidents with a police response or the number of people with mental health warning markers involved in incidents between intervention and control groups at six-month follow-up; however, incidents assigned to stations in the intervention group were more likely to have a mental health tag applied to them than incidents assigned to control stations. Ariel et al. (2016) evaluating the crime-reduction effects of increased police patrols in 'hot spots' found that 'soft' patrols by civilian police

staff with few arrest powers and no weapons were more effective in reducing reported crimes than the usual 'hard' policing power of immediate physical arrest. A later trial, also involving police hot-spots (Ariel et al., 2019) evaluating the benefits of hot-spots police patrols on previously never-patrolled, track-level highest crime platforms of the London Underground showed significant reductions in both public calls for service (999 calls) and reported crimes on treated platforms relative to controls. Another trial involving the same researchers found that police officers with body-worn cameras (BWC) were less likely to use force than officers without BWCs (Henstock & Ariel, 2017).

Other recent trials carried out in the police service yielded positive results. An RCT by Johnson et al., (2017) using block randomisation of neighbourhoods and evaluating whether police-led target-hardening crime prevention strategy for recent victims of burglary and their neighbours lowers burglary and increases public satisfaction with police found a modest positive effect of the intervention on crime and rates of re-victimisation, as well as residents' attitudes towards police without increasing their fear of crime. A trial by Koppensteiner et al. (2019) examined the effect of reducing barriers to accessing non-police services on the demand for police services in cases of police-reported domestic violence. Victims of domestic violence randomised to the treatment arm (allocation of case worker facilitating access to non-police services) showed a significant decrease in statement provision relative to that of the control group (police officers giving victims pamphlet that listed the available domestic violence services) but no significant change in perpetrator arrests or prosecution compared controls. Both non-police service use and wellbeing measures were higher for the treatment group relative to the control group.

Finally, in another recent study of domestic violence victims, Hodgkinson et al. (2022) carried out an RCT assessing the effectiveness of an audio-recording panic alarm system, compared to a standard alarm system, provided by the police to domestic violence victims who were at risk of further victimisation. No statistically significant differences were found between the two types of alarm systems across crime measures, but an estimation model indicated a significant 57% increase in criminal charges for domestic abuse offenders using the audio-recording alarm relative to the standard panic alarm system.

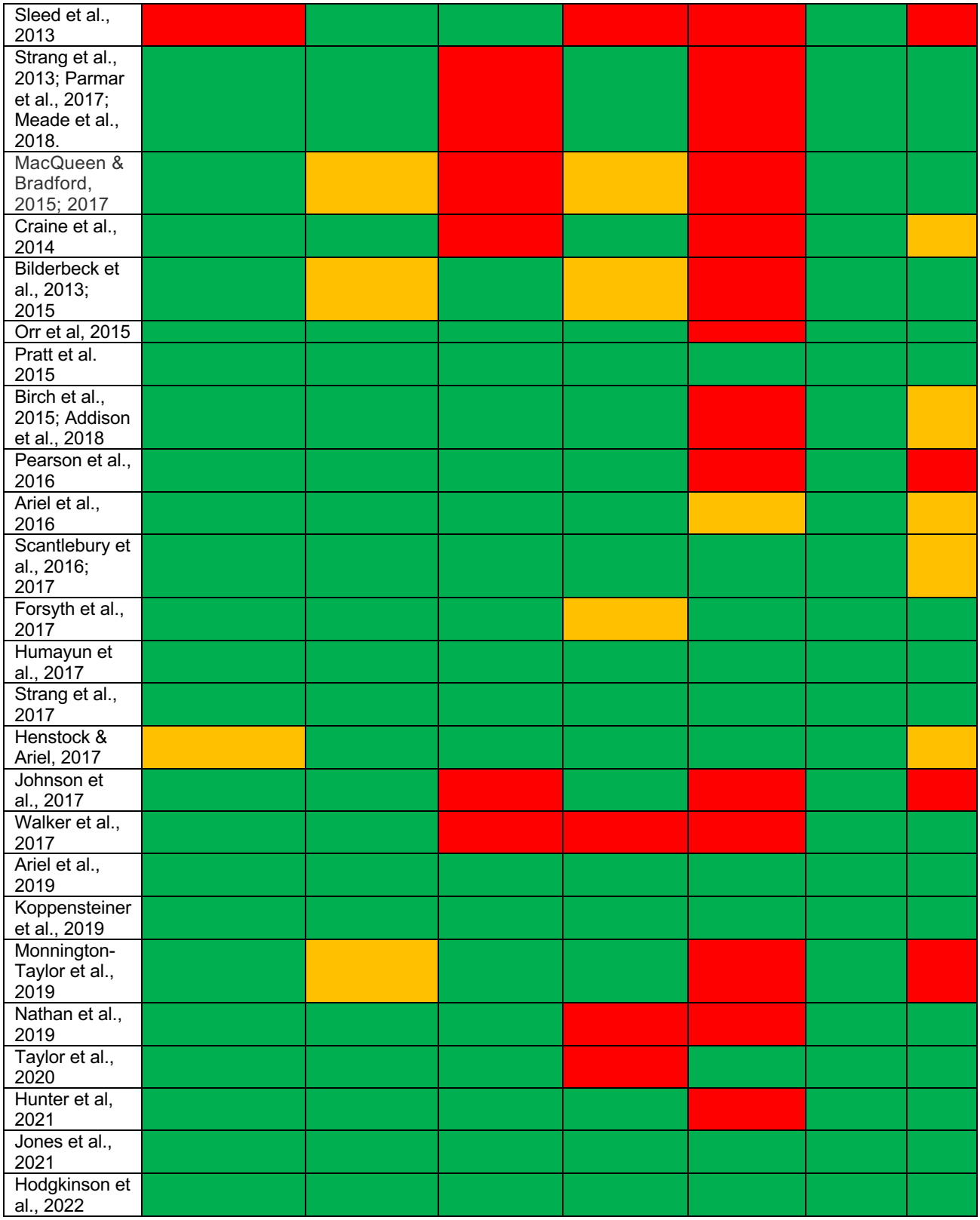
5.4.6 Risk of bias (Table 1)

There is some indication of a positive trend in the quality of the trial designs over time. In the past five years, i.e., trials published since 2017, nine of 15 (60%) were rated as having low or unclear risk of bias and only six (40%) rated as high risk of bias; whereas of those published prior to 2017 only eight of 36 (22%) trials were rated as having a low or unclear risk of bias, with the majority of trials (28 of 36, 78%) were rated as having an overall high risk of bias.

Table 1: Risk of bias for all studies

Colour coding: Low bias - green; High bias - red; Unclear bias - yellow.

Study	Random sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective reporting	Other
Vrij et al., 2001							
Biggam & Power, 2002							
Howells et al, 2002							
Mann et al., 2004							
Sherman et al., 2005; 2015 (8 linked RCTs)							
Sheard et al., 2007; 2009a							
Watt et al., 2008							
Hickman et al., 2008							
Maunder et al., 2009							
McDougall et al., 2009							
Butler & Maruna, 2009							
Tyrer et al., 2009							
Newbury-Birch et al., 2009; 2014							
Butler et al., 2011							
Sheard et al., 2009b; Wright et al, 2011							
Mitchell et al. 2011							
Jarrett et al., 2012							
Bowes et al., 2012; 2014							



5.4.6.1 Selection bias and selective outcome reporting

Most of the studies scored well in three of the seven domains of the Cochrane Collaboration tool for assessing risk of bias, namely random sequence allocation,

allocation concealment and selective outcome reporting. Thus, the majority of studies fully described satisfactory methods of random sequence allocation and allocation concealment, and therefore received a rating of low risk of bias for these two domains. For the selective outcome reporting domain, although it was only possible to obtain the original protocols for a minority of the trials, all, bar two of the published reports included all expected outcomes, including those that were pre-specified, (Bowes et al., 2012; 2014; Wright et al, 2011) and therefore the risk of bias for this domain was rated as low for these studies.

However, trials were less likely to achieve a rating of low risk of bias on other domains of the Cochrane tool, either because they provided insufficient information so that these domains were rated as unclear risk of bias, or there were clear indications from the study reports that the risks of bias were high.

5.4.6.2 Blinding of participants and personnel (performance bias)

Double-blind conditions were only possible for the four drug trials, and for all the other studies blinding of participants and personnel involved in delivering the intervention was not possible. For most of these trials, it was judged that this lack of blinding was unlikely to have affected the outcomes. However, for a minority of studies this was not the case. For example, in the study by Jarrett et al. (2012) assessing whether a critical time intervention in the first weeks post-release improved continuity of care of mentally ill prisoners by connecting them with social, clinical, housing, and welfare services on leaving prison, participants and personnel involved in the trial were not blinded and the decision whether or not they should be released by those responsible for making such decisions e.g. the Parole Board, may have been influenced by knowing which intervention they were assigned to, for example deciding not to release those randomised to the control group because of their risk being perceived as greater than it would have been if they had received the intervention.

Being randomised to the control condition may be disappointing for both personnel and participants in any trial as even in the absence of evidence, the intervention under evaluation is often perceived as being more effective than the control. Where the outcomes include measures of depression, this may bias the study's findings. For

example, the study by Walker et al., (2017) which evaluated psychodynamic interpersonal therapy (PIT) versus active control (AC) aimed at reducing thoughts and actions of self-harm and suicide risk in female offenders, not being able to blind the participants to the interventions may have affected outcomes in that participants randomised to AC may have felt more hopeless or depressed because they were not getting PIT which may have been perceived to be more effective.

In another study where participants were not blinded, the consequences were more serious. This RCT, evaluating the effectiveness of naloxone-on-release versus control in preventing fatality from opioid overdose in prisoners with a history of heroin use by injection (Meade et al., 2017), was intended to be double-blinded, but blinding of the participants was broken post release. Although the sealed packs given to both the intervention group and controls looked identical, when opened, the packs given to the former contained a syringe of naloxone, whereas the controls' packs did not. This non-blinding of participants had serious consequences and led to premature cessation of the trial, because post-release two-thirds of participants in the intervention group gave (possibly for financial gain or wanting to help someone who had overdosed) the naloxone syringe to others, who may have been in the control group or not in the trial at all, instead of keeping this for themselves.

5.4.6.3 Blinding of outcome assessment (detection bias)

In all the aforementioned studies, it was not possible to blind participants, however, blinding of researchers collecting outcome data did not always occur when this could have been possible. Thus, in some studies it was explicitly reported that the outcome assessors were not blinded (Forsyth et al., 2017, 2021; Hickman et al., 2008; Hunter et al., 2021; Mann et al., 2004; McDougall et al., 2009; MacQueen & Bradford, 2015; 2017; Nathan et al., 2019; Sherman et al, 2005; 2015; Sleed et al., 2013; Taylor et al., 2020; Walker et al., 2017; Watt et al., 2008) and in others it was not mentioned whether they were or not (Bilderbeck et al., 2013; 2015; Bowes et al., 2012; 2014; Butler & Maruna, 2009; Hodgkinson et al., 2022; Pearson et al., 2016; Power, 2002; Sheard et al., 2007; 2009a; Tyer et al., 2009; Vrij et al., 2001; Wright et al, 2011). Where the data collected was objective, such as re-offending rates obtained from police records, or records of the number of prisoners who had hepatitis C antibody testing, non-blinding of the researchers collecting this data were judged as unlikely to have biased

results of the trial, and so the risk of bias was rated as low. But where the outcomes were more subjective, for example, when the measures were self-reported by the trial participants, or the researchers were rating the participants' behaviours, non-blinding of the researchers may have introduced further bias if their attitudes or behaviour towards the participant consciously or unconsciously influenced the manner in which they elicited information from the participant. The risk of bias may have been further increased when the trial participants themselves were unblinded and therefore their responses were more prone to be influenced by their knowledge of the condition to which they were allocated.

For example, in the trial conducted by Watt et al. (2008) testing the effectiveness of an alcohol brief intervention administered to violent offenders in a Magistrates' court setting, the follow-up interviews were completed by the same person who had recruited the participants and had delivered the intervention. The authors reported that the participants in the intervention group were significantly more likely than those in the control group to report an increase in their readiness to change drinking behaviour, which may have been due to them already having developed a relationship with the assessor and wishing to please them by giving positive responses, rather than due to a direct effect of the intervention.

5.4.6.4 Attrition bias

Attrition of data was highest in those studies where the participants were offenders at greater risk of not complying or engaging in the treatment offered or being lost to follow-up (Hunter et al., 2021; Maunder et al., 2009; Nathan et al., 2019). Other reasons for loss of data included prisoners being unexpectedly transferred to other prisons or released, prisons refusing to share data, and staff shortages of personnel who were needed to facilitate data collection (Bowes et al., 2012; 2014; Sheard et al., 2007; 2009a; Sleed et al., 2013; Taylor et al., 2020; Walker et al., 2017; Wright et al, 2011).

To minimise risk of bias in estimating treatment effects in RCTs, intention-to-treat (ITT) analysis is often used (Newell, 1992). An ITT analysis is comprised of three principles: keeping participants in the intervention groups to which they were randomised,

regardless of the intervention they actually received, a principle which is always possible to apply; measuring outcome data on all participants, which may not be possible due to data attrition; and including all randomised participants in the analysis, which is also not possible if there is missing data. To compensate for this, assumptions (imputations) must be made about the missing values, which may sometimes not reflect the real reasons for the data attrition, and therefore bias the results, especially if the attrition rates are high, and/or the reasons for missing data differ between the different arms of the trial.

In several of the studies, ITT analysis had not been done (Addison et al., 2018; Bowes et al., 2012; 2014; McQueen & Bradford, 2015; 2017) and this domain was therefore rated as high risk of bias. In others where attrition rates were relatively low or the reasons for missing data were likely to have been similar in both trial intervention and control arms, the risk of bias was rated as low; however, when these conditions were not met, the risk of bias was rated as high.

5.4.6.5 Other sources of bias

Several of the trials had other sources of potential bias. Six RCTs (Ariel et al., 2019; Henstock & Ariel, 2017; Johnson et al., 2017; Monnington-Taylor et al., 2019; Scantlebury et al., 2017; Tyrer et al., 2009) anticipated problems with contamination, i.e., where some participants in the control group received the intervention. To minimise this possibility, both trials by Henstock & Ariel (2017) and Scantlebury et al. (2017) used cluster randomisation, which is often advocated to minimise treatment contamination between intervention and control participants. However, in the Scantlebury trial, contamination still occurred between the intervention and control groups as a number of officers from stations allocated to the control group inappropriately received the specialised mental health training intervention. In the RCT by Tyrer et al. (2009), repeated protocol violations led to contamination in both trial arms. This potentially biased the results so much that no conclusions regarding the efficacy of the intervention could be determined.

Moreover, as noted above, cluster trials are associated with problems of recruitment bias and baseline imbalance, thus risking defeating the objective of randomisation.

Such difficulties occurred in the study of mothers and babies in prison (Sleed et al., 2013) where the cluster design caused baseline differences between groups; and in the RCT of alcohol screening and brief intervention in police custody suites to reduce heavy drinking and reoffending behavior in arrestees (Addison et al., 2018) where the cluster design possibly caused recruitment bias as the rates of participants recruited in the three clusters differed.

Other studies reported difficulties in maintaining treatment integrity and fidelity to the treatment model. Thus Watt et al. (2008), in their RCT assessing the effectiveness of an alcohol brief intervention for violent offenders, reported that despite training and refresher sessions some interviewers didn't administer the full intervention to offenders thought to be in the 'pre-contemplative stage' as they believed that motivating change in these individuals would be unproductive. In another trial of a brief alcohol intervention (Orr et al., 2015), some staff felt ill-equipped to deliver the intervention despite training.

In the RCT by Ariel et al. (2016) evaluating whether the crime-reduction effects of increased police patrols in 'hot spots' (locations in cities where crime is concentrated) are dependent on the 'hard' threat of immediate physical arrest, or whether 'soft' patrols by civilian police staff with few arrest powers and no weapons can also reduce crime, treatment integrity was also compromised, not because the participant officers disagreed with the treatment model but because they had difficulty completing the prescribed delivery of 15 minute patrols 3 times per shift due to the polygon shape of the hotspots.

5.4.7 Reported difficulties in implementation

Specific difficulties and challenges encountered in implementing the trials in the respective settings of the criminal justice system in the UK were reported in all but eight of the published studies (Biggam & Power, 2002; Butler et al., 2011; Butler & Maruna, 2009; Hodgkinson et al., 2022; Koppensteiner et al., 2019; Mann et al., 2004; Mitchell et al., 2011; Vrij et al., 2001. To some extent, these difficulties were specific to the particular setting and location of the trial (i.e., prison, probation, police, courts,

youth offending services); however, for the most part similar obstacles and impediments to implementation were described regardless of the setting.

5.4.7.1 Attrition

The most common problem reported was the high attrition rate of offenders, whether they were the direct participants i.e., unit of randomisation, in the study, as was the case in the majority of the trials (Addison et al., 2018; Bowes et al., 2012; 2014; Howells et al., 2002; Humayun et al., 2017; Hunter et al., 2021; Jarrett et al., 2012; Maunder at al., 2009; Nathan et al., 2019; Orr et al., 2015; Pratt et al., 2015; Sheard et al., 2007; 2009a; Strang et al., 2017; Walker et al., 2017; Wright et al., 2011) or the unit of inference, as in some of the cluster RCTs (Newbury-Birch et al., 2009; 2014; Sleed et al., 2013). This was due to offenders not engaging in or completing the treatment intervention or being lost to follow up after receiving the intervention. In some cases, this may have been due to lack of motivation on the part of the offender, but in many other cases, especially where the trial was being conducted in a prison, participants were lost after being unexpectedly transferred to other prisons or released and changing addresses and telephone numbers or giving erroneous contact details. Some of the studies employed specific strategies to avoid losing participants, for example only enrolling prisoners who were not due for imminent release, but such precautions were not always successful. In some trials, eligible participants refused to be enrolled prior to randomisation (Sheard et al., 2007; 2009a; Sherman et al., 2005; 2015; Watt et al., 2008).

5.4.7.2 Failures of communication

Frequently cited institutional barriers to implementation were poor communication and collaboration between the different agencies within the system, especially where there were different institutions responsible for developing and evaluating the trial, difficulties in sharing information and delays in getting ethical approval, obtaining researchers' security clearance, and completing and collating trial accreditation documents (Bowes et al., 2012; 2014; Craine et al., 2014; Meade et al., 2018; Parmar et al., 2017; Sheard et al., 2007; 2009a; Sherman et al., 2005; 2015; Strang et al., 2013). Other practical difficulties included problems in prisoners giving informed consent (Sherman et al., 2005; 2015) and understanding trial processes due to noisy and chaotic environments (Sheard et al, 2007; 2009a).

5.4.7.3 Negative attitudes

Some of these challenges were due to complex bureaucratic processes and procedures that differed between the agencies involved, but there were also many reports of more active resistances from the staff and institutions in which they worked (Bilderbeck et al., 2013; 2015; Craine et al., 2014; Hickman et al., 2008; Jarrett et al., 2012; MacQueen & Bradford, 2015; 2017; Newbury-Birch et al., 2009; 2014; Orr et al., 2015; Sheard et al., 2009a; Sherman et al., 2015; Tyrer et al, 2009; Walker et al., 2017). One study (Sheard et al., 2009a) highlighted the refusal of some prison healthcare departments to share information for the purposes of the trial, leading to loss of follow-up data. In the restorative justice RCTs (Sherman et al., 2015) the sample that was randomised represented only a small proportion of those eligible to participate in the study, whether this was due to offenders actively refusing to be enrolled, or the unwillingness of staff to recruit them; another study (Craine et al., 2014), described the negative attitudes of prison health staff towards the trial they had agreed to take part in such that there were concerns that the intervention had not been offered to all the prisoners allocated to the treatment group; and a further study (Newbury-Birch et al., 2014) related how some staff did not rate the problem in their client group that was being investigated in the trial (alcohol misuse) to be of sufficient importance. Similarly, in another trial of an alcohol related intervention, Orr et al. (2015) reported that some staff felt that harmful/hazardous drinking was not a key priority for this client group relative to their other criminogenic needs. Tyrer et al. (2009) reported a lack of authority within the prison hierarchy and rivalries and resentments between different prison wings as being impediments to implementation. Walker et al. (2017) described interruptions by prison lockdowns, appointments with solicitors and visits, difficulties finding suitable rooms for therapy to take place and disruptions to therapy sessions.

5.4.7.4 Work related pressures

Resistances to facilitating implementation of the trial were also reported to be a result of poor staff morale and motivation due to their high workload, staff shortages, information fatigue, and other work-related pressures (Hunter et al., 2021; MacQueen & Bradford, 2015; 2017; Newbury-Birch et al., 2009; 2014; Taylor et al., 2020; Wright et al., 2011). In one study (Wright et al., 2011), data collection was slow due to access

issues with key personnel who had to prioritise their own workload before undertaking trial tasks. Other studies mentioned the negative impact of wider organisational changes imposed on the system by the government, as well as an increased prevalence of regime disruption. Taylor et al. (2020) described a prison climate of poor staffing levels and increased levels of violence which limited the delivery of and access to the intervention; and Hunter et al. (2021) reported discontinuity in the practitioners delivering the intervention due to staff turn-over and illness.

5.4.7.5 Ethical issues

In some trials, ethical issues were raised regarding randomisation, with reluctance of staff to refer clients due to the risk of being allocated to treatment as usual (Bowes et al., 2012; 2014; McDougall et al, 2009; Meade et al, 2018; Parmar et al., 2017; Sheard et al, 2007; 2009a; Strang et al., 2013). In one trial (McDougall et al., 2009) such ethical concerns about withholding treatment were overcome by a waiting list control group, and the provision of a cohort group to fast-track priority offenders prior to random allocation. However, this resulted in a larger number of offenders than expected included in the cohort group, which meant that the characteristics of the trial sample were not representative of the population originally targeted. Nathan et al. (2019) reported reluctance of staff to refer clients as randomisation was seen to restrict access to an effective specialist service. Another ethics-related issue was that of remunerating offenders for their participation in the trial (Addison et al., 2018; Sheard et al., 2007; 2009a), which also sometimes played a key role in incentivising their engagement and retention but was in one trial disapproved of and resisted by leadership in the organisation where the study took place (Addison et al., 2018).

Other challenges encountered were unfamiliarity of research methodology amongst personnel within the criminal justice system (Orr et al., 2015; Tyrer et al, 2009), and difficulties in training staff who delivered the interventions such that there was variability in how it was delivered, which compromised treatment integrity (Orr et al., 2015).

5.5 Discussion

Although the number of RCTs implemented to date in criminal justice settings in the UK since 1994 that have been identified by this review is greater than the number identified in the earlier reviews by Farrington (1983) and Farrington and Welsh (2005), it remains tiny in comparison to the number of RCTs evaluating health interventions. Moreover, of the 50 published trials, 32 shared authors with at least one, if not more, of the other identified trials, indicating that the research community involved in empirical research in the criminal justice system to date remains very small.

The findings of this review suggest that the quality of these RCTs has only begun to improve very recently, with the majority of selected studies published before 2017 being rated as high risk of bias. This seems surprising given the not insubstantial literature that has accumulated highlighting the resistances to conducting evidence-based research, and particularly RCTs in crime and justice settings, and suggests that the longstanding expertise and practice of empirical research derived from evaluating therapeutic interventions within the field of health has not yet been fully embedded within the criminal justice system.

As noted above, some of methodological weaknesses in the designs of the RCTs that contributed to risk of bias examined in this review were independent of environmental challenges and therefore should have been considered and addressed during the early development of the trials. These issues include applying correct methods of randomisation sequence and allocation, and utilising robust methods of statistical analysis, to minimise as much as possible the risk of bias stemming from missing data. Many of the studies failed to use ITT analysis such that it was not known whether their reported outcomes were valid. Several studies also did not mention whether the researchers collecting data were blinded. Although this may be particularly problematic in increasing the risk of bias where the outcomes are subjective (Wood, 2008), such as in participant-rated symptoms or behaviours where the researcher may consciously or unconsciously influence the participant to respond in a particular way, lack of blinding in RCTs has also been associated with more exaggerated intervention effects even when the outcomes are objective (Pidal, 2007).

The ease of rating some of these trials was hampered due to insufficient or lack of detail regarding the studies' designs and methods. In a review of 38 RCTs conducted in criminal justice settings between 2002 and 2008 Gill (2011) highlights the importance of descriptive validity on the external validity of a trial. Descriptive validity is the transparent and detailed reporting of studies - the presentation of key features of an evaluation in a research report - and is thought to be second only to internal validity in terms of importance for assessing the quality of a trial and making judgements about methodological rigour (Farrington, 2003b; Gill, 2011). Quality standards for the reporting of trials have been well established in health and medical sciences, and the Consolidated Standards of Reporting Trials (CONSORT), an evidence-based, minimum set of recommendations for reporting randomised trials, has been adopted by many leading medical journals. Only a minority of the trials evaluated in this review were explicit about following the CONSORT guidelines. Gill's review showed that there was much variation in the quality of reporting on key issues, especially regarding attrition of participants, findings which are replicated in this review which includes studies published a decade later than those in her paper.

Other sources of risk of bias, however, were more difficult to avoid despite careful study design, and were exacerbated by specific implementation problems in the criminal justice setting. Blinding of participants and personnel is often impossible in studies which are not drug trials as the nature of the intervention cannot be disguised, as was the case in most of the RCTs in this review. For the majority of studies it was assessed that the lack of blinding would not have significantly biased the trials' results; however in two cases, as reported above, conditions specific to the particular setting meant that the lack of blinding may have biased the study's outcomes, such as where prisoners were more likely to be released if they had been randomised to the treatment due to a perception that it would lower their risk, even if this was not one of the specified outcomes. This particular example may highlight a potential source of tension between researchers and policy makers in the criminal justice system, where there is debate as to whether the primary outcome of a trial evaluating an intervention for offenders should be related to promotion of the offender's health or reduction in their risk. Interestingly, in this review, whilst 23 of the 50 trials had one or more measures of offending, 34 reported outcomes related to offender health or well-being.

The most common source of bias found in the trials reported in this review was data attrition, which in many cases was linked to factors related to the trial participants, personnel, and settings, which the researchers had little influence over. These have been described in detail above, but on the part of offenders included their lack of motivation to engage in the trial, drop-out, and difficulties in follow up due to their chaotic lifestyles and frequent changes of telephone numbers and place of residence. Data loss was also frequently cited as being due to staff reluctance and institutional resistances to being involved in the trial, resulting in poor communication between agencies, delays in being allowed access to prisons, and obstacles to data transfer. This lack of co-operation was attributed to a variety of reasons – ethical concerns, lack of familiarity with research, and decreased staff morale due to increased workloads, high staff turnover and organizational change.

All the challenges that the authors of these studies reported in implementing and delivering the trials in criminal justice settings have been well-documented previously in the literature, as described in the introduction, except for issues related to increasing work pressures for staff employed within the criminal justice system. Several of the most recently published studies in this review reported organisational issues as specific impediments to trial implementation (Forsyth et al., 2017; Hunter et al., 2021; MacQueen & Bradford, 2017; Scantlebury et al., 2017; Taylor et al., 2020), with Forsyth et al. explicitly highlighting staff shortages and reduction of specialist officer roles due to the UK government, whilst the trial was being conducted, introducing policies with the intention of reducing the full-time equivalence of staff across the National Offender Management Service as a whole. This is a significant finding which illustrates the influence of wider economic and political factors on conducting research in a criminal justice system under considerable pressure and turbulence as a result of frequent and on-going organisational changes and financial constraints on public services in a time of austerity in the UK.

Careful attention to the planning and design of future randomised controlled trials in crime and justice settings may go some way towards facilitating their success in completing what they set out to investigate in the least biased way. Cluster randomised trials are commonly advocated to reduce the risk of contamination between interventions being delivered and to maintain treatment integrity. However, cluster

trials are at risk of recruitment bias and need larger samples than would be required in similar, individually randomised trials (Torgerson, 2001), although this may be addressed with block randomisation to ensure the equivalence of groups and maximise statistical power. Cluster-randomised trials undertaken in the criminal justice settings have often used the setting or place – prison, probation office or police suite - as in the cluster RCTs in this review but may be limited in the number of sites that can be identified to participate (Weisburd, 2005). Nevertheless, despite these limitations, and associated practical and statistical complexity, a stepped wedge trial, where all clusters or places containing individuals will eventually receive treatment, may overcome ethical objections regarding the process of randomisation depriving individuals of what is thought to be the effective intervention (Pearson et al., 2016), and illustrates how methodological limitations need to be balanced with contextual factors.

Problems in implementation may be mitigated if they are anticipated and active measures put in place. For example, in a recent RCT (Ariel et al., 2019) evaluating the efficacy of hot-spots police patrols in reducing crime on platforms of the London Underground, the authors describe processes put in place to optimise implementation, including monthly meetings with the research team to maintain treatment fidelity; motivating officers by monthly 'motivational debriefs' which gave feedback about noteworthy incidents, crime figures during the previous month, and treatment dosage data; and encouraging officers to engage as much as possible with members of the public and not to stand idle on the platforms.

However, the wider organisational and systemic issues described in the literature and identified in this review that impede the development of empirical research within the criminal justice system also need to be taken seriously if criminological interventions are to be evidence-based. What seems central is the importance of constructive, collaborative and communicative relationships between a well-led skilled research team and all levels of the agencies and organisations involved in the development and evaluation of the intervention, ensuring the active participation of institutional staff, including senior management, clinicians and therapists delivering treatment, trial participants, commissioners and where possible, policy makers, who may be helped to understand the principles and rationale behind randomisation and how it is ethically

imperative to provide treatments for offenders and other interventions within the criminal justice system that are based on the best possible evidence.

5.6 Study limitations

Although the electronic databases searched were those chosen as being the most likely to list the majority of existing published studies eligible for this review, and further searches were conducted via handsearching of a key journal, cross checking references of selected papers and contacting experts in the field, it is possible that searching other databases may have revealed more studies. Moreover, time and practical limitations meant that there was a single reviewer responsible for the literature searches and the selection of papers, which may have increased the risk of subjectivity and errors (Buscemi et al., 2006). Having only one reviewer also meant that she was not blinded to the name(s) of the study author(s), their institution(s) or publication sources at any stage of the review. Furthermore, although the Cochrane risk of bias tool is widely used and recommended in the scientific community as being the best quality assessment tool for RCTs (Zeng et al., 2014), it has also been criticised as having low reliability (Armijo-Olivo et al., 2014) and therefore having another researcher trained in the tool available to rate at least a proportion of the published trials chosen for this review may have increased the reliability of the findings.

5.7 Conclusion

The limited number of studies that have been identified from this systematic literature review of published and completed RCTs carried out within the criminal justice system in the UK is evidence that although the rate is increasing steadily, the total number of RCTs ever carried out in these settings in the UK is a tiny fraction of the number of RCTs conducted within health settings. It seems therefore crucial to promote and facilitate the successful development and delivery of high quality RCTs within criminal justice settings if therapeutic interventions for offenders and other strategies to reduce and prevent crime are to be truly evidence-based. This may be partially achieved by funding more rigorous trial designs that address sources of bias by adhering to quality standards such as COHORT which are then reported more transparently. However, as this review confirms, biased outcomes may be also the result of contextual factors inherent to the structure, culture and constraints of the specific setting and its staff,

which are in turn influenced by the wider organisational, political and financial pressures of the criminal justice in its entirety. Future studies should consider embedding a robust qualitative ethnographic component from the outset, where in-depth observation and individual and group discussions with all participants in the trial may elucidate more subtle and subjective contextual factors concerning human relationships, attitudes, and organisational dynamics, that might be missed with a quantitative investigation, but which may exert significant influence on the results of a randomised controlled trial (Sherman & Strang, 2004; MacQueen & Bradford, 2017).

Chapter 6: Evaluating the implementation of a randomised controlled trial of mentalizing-based treatment for antisocial personality disorder in the criminal justice system in England and Wales: Experience of the MBT teams

6.1 Introduction

The literature on the challenges of conducting experimental studies with criminal justice systems is situated within the field of implementation science that has emerged over the past 20 years. Implementation science has been defined as 'the scientific study of methods to promote the systematic uptake of research findings and other EBPs into routine practice, and, hence, to improve the quality and effectiveness of health services' (Eccles & Mittman, 2006, p.1). It addresses the research-to-practice gap that has impeded the adoption and incorporation of evidence-based interventions into standard general practice (Bauer et al, 2015). However, studies of the difficulties in promoting robust and systematic research methodology in criminal justice settings differ from the aims of most implementation science research on two accounts: firstly, implementation science is for the most part concerned with the implementation of the findings of empirical research studies, rather than the implementation of the research studies themselves; and secondly, implementation science has been focussed to date on implementing evidence-based practices in health rather than criminal justice settings.

As described in chapter 5, there is a growing body of research interrogating the challenges and resistances that arise in implementing randomised experimental studies within criminal justice settings. However, most of the literature consists of papers describing the authors' experiences and observations of their difficulties in implementing the RCT that they are directly involved in. For example, Drover & Ariel (2015) documented the challenges they encountered in the implementation of a police led RCT within a large British police force of the use of body worn video cameras to reduce public complaints against police, police use of force, and attrition of prosecutions due to lack of physical evidence, and how these challenges were overcome. Similarly, Pearson et al. (2010) described and compared their experiences

of implementing two different designs of RCTs which evaluated the same cognitive-behavioural intervention for offenders on probation in the UK in two different probation areas.

In contrast to the number of such descriptive accounts within the literature, there is a dearth of studies which utilise a more systematic and empirically-sound methodological approach to investigate the problems which arise in implementing randomised trials in criminal justice settings. Of the 50 RCTs carried out in the UK criminal justice system identified and discussed in chapter 5, only two included a formal qualitative study of the difficulties encountered.

McQueen & Bradford (2017) conducted a retrospective qualitative process evaluation to explore why an RCT carried out in a Scottish police force testing an intervention intended to improve the public's perceptions of the police failed to produce the hypothesised results. Following the completion of the RCT, the authors held nine digitally recorded group interviews of a total of 55 police officers who had implemented the experiment to gain their perspectives of what the impacts of their participation were on officer practice. The transcripts of the interviews were analysed by the thematic analytical approach as described by Braun and Clarke (2006). The main findings were that the participating officers identified breakdowns in communication, negative attitudes of police towards research, and organisational reforms and perceived organisational injustice as being the main obstacles in implementing the RCT.

Forsyth et al. (2017), in their RCT evaluating an intervention, the Older Prisoner Health and Social Care Assessment and Plan (OHSCAP), to improved social care for older prisoners, embedded a qualitative component to their trial from the outset. They conducted semi-structured interviews with the staff delivering the intervention (healthcare workers and prison officers) and the prisoner participants who had received the intervention to identify the barriers and facilitators involved in its delivery and to gain an understanding of the processes involved. The interviews were analysed thematically. Four overarching themes were extracted from the qualitative data which they named 'the broken prison system', 'rigid prison processes', 'prisoner and staff relationships' and the 'OHSCAP procedure itself'. Both the prisoners and staff believed that the successful implementation of the intervention was fundamentally blocked by being delivered within a prison system that was in crisis. Rigid prison processes and

procedures, a lack of meaningful partnerships between prison and healthcare staff, and poor buy in by the prison staff negatively interfered with the OHSCAP process.

The current study is a qualitative exploration of the challenges and obstacles encountered by staff involved in the implementation of an RCT evaluating a psychological treatment for violent offenders in the UK criminal justice system across 13 sites in England and Wales. By conducting semi-structured interviews with staff who were currently involved in conducting the trial, which were subsequently systematically subjected to thematic analysis, this study adds to the literature on the challenges in conducting RCTs in the criminal justice system in the UK in its robust methodological design and empirically derived findings.

6.2 Methodology

6.2.1 Setting for the study

As described in chapter 4, the Mentalizing for Offending Adult Males (MOAM) was a multi-site pragmatic randomised controlled superiority trial, the primary aim of which is to investigate whether, in a sample of offenders under community supervision in the National Probation Service who meet DSM-IV-R criteria for ASPD PAU supplemented with MBT is more effective than PAU only for reducing aggressive antisocial behaviour.

Participants were eligible for the study if they met the following criteria:

- Male
- Aged 21 or over
- Have a history of violent behaviour
- Subject to statutory provision by the NPS
- Have at least 6 months remaining on their licence

Participants were excluded from the study if they met the following criteria:

- Convictions for child sexual offences (including child pornography offences)
- Current diagnosis for schizophrenia or bipolar disorder
- Inadequate English or cognitive capacity to provide informed consent and participate in group therapy

The primary outcome was the weighted frequency of aggressive antisocial behaviour as measured by the interview-based Overt Aggression Scale-Modified (OAS-M). Secondary aims were centred on improving the management of the mental health needs of offenders with ASPD in the community, measured with a variety of self-report questionnaires conducted with participants exploring violence; health-related quality of life; mental health; alcohol use; drug use; self-harm behaviours; suicidal behaviours; treatment engagement and help-seeking behaviour; personality dysfunction; mentalizing ability; health service use and offending behaviour. Data was collected at baseline and either 3 or 6 month follow up points for two years. The relative costs and cost effectiveness of MBT and PAU were also evaluated.

The trial was led by University College London and funded by the National Institute for Health Research, HTA (14/186/01).

6.2.2 Ethical approval

Ethical approval for the current study is included within the full ethical approval for MOAM received from the NHS Research and ethics committee (14/LO/1696) and National Offender Management Service (NOMS) (2014-315).

6.2.3 Sample

The sample population of this current study of the challenges and obstacles encountered by staff involved in the implementation of this RCT was comprised of the MBT teams, research assistants, and experts by experience involved in implementing the trial at the 13 sites across England and Wales (Bristol, Devon, East London, Leeds, Lincoln, Liverpool, North West London, Nottingham, Preston, South London, South East London, Tamworth, and Llianelli in Wales).

The MBT team in each site was comprised of 3 MBT therapists, a specialist offender manager, and an assistant psychologist, all of whom were trained in MBT. The MBT therapists were usually clinical or forensic psychologists, although a few were mental health nurses, mental health practitioners or psychotherapists. The lead MBT therapist

was employed as a senior clinician at a Band 8C AfC pay scale[1], the other two therapists at Band 8A and Band 7 respectively, ensuring that there was a sufficient level of clinical expertise and range of experience within the MBT team necessary for the treatment of this 'hard to engage' population of offenders with ASPD with complex pathology, co-morbidity and increased mortality. The therapists were primarily responsible for conducting the clinical assessments of trial participants and delivery of the MBT sessions. The MBT specialist offender manager (SOM) was a senior probation officer working in the NPS, whose main role in the trial was to liaise between the team and local probation service to promote the trial and generate referrals. The assistant psychologist was responsible for meeting with the trial participants to administer the trial measures used in the trial, including the Structured Clinical Interview-II (SCID-II) (First et al, 1997), as well as being the administrator and coordinator of the MBT team's activities. Both the MBT SOM and the assistant psychologist were permitted to facilitate the group in conjunction with the MBT therapists. The MBT therapists and assistant psychologist were employed by the local NHS mental health trust in each site and seconded to work on the MBT project in the local probation office of the NPS.

Each MBT team was recommended to have an expert by experience, (EbE), although in practice some of the teams were unable to recruit someone suitable to the role. As described in chapter 4, the EbE was a male ex-offender who had lived experience of personality disorder or difficulties and who had benefitted from previous group treatment. The EbE's role in the trial was to promote engagement of participants by acting as a role model as someone who had experienced similar difficulties within the criminal justice system. They had a particular role to play in relation to helping prospective participants understand what they were committing to, managing participants' expectations (e.g. no 'magic cure') and assisting their engagement, in being involved in the assessment phase, facilitating the group alongside the MBT therapists, and being available to participants at risk of disengaging from treatment. The EbEs were not formally trained in MBT but were encouraged attend training days delivered by the Anna Freud Centre three times a year, where they received some

[1] Agenda for Change (AfC) is the current NHS grading and pay system for NHS staff, with the exception of doctors, dentists, apprentices and some senior managers.

basic training in MBT principles and skills as well as sharing and learning from each other's experiences.

The research assistants were employed by University College London and were responsible for collecting data from the participants in the trial across the country.

For this study I conducted 19 focus group interviews over a 14-month period between February 2017 to April 2018: 13 interviews with the MBT teams at each of the 13 sites, one interview of a group of six MBT SOMs, one interview of a group of five assistant psychologists, one interview of two research assistants, and two interviews of a group of EbEs (see Table 2). I conducted one further interview of a group of EbEs in February 2020.

Table 2 Schedule of interviews

Interview	**Date**	**Location**	**Participants: role, gender, years of experience in forensic work**
Nottingham MBT team	14.2.17	Community Forensic Service, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham	Clinical & forensic psychologist & site lead, female, 21 years Clinical psychologist, female, 7 years Forensic psychologist, female, 5 years Assistant psychologist, female, 2 years
Assistant Psychologists	21.6.17	MBT All Sites Day, Bristol, Avon	AP Bristol site, female, 2 years AP Merseyside site, female, AP SLaM site, female, 2 years AP Staffordshire site, male, 18 months AP Wales site, female, 6 months
East London MBT team	26.6.17	Approved Premises, Stratford, London	Clinical psychologist and lead MBT therapist, male Forensic psychologist, female Forensic psychologist, female Assistant psychologist, female
Staffordshire MBT team	6.7.17	Tamworth Probation	Clinical psychologist and lead MBT therapist, female, 9 years Clinical psychologist, female, 2 years

		Office, Staffordshire	Assistant psychologist, male, 18 months Specialist offender manager, male, 16 years
Experts by Experience	18.7.17	Anna Freud Centre, London	EbE East London EbE Lincoln EbE Nottingham site EbE Wales site
Wales MBT team	3.18.17	Llianelli Probation Office, Wales	Clinical psychologist, female, 5 years Clinical psychologist, male, 18 months Assistant psychologist, female, 6 months Specialist offender manager, female, 17 years
Liverpool MBT team	10.8.17	Mersey Care NHS Foundation Trust, Liverpool, Merseyside	Clinical psychologist and lead therapist, female Nurse therapist, male Assistant Psychologist, female
South East London (Oxleas) MBT team	17.8.17	Lewisham Probation Office, London	Clinical psychologist & lead MBT therapist, male, 11 years Clinical psychologist, female, 11 years Clinical psychologist, female, 7 years Assistant psychologist, female, 2 years Offender manager, female, 12 years
Lincolnshire MBT team		Lincoln Probation Office, Lincolnshire	Clinical and forensic psychologist & lead MBT therapist, female, 16 years Clinical psychologist, female, 4 years Specialist offender manager, female, 8 years
South London and Maudsley MBT team	12.10.17	Mitre House, National Probation Service, London	Clinical psychologist & lead MBT therapist, male, 7 months Specialist offender manager and mental health practitioner, male, 12 years Assistant psychologist, female, 2 years
MBT Specialist Offender Managers (SOM)	5.12.17	MBT All Sites Day, London	SOM Bristol site, male, 12 years SOM Devon site, female SOM East London site, male SOM Lancashire site, male, 14 years SOM Oxleas site, female, 12 years SOM SLaM site, male, 12 years
Bristol MBT team	13.12.17	Bristol Probation Office, Avon	Clinical psychologist & lead therapist, female, 6 years

			Clinical psychologist, male, 9 years Forensic psychologist, female, 9 years Assistant psychologist, female, 2 years Offender manager, male, 12 years
Lancashire MBT team	18.12.17	Preston Probation Office, Lancashire	Clinical psychologist & site lead, female, 12 years Nurse therapist, female, 17 years Assistant psychologist, female, 4 years Specialist offender manager, male, 14 years
Leeds MBT team	19.12.17	Leeds Probation Office, Yorkshire	Clinical psychologist & site lead, female, 16 years Forensic psychologist, female, 3 years Psychotherapist, female, 4 years Specialist offender manager, female, 23 years
Devon MBT team	2.1.18	Langdon Hospital, Dawlish, Devon	Clinical psychologist & site lead, male, 20 years Clinical psychologist, female, 15 years Assistant psychologist, female, 3 years
North West London (BEH) MBT team	25.1.18	Islington Probation Office, London	Clinical psychologist, female, 13 years Offender manager, female, 13 years
Research assistants	5.3.18	User Voice Office, London	Research assistant, male 3 years Research assistant, female 2 years
Experts by Experience	30.4.18	Anna Freud Centre, London	EbE Bristol site EbE Devon site EbE East London EbE Lincoln site
Experts by Experience	24.2.20	Portman Clinic, Tavistock and Portman NHS Foundation Trust, London	EbE Bristol site EbE Devon site EbE East London EbE Lancashire site

Although it was not possible to interview all the members of staff involved in the project due to the difficulties in finding suitable times to meet with all members of each team, nevertheless, 81% (51 of 64) of all those working in the MBT teams at all 13 sites at

the time of the interviews were interviewed, which included 11 of the 13 assistant psychologists and 11 of the 13 SOMs. The group interviews of the assistant psychologists and SOMs respectively contained some staff who had also been interviewed as part of their individual site interview. Of the eight EbEs interviewed, two participated in two interviews and one participated in three of the interviews.

Regarding the demographics of the staff interviewed for this study, in relation to gender, 22 of the 29 MBT therapists were female (76%), 10 of the 11 assistant psychologists were female (91%), 6 of the 11 SOMs (55%) were female and of the two RAs, one was male and the other female. Of the 61 individuals interviewed overall, there were only two from a BAME background – one assistant psychologist, and one EbE. In terms of experience, the average length of time working in forensic settings was 9.3 years for the MBT therapists (range 6 months to 21 years), 2 years for the assistant psychologists (range 6 months to 4 years) and 14 years for the SOMs (range 8-23 years).

Table 3: Demographics of participants

Role in trial	**Number interviewed**	**Gender ratio (% female)**	**Average time working in criminal justice system (years)**
MBT therapists	29	76%	9.3 (range 0.5-21)
Assistant Psychologists	11	91%	2 (range 0.5-4)
Specialist Offender Managers	11	55%	14 (range 8-23)
Research assistants	2	50%	2.25 (range 2-2.5)
Experts by experience	8	0%	N/A

6.2.4 Data collection

The interviews of the MBT teams were carried out in the probation offices where each site delivered their group. The interviews of the assistant psychologists and MBT specialist offender managers respectively were carried out at one of the national all-sites meetings held three times a year where all sites came together to review their progress in the trial. The interview of the research assistants was conducted at the

London office of User Voice, a service user organization which employed the peer researchers involved in the trial. Each interview of the EbEs was carried out at one of the EbE training days held three times a year in London to support the EbEs involved in the trial.

The interview was semi-structured and was comprised of 4 questions, the bulk of the interview focusing on questions 3 and 4:

1. What is your profession, and how long have you been working in/with the criminal justice system?
2. What has been your involvement in the trial?
3. What difficulties or challenges have you encountered in your involvement with the trial?
4. How might these challenges have been avoided or remedied?

The interviews each lasted one hour and were audio-recorded and transcribed verbatim.

The three interviews with the EbEs were analysed separately from the other 16 interviews.

6.2.5 Data analysis

The data was analysed via thematic analysis. This is a qualitative method of analysis used to identify, analyse, and report patterns or themes within sets of data. For this study, thematic analysis was chosen over other qualitative methods of analysis as it is not derived from a particular theoretical or epistemological position, such as interpretative phenomenological analysis (IPA), grounded theory or narrative analysis, and can therefore be more flexibly applied across a range of theoretical and epistemological approaches to provide a rich and detailed, yet complex, account of the data (Braun & Clarke, 2006).

In conducting the thematic analysis of these interviews, I used the six-phase method as described by Braun & Clark (2006) (Step 1: Become familiar with the data; Step 2: Generate initial codes; Step 3: Search for themes; Step 4: Review themes; Step 5, Define themes; Step 6: Write up). Themes were identified at the semantic, rather than

latent level, in other words, within the explicit or surface meanings of the data, rather than looking at the level beyond what the participants said to identify underlying ideas, assumptions and conceptualisations that might have shaped or informed the semantic content of the data.

Moreover, although I have a pre-existing theoretical knowledge in the topic, i.e., a familiarity of the literature on the types of obstacles that have been encountered in implementing trials in the criminal justice system, as well as my own experience of problems in conducting this trial, as much as possible the analysis was an inductive or 'bottom-up' theoretical thematic analysis in which the themes were data-driven, rather than a 'top-down' analysis driven by the specific research question where the data coding is fit into a pre-existing coding frame.

6.2.6 Stages of analysis

Step 1: Become familiar with the data

I read and re-read all the transcripts of all of the interviews to become familiar with the entire body of data and noted my initial impressions and ideas. For example, a prominent theme seemed to be that staff felt too busy or overwhelmed with work to focus on conducting the trial; another was of the difficulties they experienced in trying to engage men in the trial.

Step 2: Generate initial codes

I then carefully re-read the interviews and identified all segments of data that were relevant to the research question to generate initial codes. Open coding was used in that there were not pre-set codes, but codes were chosen, developed, and modified as the coding process proceeded. The length of chunks of text identified for each code varied considerably between a short paragraph of 2 or 3 lines of text, and several paragraphs comprising 130 lines of text (see Table 4 below for examples). I highlighted the relevant chunks of text and put the initial codes in the margins. After systematically coding the entire transcripts, I collated all the codes as a single list.

Table 4: Examples of coding segments of text

Segments of text	Codes

Participant 1: I think it's sort of… the nuances are just delivering to this group of people… like delivering this therapy to this group of people in the community… it's… it's such a challenge to… just to get that… those people in a room without some level of kind of coercion…	Challenge to get offenders in room without some level of coercion
Participant 2: I just don't think I'd buy into the model for this group, I think that another challenge for me… to feel it's a little bit sort of Emperor's new clothes. I… I… having been involved in this project now for a fair amount of time, on and off obviously… **Interviewer:** Yeah. **Participant 2:** (umm) And I was excited by it to begin with because I thought you know great the idea that people might have access to an intervention who otherwise would have been very excluded and… and not thought about. But increasingly because I run… I'm involved in another project for offenders which is a sexual offending group, we challenge for personality disorder defenders and probation. So there's quite a lot of parallels in… in who we're looking at, although obviously sex offenders can be a little bit different. (umm) But we do take a lot of the more antisocial ones too. And I just compare the two models and the absence of structure within MBT… and I think it's not necessarily the right model. You know (umm) I think these… this is anecdotal, but in my experience of working with these men, they've acquired something to hang things onto and the… the lack of structure is unsafe and uncontaining I think. **Participant 1:** Is that the structure in the group, but also maybe that then carries on through you know the actual structure of how we're doing the assessments and kind of feeding back on things. Maybe there's an element of this because there's… you know because I haven't done the training and then sort of observed the group that wasn't really a group, I still haven't got a clue really what MBT is. (umm) And that's quite hard isn't it, saying to offender managers what they actually do in a group, you know and actually not… not maybe having a worksheet or a booklet that I can sort of show people that you would normally… for any other programme, you would say oh this is what they're working for on the next kind of eighteen sessions and things like that. I just don't know whether that whole, like I said lack of structure then impacts on the way	MBT is wrong model for this client group. They need treatment that is more structured to contain them

the whole team works that actually you know we're not doing a strict formula for the assessments and… at what point there giving out to people or feedback to people and things like that. Maybe the whole thing is a little bit… well I used the word 'bitty' , but yeah. And I think the programme… I mean how long is [Challenge]? **Participant 2:** Sixteen months. **Participant 1:** Yeah. **Participant 2:** And it's really well attended, you know so by comparison we don't really have any difficulties getting people there every week, we don't have difficulties getting buy-in from the offender managers, we don't have difficulties generating…	
Participant 1: And the sex offender having some… a degree of clarity because it's a bit of a compromise issue around sex offenders at the moment. And (umm) it… it can be a factor for some group members whether they're in a group or not with other sex… you know people who've committed sexual offences. So that does… then an issue that's arisen on occasion. (umm) **Interviewer:** So the system, there's a lack of clarity around it or? **Participant 1:** Well for the group members to know well… are they coming to a group where there's going to be sex offenders or not. (umm) And that's been a sensitive issue for one or two people, they… they've… when it's emerged that one of the guys had committed a sexual offence, (umm) that would… well I think that finished off a couple of people's attendance and they exited the group. **Participant 2:** Yeah, exited, yeah. **Interviewer:** But so do you mean lack of clarity for the actual offenders or… because I thought you meant lack of clarity in terms of you didn't… you weren't sure whether or you accept sex offenders. **Participant 1:** (umm) Well… well we know what the criteria are, but they're a bit of a fudge.	Difficulties with criteria changing so that sex offenders were allowed in group.

Interviewer: Yeah. **Participant 1:** So… so… you… you… it would be very clear if there were no sex offenders on the MBT project. And that would be a lot of clarity. And that's how a lot of the offenders are used to working, so if somebody… you're either on a you know sex offender or you're either in (umm) Ball, whatever it's called or not. So then typically they're working with real clarity, they know whether they… it's a group for violent offenders or sex offenders. (umm) Or they know area the prison is in, (umm) in the MT project it's less quite. So you may have somebody in the group and it slowly emerges then that the… the other participants had assumed that it wasn't a sex offender group or a sex offender focussed group. And it's emerged that one of the other participants has a history of sexual offending and… and you know the other two have dropped out. So I guess it does bring more people into the project, but potentially it… the risk of losing some people in terms of those more traditional mentalities. And that… that was an issue that I rose in supervision because I… I had some opinions about that (umm) that weren't necessarily shared with the supervisor in terms of having somebody who's been the victim of sexual abuse on the group and whether they should be obliged to take part in discussions about… about sexual offending and that kind of thing. **Interviewer:** So yeah just say a bit more about that because that would be one of the things you might think that might help or make it better or improve the whole project, in terms of what… **Participant 1:** Sorry, I'm not… I'm not really saying one thing or another really. It… it's (umm) I… but I do think if… if you've been the victim of sexual violence and you're taking part in a group therapy programme, I think it would be reasonable to request some clarity around whether you'll be treated with people who've committed sexual offences or not. **Interviewer:** So you think we should be upfront about it at the start that as a group… which may include men with sexual offences? **Participant 1:** Yeah. So… so the rules have changed a little bit over the time of the group, so I… I'd given some assurances to the gentleman in question that… that he wouldn't be treated with sex offenders. So one	

of the question he asked you know 'Is this a group of sex offenders?' and I said 'No'. **Interviewer:** Right. **Participant 1:** (umm) And… but the… the treatment trial issues changed over time so he was still in the group and then it emerged that one of the other people who been set on the group was a sex offender. **Interviewer:** Right **Participant 1:** So while I have a very sympathetic stance to his situation, (umm) but didn't really feel that was very effectively sort of discussed or supervised. **Interviewer:** What actually happened then for… in that particular case? Did they both stay in the group or? **Participant 1:** No, he left the group, yeah. **Interviewer:** Which one left the group? **Participant 3:** Or got recalled. (umm) The sex… the sex offender got recalled and then it was all the in the papers and then the other guy knew and he left. **Participant 1:** Yeah, in… in really quite angry sort of… **Participant 2:** Yeah, he was not happy was he? Because he felt he'd been lied… or he had been lied to, yeah, or he felt he'd been lied to. **Participant 1:** Well he'd definitely been lied to, so yeah. So I… I… and that was… I kind of… I don't know I (*laugh*) ever since then… **Participant 3:** No, you haven't, yeah. **Interviewer:** Oh really. **Participant 1:** Yeah. So I… I took a backseat at that point as well.	

Interviewer: Oh dear. Right. **Participant 1:** Yeah. **Interviewer:** But regardless of the sort of you know specific issues, you feel… happy, feel in general that that there should be… it should be clearer, men should know. **Participant 1:** I think it would have been really helpful at the start to think through so it didn't put me in the situation of assuring people that he wasn't going to be treated or talking about sensitive issues for himself in a situation where there would be sex offenders. So it put me in a very compromising kind of position as well. So (umm) I… **Interviewer:** All this stuff is very useful to me hearing about all this… **Participant 1:** Well I… I don't think anybody wanted to (umm) see that situation arise. It was… it was just something that did arise and… and maybe that would be good learning for future trials. **Interviewer:** Yeah, yeah. **Participant 1:** Just add a bit of clarity. **Interviewer:** Exactly as the aim of these interviews! **Participant 1:** Yeah. **Interviewer:** Yeah. **Participant 1:** So in terms of future trials, I think it would be good to have that… that policy fairly well explored prior to… so that anybody participating in the trial, asking those kind of questions, could have real clarity around the situation. Changing those rules about the… the attendance of sex offenders and non-sex offenders during the treatment trial was for me a bit of a (umm) well put me and the gentleman in question in a difficult situation.	

Step 3: Search for themes

I then grouped these initial codes into a shorter list of codes, for example, the following 8 initial codes from the interviews mentioning difficulties in recall are grouped under the overall code recall:

- Recall a problem. Offenders have a lot of restrictions post-release. MBT try to offer alternative to recall (Site 11)
- Many APs are risk focussed, not psychologically minded and may recall offenders for small breaches (Site 10)
- Getting enough people in group when half lost to randomisation, then half of those randomised to MBT lost to recall (Site 6)
- Recall and reoffending. Try to mitigate by writing reports saying he's in MBT. Helps knowing people in PD pathway to support this (Site 4)
- Challenge keeping men out of prison, not being recalled (Site 12)
- Men recalled or drop out (Site 1)
- Recall is a problem, especially by AP staff over minor things. Trying to help with that by going to APs and doing formulations with them (Site 9)
- Offenders being recalled or going AWOL (Assistant psychologists)

I then identified initial potential themes amongst these codes, gathering all codes relevant to each potential theme.

For example, the following codes were grouped under the theme:

'*Hard to engage, distrustful, chaotic population with attachment issues'*

- Focus on trial detracts from focus on clinical work, and interferes with developing therapeutic alliance/engagement – especially in men with attachment difficulties
- Chaotic, substance misuse
- Recall/reoffending
- Not thinking they need treatment
- They don't like ASPD label – what to feed back to them
- Don't like doing SCID, or are dishonest so don't meet threshold although team know they are ASPD

- Think they are being used as guinea pigs
- Reluctance to be filmed/ worried about confidentiality and distrustful as to what will be fed back to their OMs
- Difficulties for men coming for therapy in a probation setting
- Don't want GP knowing
- Don't like doing groups
- Upset when randomised out
- Don't believe randomisation is really random
- Being randomised out may have negative effects on their behaviour
- Not on licence or post-licence
- Not knowing results of trial so nothing to feed back to men
- Men straight out of prison too unstable for treatment
- Offenders may have serious mental health issues – e.g., self-harm – difficulty liaising with mental health services
- Non-trial men not getting vouchers
- No GP, GP moved
- Facilitators change each week so no continuity

I then collected these themes into fewer superordinate themes. For example, the theme mentioned above, '*Hard to engage, distrustful, chaotic population with attachment issues'* became a subordinate theme under the superordinate theme '*Attrition: difficulties in engaging and maintaining antisocial men in trial'.*

This resulted in the following 4 superordinate themes and their respective subordinate themes in relation to challenges and obstacles identified:

1. Attrition: difficulties in engaging and maintaining antisocial men in trial
   a) *Hard to engage, chaotic, mistrustful, population with attachment issues*
   b) *Problems with the MBT model/treatment*
   c) *Expert by experience*
2. Lack of support from probation
   a) *Randomisation*

b) *Confusion re whether on licence or not, how to enforce, how to present to participants*
   c) *Staff too busy or overwhelmed – high caseloads – to prioritise MBT*
   d) *More active resistance*
3. Problems with trial co-ordination and delivery
   a) *Communication*
   b) *Difficulties for RAs*
   c) *Inclusion criteria and measures*
   d) *Problems within local sites*
4. Systemic issues
   a) *Turbulence of system/malfunctioning*
   b) *Antitherapeutic culture/active resistance*

I also listed all the codes which pertained to what was thought to be helpful and what would improve the trial.

Step 4: Reviewing themes

I then spent some time reviewing, modifying, and developing the preliminary themes identified in Step 3 above to see whether they worked in relation to the coded extracts. I tried to generate themes that were coherent and distinct from each other by considering whether the themes made sense, whether they overlapped, was I trying to fit too much into a theme, and whether there were further themes and subordinate themes that I had not identified.

I started by seeing which of these themes were most the most frequently cited, by rating the frequency of initial codes which fit into the codes, superordinate themes and subordinate themes. The numbers refer to the number of codes within each superordinate theme and subordinate theme. For example:

Superordinate theme: Attrition: difficulties in engaging and maintaining antisocial men in trial (126)

Subordinate theme: *Hard to engage, distrustful, chaotic population with attachment issues (67)*

- Recall/reoffending (8)
- Focus on trial detracts from focus on clinical work, and interferes with developing therapeutic alliance/engagement – especially in men with attachment difficulties (6)
- Chaotic, substance misuse (6)
- Upset when randomised out (6)
- Reluctance to be filmed/ worried about confidentiality and distrustful as to what will be fed back to their OMs (6)
- They don't like ASPD label – what to feed back to them (5)
- Facilitators change each week so no continuity (5)
- Don't like doing SCID, or are dishonest so don't meet threshold although team know they are ASPD (3)
- Not on licence or post-licence (3)
- Don't like consent or PIS form (3)
- Offenders may have serious mental health issues – e.g., self-harm – difficulty liaising with mental health services (2)
- Men disappointed no group (2)
- Think they are being used as guinea pigs (2)
- Being randomised out may have negative effects on their behaviour (2)
- Difficulties for men coming for therapy in a probation setting (1)
- Not thinking they need treatment (1)
- Don't want GP knowing (1)
- Don't like doing groups (1)
- Don't believe randomisation is really random (1)
- Not knowing results of trial so nothing to feed back to men (1)
- Men straight out of prison too unstable for treatment (1)
- Non-trial men not getting vouchers (1)
- No GP, GP moved (1)

I then checked if the themes worked in relation to the coded extracts across the entire data set by first re-reading through all of the transcripts and adding more codes, and re-rating the frequency of superordinate themes and subordinate themes across interviews.

I then reviewed, revised, and defined all the codes and themes further. Codes that occurred less frequently in the text (fewer than three times, as illustrated above) were removed. Codes which referred to emotionally charged statements were highlighted e.g., feeling shame and anxiety when the team see their low target figures, feeling demoralised when men don't turn up, the site or the OMs feel isolated, feeling demoralised when there are small group numbers, or the assistant psychologist feeling belittled by others. Codes, including those pertaining to what was thought to be helpful and what would improve the trial, were then re-distributed in revised superordinate themes and subordinate themes. These changes were:

- A new superordinate theme was created called *'Staff too busy/overwhelmed'* which included the sub-theme *'Staff too busy or overwhelmed – high caseloads – to prioritise MBT'* originally listed under probation, as well as other codes that had been listed under the subordinate themes '*Difficulties for RAs', 'Inclusion criteria and measures'* and *'Problems within local sites.*' This new superordinate theme included the majority of emotionally charged comments.
- The superordinate theme '*Lack of support from probation'* was removed and its subordinate themes were subsumed under the other superordinate themes - shifting '*Randomisation*' to the superordinate theme *'Problems with trial methodology';* shifting *'Confusion re whether on licence or not, how to enforce, how to present to participants'* (renamed '*Problems with licence conditions'*) to the superordinate theme *'Problems with trial methodology';* shifting *'More active resistance'* to the superordinate theme *'Systemic issues'.*
- The superordinate theme *'Problems with trial co-ordination and delivery'* was replaced by *'Problems with trial methodology'*
- The subordinate theme *'Problems with communication'* was subsumed under the superordinate theme *'Staff too busy/overwhelmed'.*

This resulted in reorganising the data into the following 4 superordinate themes, and their respective subordinate themes, listed in order of the frequency which they were cited (number of codes). The numbers refer to the number of codes within each superordinate theme and subordinate theme. This is also illustrated in a thematic map (See figure 2).

1. Attrition: difficulties in engaging and maintaining antisocial men in trial (101)
    a) *Hard to engage, chaotic, mistrustful population with attachment issues (58)*
    b) *Problems with the treatment intervention (35)*
2. Staff too busy/overwhelmed (80)
    a) *Not enough time (25)*
    b) *Staff turnover/lack of staffing (22)*
    c) *Lack of support from central team (21)*
3. Trial methodology (68)
    a) *Problems with randomisation (28)*
    b) *Problems with licence conditions (14)*
    c) *Other problems*
4. Systemic issues (58)
    a) *Turbulence of system/malfunctioning (29)*
    b) *Antitherapeutic culture/active resistance (29)*

Figure 2: Initial thematic map of obstacles encountered by the MBT teams in implementing the trial

Step 5: Defining and naming themes

However, when I started to write up the results, re-reading the transcripts and reviewing the codes, I became more aware of how many emotive statements there were, mostly subsumed under the superordinate theme *'Staff too busy/overwhelmed'*, but also cutting across the other main themes. I therefore decided to rename the theme *'Staff too busy/overwhelmed'* with *'Emotional impact of* work', under which there were three subthemes – *'Lack of staff and time', 'Lack of support within RCT'* and *'Working with antisocial men'*. This superordinate theme *'Emotional impact of* work' now became the most dominant, both in terms of number of codes contained within it, but also in terms of its emotional salience. This theme overlapped to some extent with one of the other superordinate themes, 'Systemic issues', as the stresses on the probation officers were often attributed to the turbulence of the criminal justice service. However, this theme was differentiated by being specific to the impact and subjective experiences of the work for the individuals involved in the RCT and in the wider system.

It also made more sense to remove *'Problems with treatment intervention'* from being a subordinate theme to *'Attrition'* to being a main theme in its own right, as not all the issues regarding the intervention directly impacted on attrition of men from the trial. The main theme *'Attrition: difficulties in engaging and maintaining antisocial men in trial'* was then subdivided into 3 subthemes: '*Unstable, chaotic and paranoid',* '*Attachment difficulties' and 'Practical difficulties'.*

This resulted in the final thematic organisation of the data:

1. Emotional impact of work
   a) *Lack of staff and time*
   b) *Lack of support within RCT*
   c) *Working with antisocial men*
2. Attrition: difficulties in engaging and maintaining antisocial men in trial
   a) *Unstable, chaotic and paranoid*
   b) *Attachment difficulties*
   c) *Practical difficulties*
3. Systemic issues

   a) *Turbulence of system/malfunctioning*
   b) *Antitherapeutic culture/active resistance*
4. Trial methodology and delivery
   a) *Problems with randomisation*
   b) *Problems with licence conditions*
5. Problems with the treatment intervention
   a) *Group format*
   b) *MBT model*
   c) *Problems with expert by experience*

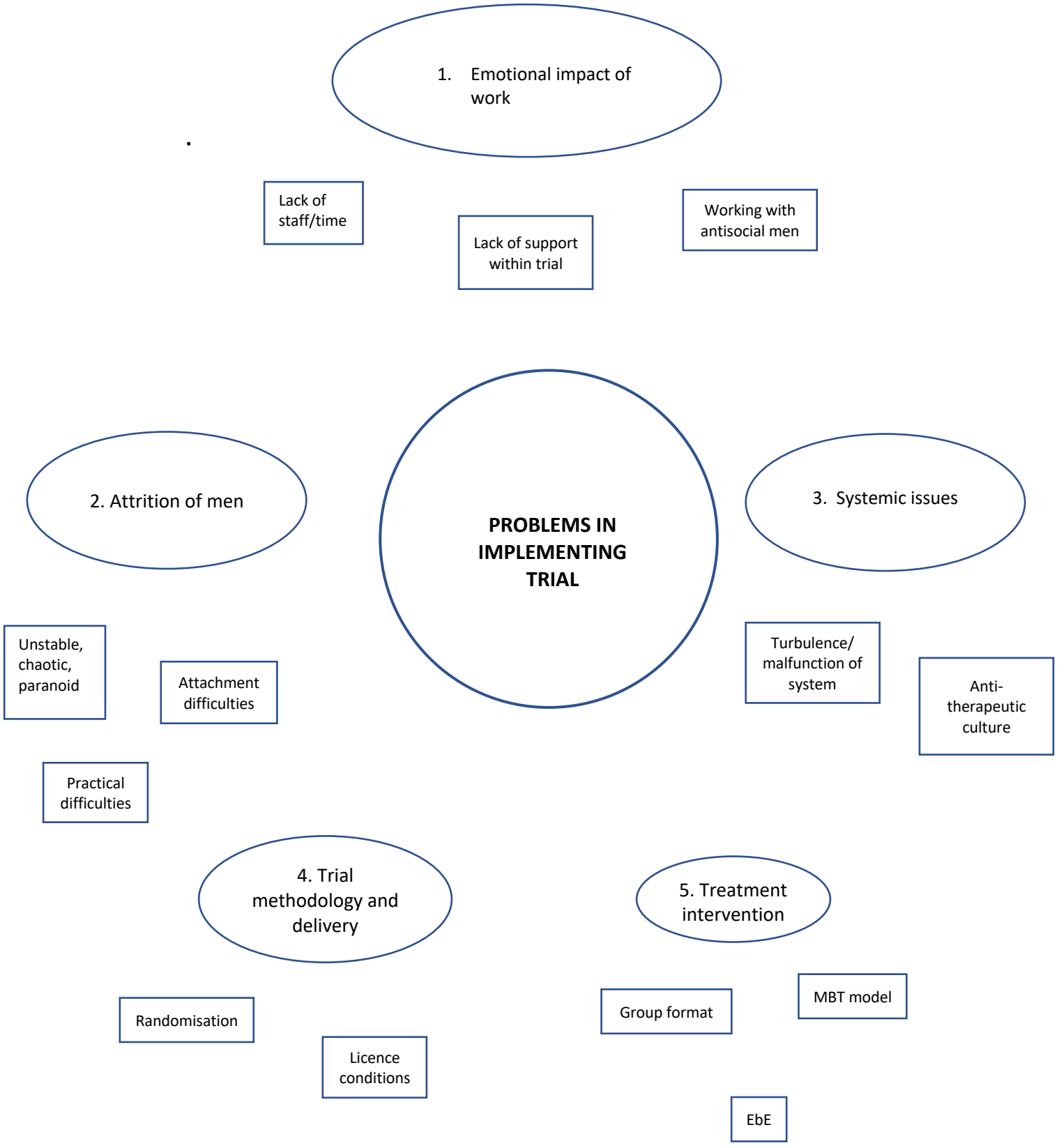
Step 6: Producing the report

In the final phase of the analysis, I re-read the transcripts and collated data extracts, selected vivid extracts of text to illustrate each of superordinate themes and subordinate themes, and organised them into a coherent account, which was then written up in narrative form, linking to the research question and related literature.

6.3 Results

The qualitative analysis of the 19 interviews produced the following five superordinate themes and their respective subordinate themes, presented in a thematic map (figure 3).

Figure 3: Final thematic map of obstacles encountered by the MBT teams in implementing the trial



6.3.1 Emotional impact of the work

Working in a financially constrained system in constant flux inflicted a heavy emotional toll. Many of the staff involved in implementing the trial were described as being overworked or overwhelmed by the tasks and conditions in which they were working. These stresses were felt both by the people involved directly in the trial i.e., the MBT teams and research assistants, and the offender managers working in the wider probation service who were needed as the main source of referrals to the trial.

6.3.1.1 Lack of staff and time

A few sites complained about being overworked due to being short-staffed in their own MBT teams, often due to difficulties in attracting suitable candidates who were willing to work only one day per week on the project. However, the majority of comments in the interviews concerning the negative impacts of high staff turnover and poor staffing levels referred to the offender managers on whom they were reliant for referrals and support of their clients in the trial.

MBT offender manager: So, a lot of more experienced probation officers have been… gone into those roles because they've like actually… it's a bit more predictable or something like this or they fancy a change in jobs or… with the creation of the National Probation Service, there's been a lot of different project jobs that have gone up. So, a lot of experienced probation officers have gone then for different jobs and promoted or gone sideways into different certain things. So, there's just generally been a lot of movement of staff. I mean they massively underestimated the amount of probation officers they needed for the NPS. (umm) *Which… so combined with people just leaving because they're fed up, people getting…moving and all this kind of stuff.*

Lead MBT therapist: And people going off sick with stress.

MBT offender manager: People going off with…

Lead MBT therapist: There's been so many probation officers who've gone off with stress and then everyone else's caseloads get bigger (MBT team interview, site 2).

There were many complaints from members of the MBT teams of not having enough time dedicated to the MBT project, often attributed to only working one day per week, but also having to cover a large area in some of the more rural sites. A recurring theme was of not having enough time to do the clinical work, including time to engage the men into treatment.

Lead MBT therapist: (laugh) (umm) She talks about the (umm) the rewards of being an MBT therapist on the trial is limited! And (umm) because you're not like… and I guess this is from the perspective of a psychologist… a clinical psychologist, so your rewards are generally in terms of therapeutic work. And because the… that's limited at the moment. It… it involves mainly chasing OMs and recording information and… (umm) yeah.

The research assistants reported daily stresses due to the limited time available to them, including having to travel long distances to see trial participants at the sites outside London, difficulties in arranging appointments with the men at times which they could make, men not turning up after the they had travelled a long way to see them and therefore follow ups getting missed, having no food expenses and difficulty accessing emails remotely.

Research assistant: Yeah, I've said before as well I would be able to follow up my participants more effectively if I had more time. Because the amount of time it takes to get in touch with the offender manager, get in touch with the participant… and you can't access all the information that you need if it's on the UCL computers. So, it's like more organisation to make sure you've got someone's name, someone's telephone number and then you might be in between the trains… changing stations and trying to find a quiet room to make a phone call and you've got tannoy speakers everywhere at train stations! It's quite impossible to organise follow-ups and stuff. When you're out in the field. (Research assistants' interview).

6.3.1.2 Lack of support within RCT

Negative perceptions and experiences of feeling unsupported by the central team which co-ordinated and managed the sites, and/or the research team, were prominent.

Many interviewees described feeling confused by changes in guidance throughout the trial. Another common source of irritation concerned communications from the central coordinating team in the form of too many long and dense emails, their negative tone, and not always being clear as to who they were from.

Powerful feelings of being personally criticised or exposed by the research team were evoked when they were not achieving their recruitment targets or not being given enough positive feedback.

Lead MBT therapist: Yeah, I'm just thinking also that you said earlier about sort of the email of shame almost as it is! (laugh) It isn't… and it's not that, it's not intended to be that, but there is almost every time you see that email from the centre, I get this kind of anxiety and I'm like oh my God where are we going to be this time? Are we going to be at the bottom? And (umm) when did I… I'm not sure that that's necessarily helpful. When you're at the top it's great because you can 'Oh we did really well!' (MBT team interview, site 6).

MBT therapist: .... I feel like (sigh) this is just a personal thing, I'm not speaking for the others, but I feel like …I feel like there's not much appreciation of the difficulty of managing those guys in a room and then trying to do MBT on top of that. So (umm) we get a bit in the all-sites stuff don't we, where people go 'Oh that looked really hard' and that, but it… other than that it doesn't… it doesn't feel like other people are saying that there's much acknowledgement of just how hard it is to even get them in the room and contain that. (MBT team interview, site 3).

The assistant psychologists described particular stresses that they felt were linked to their role, including feeling pressured by the rest of their MBT team to get offenders into the group, feeling disjointed from the other team members due to being in different locations at different times, feeling belittled by others as they were young and had the lowest ranking occupation, and not getting replies to their emails as it was clear from their signatures that they were assistant psychologists.

Assistant psychologist 1: I think as an assistant when I was… I'm not doing this presently which is fair enough, but when I was doing it, I think I've kind of… I don't

know if this is just me personally, but I kind of… there was a little bit when… when like nobody would turn up to the group and you'd get the therapist and they're like 'Oh God! This is such a waste of time!' And you'd be like 'Ok, I'm sorry, it's me who's supposed to be getting them in and I haven't done enough'. So I think that was for me like sometimes it was just you'd feel like… and I can see that in the assistant that's taken over my role now, she feels very pressured to… to get people in and I think that's been like a stressor for the job in a way, maybe not an obstacle but the stress of it…that (umm) and that feeling that you know you need to see more people, you need to find more people which is a good thing, but also kind of more stressful.

Assistant psychologist 2: I think for me another thing is that feeling quite disjointed from the rest of the team because we're all at different places, sometimes we only come together once a month (umm) so we… we all… we're all kind of operating separately and just communicating via email maybe… we might overlap at probation before the group maybe for like an hour before. (umm) So yeah not having that kind of face-to-face time to talk about thing, and lots of email chains going round and it getting a bit confusing like where are we at with this guy, who even is this guy, like we can't remember who he is… not having access to the database unless I'm at probation to kind of look over things. (umm) So yeah, those (umm) logistical things. (Interview with assistant psychologists).

6.3.1.3 Emotional impact of working with antisocial men

Efforts to engage antisocial and violent offenders, many of whom were ambivalent or resistant to being treated, provoked feelings of dejection and resignation in the MBT teams.

Lead MBT therapist: When you're getting nobody turning up, you know particularly, you know, on winter evenings, you're staying in to run the group and nobody's there. It does start to have a bit of an impact on… on the team about feeling about… you know really wanting the group, but then it not happening and that… that… I mean it didn't impact in terms of us not being there. But (umm) you start to kind of then anticipate… spending time anticipating whether people are going to turn up and… you know sat in that room many evenings till half past six… (laugh) going 'No one here!' Yeah. (MBT team interview, site 7.)

Retaining hopefulness and positivity when confronted with the trial participants' opposition and antagonism towards therapy was challenging for the therapists.

MBT therapist: So, I think that… I think that's been a… I think the difficult… the challenge, all these barriers and challenges to getting the group off the ground and all those… penetrate through to staff as well, so I think it's really difficult to keep the… when you're not having as pertinent as a professional unit, in terms of you're not having these positive reinforcements of feeling you're having… engaging an effective treatment, that can be quite difficult.

Lead MBT therapist: … you've got to try and maintain some kind of optimism for… for the therapy in the face of that constant hostility so you've got to have quite a lot of buy-in to them. (MBT team interview, site 4).

On the other hand, the palpable disappointment of those men who wanted treatment, but were randomised to the PAU arm of the trial, made some MBT team members feel demoralised and disengaged themselves from the process of facilitating men to enter the trial.

Lead MBT therapist: And it's tough when people are randomised out as well. It's hard to pick yourself up and assess the next one and you do find yourself becoming a little bit more detached in the assessment process… (MBT team interview, site 2).

There were, however, several, spontaneously offered, positive comments about their experience of involvement in the trail, which conveyed the presence in the teams of more pleasurable emotions, and a sense of belonging and optimism.

MBT therapist: But (umm) particular with [the neighbouring site] and with [site MBT supervisor] as well, it feels like we are a bit of a gang, I think! [LAUGHTER] And I think… but I think that's really nice. And (umm) [site MBT supervisor]'s been really accessible as well I'd say. I'd say when we've emailed him with things, he's always got back and (umm) it's (umm) that… so that, it feels like a bit of a family which is really… really valued. (MBT site interview, site 6).

Assistant psychologist: For us one of the best things is having an offender manager who is really on it as well. So, like they kind of be the bad cop for you in a way, they're like 'Oh he's missed an appointment, I'll get him in' or 'I'll do this' or 'I'll…'and you know you can… almost like oh wow, I didn't even have to say anything! That's amazing! So, I think for us it's like… yeah, I guess making the… or the offender manager's excited about MBT. (Interview with assistant psychologists).

6.3.2 Attrition: difficulties in engaging and maintaining antisocial men in trial

The second most prominent theme which became evident from the analysis of the data was the challenges in engaging the participants in the trial and preventing them from dropping out. This attrition was for the most part attributed to the offenders' problematic behaviours, antisocial lifestyle and disturbed pattern of relationships, and to a lesser, but still significant, extent linked to the practical difficulties of time and distance in relation to the assessment and treatment.

6.3.2.1 Unstable, chaotic, and paranoid

The personality difficulties of participants with a diagnosis of ASPD presenting challenges to engagement was a theme that came up in all of the interviews. The men's lives were portrayed as chaotic and clinically unstable, with problems of substance misuse or other mental health difficulties such as anxiety or self-harm.

MBT therapist: Have we talked about like the nature of (umm) the men in themselves? It's not necessarily conducive to things that require structure and getting people into appointments sometimes, getting people to group on time, you know they lead very chaotic lives, we're chasing up… chasing them, they're sort of avoiding us a bit! (laugh) And then sometimes fluctuating with a bit of dependency and managing that from an organisation… basic organisational level is… like for example the man that just arrived now! (laugh) He's three hours early because he couldn't remember when he was supposed to come (MBT team interview, site 10).

Several sites mentioned strategies they employed to remind the men of their MBT appointments and encourage them to attend, including being in regular contact by phone, having three-way meetings with the offender, their offender manager and a

member of the MBT team, and their offender manager arranging their regular appointments with the offender on the same day that the MBT group took place.

The men were frequently described as paranoid, for example, being worried about confidentiality, and how much of what they said in the assessment or in the group therapy sessions (which were video recorded) would be fed back to their offender managers.

Assistant psychologist: Yeah, but with… with other people I've had very… they've been quite paranoid about…Especially on a SCID sort of like before the age of fifteen did you steal something or something like that? I think now I've learnt just to maybe say to them that if you tell me you stole a chocolate bar it's now not going to get reported or something! And that it's… it's for research. (umm) So I think that sometimes does help. But then still I think they are… they do just get quite paranoid about some of the questions that you're asking them. Whether it would get back to their OM or the police.

MBT therapist: I have to reassure during the SCID as well. I think they thought I'd report it to the police! (laugh) (MBT team interview, site 4).

Awareness of the participants' lack of trust and anticipation of them misinterpreting their intentions influenced in turn how the MBT team and research assistants interacted with the men, making them more cautious about what they fed back to them about the findings of the SCID. There was particular concern about the participants receiving a formal diagnosis of ASPD in that it might be experienced as a stigma or prevent them from receiving future therapeutic interventions due to the perception that they were untreatable.

MBT therapist: But I do also (umm) have a bit of an issue around you know personality disorder diagnosis and ASPD diagnosis in general, what that means and how to discuss it with people. And I know it's part of MBT-I, but I think it's an ongoing challenge. (umm) And I'm not sure whether we talk about our personal position and feelings about it often enough as clinicians as well which might then translate into

mixed messages to the service users. So, yeah, a bit of a problem. (MBT team interview, site 10).

There were also concerns that the participants were dishonest as well as distrustful, for example, not being honest in their responses to questions on the measures of personality disorder or violence, which at times meant that they didn't meet the threshold for being accepted into the trial, even though it was known from their records or offender managers that they were suitable. Reoffending was another obstacle hindering the men's retention in the trial when it resulted in being recalled back to prison.

One positive aspect of the trial that was mentioned by two of the sites in relation to recall was that unlike other treatment programmes, if they were recalled and then released within a few months, the men were allowed to return to the MBT group and make up the time spent in prison by adding this on to the length of treatment, this providing a sense of continuity and care.

6.3.2.2 Attachment difficulties

There were many references to the men having attachment difficulties which contributed to their lack of engagement in the trial. Several sites reported that they felt pressured to focus on recruiting men at the expense of time and attention spent on the clinical work, notably in being able to develop a therapeutic alliance with men who were so distrustful of attachments and relationships.

Lead MBT therapist: And we've had people who've been randomised in who probably haven't been as attached to the group as people who had assessments previously, by the point of being accepted on to the group so then we lose them very quickly if it's not exactly what they thought it was going to be. So, we… we've had people drop out very fast at the start of a group. (umm) Where I think possibly previously when there's longer assessments and things, a bit of an attachment is built up before you start. (MBT team interview, site 2).

Randomisation also presented a problem in that the therapists were wary of fostering engagement with participants at the assessment stage in order to avert

disappointment or anger in case they were not randomised to the treatment arm. Others worried about not being able to provide sufficient continuity of care when the participant would see a different member of the MBT and research teams at each stage of the assessment, and then if randomised to the treatment arm might have to get to know several different members of the treating team, who alternated or rotated as therapists in the MBT group therapy sessions.

Assistant psychologist: Because I think it is difficult for the client as well when they come into every session and there's a new person and you ask very personal questions. Because when you have that time to build that trust a little bit, they might feel a bit more able to open up. But yeah.

MBT therapist: And ultimately we're working with people with interpersonal relationship difficulties and attachment problems and we're going from one different person to another. So… quite difficult. Yeah (MBT team interview, site 9).

MBT offender manager: I think there is a problem with the facilitation model in some ways, but I think it's probably the best of… so I think the problem is that you don't have the attachments and there's a sense that we're expecting them to commit to every group, but we don't. And there's… I think it has worked better when maybe they just did a long stretch. However, the benefit of that is that if people are saying it, you can easily rotate people in, people get more experience… so there's pros and cons of both models. But I think there's an effect on cohesion and if we expect them to commit and we don't commit to every group, and… (MBT team interview, site 2).

6.3.2.3 Practical difficulties

Attrition was sometimes attributed to the practical difficulties of living too far away from where the group was held, particularly in those sites covering large rural areas, or the group being held at a time when the participant was working.

Assistant psychologist: We've lost quite a few people like mid-way through as well. So, they've started MBT and they… they're doing it and then they're like 'Oh I've got a job, sorry, won't be back next week' and all of a sudden your group dynamics have changed (Interview with assistant psychologists).

Several of the sites mentioned how much easier it would be if the treatment intervention was being rolled out in prisons where attendance at the group could more successfully be encouraged or enforced with incarcerated offenders than for those on licence living in the community.

Attrition was also linked to the men not liking the group format of treatment and therefore dropping out, and to losing some of those men who came to the end of their licence period during their treatment or follow-up period. These problems can be seen not as a manifestation of the participant's difficulties in engagement due to their inherent mistrust and attachment difficulties as described above, but because concerns about the group structure came up several time in the interviews, this formed a separate subtheme in itself, under the theme 'Problems with treatment intervention' (see below).

6.3.3 Systemic issues

All of the sites spoke about encountering challenges which they attributed to wider problems affecting the criminal justice system in its entirety. These could broadly be split into difficulties which were seen as symptomatic of a dysfunctional organisation under the constant pressure of political decision making, structural changes and cuts to funding; and problems stemming from a system experienced as more actively anti-therapeutic and resistant to the rehabilitation of offenders.

6.3.3.1 Turbulence/malfunction of the criminal justice system

The RCT commenced shortly after a massive reorganisation and part-privatisation of the probation service, 'Transformation Rehabilitation (TR)', which involved splitting it into privatised companies called Community Rehabilitation Companies (CRCs) which managed low- to medium-risk offenders, and the remaining National Probation Service, which managed high and very high-risk offenders. Many of the interviewees described staff leaving the service resulting in vacant posts, and increased caseloads for those staff remaining, many of whom were less qualified than previously, all of which adversely impacted the trial.

MBT offender manager: I think from the probation side, an issue we've had is because of the huge turnover of staff, the operation in general is outside of our little team. You

know the… you'll ring… I'll ring up an offender manager and say 'Hi, have you thought about this offender coming on a programme?' and it'll be… how often do you hear 'Oh, I've only been their offender manager for three weeks, I'm not really… comfortable having that discussion at the moment'? And then you add into that that you're getting more complex cases held by less experienced staff who six months ago would never have been allocated that case. They don't have the training and experience that other people would have and their approach to offender management sometimes doesn't sit well with our approach, you know the flexibility and the (umm) you know the kind of going where the… you know going to where the offender is and that kind of thing doesn't sit with staff because they don't have the experience, and following a tick box formula… and that… its creating a bit of a conflict. But I certainly think our referrals, people who are getting into the group and engaging are all from older more experienced officers. And the people who have… you know who are held by the less experienced, less qualified staff seem to fall at an earlier hurdle for us. (MBT team interview, site 5).

MBT offender manager: I mean we've got all this knowledge what's happening in the Probation Service, it's decimated. You know the amount of numbers of probation officers is far too low at the moment. They're struggling to recruit. (Interview with offender managers).

Communication between probation offices was limited due to shortage of staff, office closures and poor IT systems which were not compatible with those in the NHS.

MBT offender manager: And I think whereas historically it would have been you know (umm) obviously some towns with a duty officer whose responsibility it was to pick up stuff that didn't get done if someone was off sick…or on leave. That hasn't happened because we haven't had that same system in… in place and… and where stuff has… where emails haven't been answered, where phone calls haven't been answered, it's just been left. And I think that… that's… that's really challenging in terms of chasing people down you know … and you know sometimes you can take two, three, four tries just to email somebody, phone them… it's difficult. (Interview with MBT offender managers).

MBT therapist: Well, this office is only open two days a week now …So if anybody is ringing in here, they're not going to get anybody! (laugh) (MBT team interview, site 12).

MBT therapist: Yeah, I think we're somewhat spoilt by our NHS (umm) background in terms of the systems that we can access, probation systems are just awful… kind of practicalities of being able to kind of… access the emails (laugh) from the NHS is… a challenge. (MBT team interview, site 9).

In other sites, suitable rooms to hold the group therapy sessions were difficult to find, or in one site unavailable altogether.

MBT therapist: So, we had the building shut down for a number of months, didn't we? At that point I think we'd have to use the term 'group' loosely because we actually only had two, but we just saw them individually for that period of time, didn't we?

Interviewer: How long was it shut down for?

MBT therapist: Three, four months …. It was a long time wasn't it? …Yeah, so we just went out and saw the guys individually in cafes and Costa Coffees and that (MBT team interview, site 3).

6.3.3.2 Antitherapeutic culture

In many of the interviews a less benign picture emerged of a system which was not only under immense strain but was one in which therapeutic efforts were more actively opposed, whether implicitly or explicitly.

Lead MBT therapist: So… I think the environment in probation is generally more worn out than underfunded and (umm) than it is health. And I think that has an influence. Because I work in groups in health, MBT groups with ASPD men in health and here, and I… do think there is a sense of feeling looked after in the health environment that is more attended to differently than it is in probation. And I feel that as a health professional coming in here. You know there's hardly ever any paper towels, there's sometimes not any water! There was no water sometimes! (umm) So those kind of

practical things, I think that's there because they kind of say something about (umm) how the person is… how the… you know the customer is being thought about! (laugh) (MBT team interview, site 10).

Lack of support for the trial from senior management was cited as a significant obstacle:

Offender manager: But because this really falls by the wayside and you have to think that a lot of senior probation officers, I think about some of the ones in [Site X] are very, very (umm) opposed. So, they're culturally, they think that you know oh psychology… they… they think it's wet, you know so there's a lot of… well they are aren't they? (Interview with MBT offender managers).

Prison staff could also be unhelpful in impeding the MBT teams', research assistants' and peer researchers' (ex-offenders trained as research assistants) access to trial participants who had been recalled to custody.

Research assistant 1: It is really the custody and it's really frustrating because we can't speak to them to try and engage them or try and find out whether they want to continue with the trial or whether it's just this time, you know or that. It's passed on down like Chinese whispers through all these different prison guards. (umm) I know I've had one situation where I was trying to encourage the person to come down and to kind of explain that we need to kind of set up a plan for how to get… because we pay them in vouchers, how they're going to get their vouchers if they're still in custody. (umm) And they… rather than repeating it how I said it, they kind of… I heard them telling the (umm) the next guard what to say and it was literally like 'Tell so-and-so to get down now or he's not going to get his money!' And it's so… they switch… they change it and make it punitive, and they make it very… and obviously when we're working with antisocial guys, (umm) antisocial personality disorder guys, I don't think giving people those ultimatums and pointing them into a corner is going to get a very positive result. (umm) So God knows what they're saying about us when we're in the cells.

Research assistant 2: …one of our peer researchers has been banned from quite a few prisons…We can't see any other reason for it other than the fact that they

obviously have realised he's from a charity which employs ex-offenders and they don't want him coming in as a visitor. (Interview with research assistants).

The MBT teams described in the interviews the efforts they made to counteract these systemic resistances in being as visible and available as possible. Thus, they highlighted how helpful it could be to do presentations and roadshows around the different MBT offices to advertise the trial; the importance of building relationships at an individual level with OMs, which was particularly facilitated by the role of the MBT OMs liaising with their OM colleagues, and the assistant psychologists sitting in probation offices; and the teams making active attempts to be seen as helpful, accommodating and pragmatic.

MBT therapist: I think… I think as a team we're quite pragmatic and we're quite flexible and I think that's probably why we haven't got hundreds of issues with… or challenges. (umm) And I know that other sites have really struggled with recruitment, and we just haven't because again we've been quite pragmatic about… and flexible in… in the approach we've taken and quite proactive... and because we're so embedded, again I think that mitigates some of the challenges. (MBT team interview, site 7).

6.3.4 Trial methodology and delivery

Two significant areas concerning the methodology of the trial were identified by all the sites as challenges to its implementation: randomisation and the use of licence conditions.

6.3.4.1 Problems with randomisation

The most frequently cited reason for concerns regarding the process of randomisation was that the offenders referred to the trial were disturbed by the prospect or result of being allocated to the probation-as-usual arm. The participant's experience of being rejected was often linked to their previous life experiences.

Assistant psychologist 1: I think in terms of telling people when they've been randomised out, (umm) I've had quite a few people say to us… say to us 'Oh so you don't want… you don't want me', 'Am I not good enough?' (umm) and kind of feeling that

sense of rejection and it kind of feels like we're repeating (umm) some of their earlier experiences of rejection.

Assistant psychologist 2: Yeah, so it sort of mirrors the experiences they've already had in the business service with forensic psychologists, where they might come in, do a little bit of work and then they're gone again. (umm) And they feel that that's what it is, they're being used as a guinea pig, (umm) a few of them have said. They become quite agitated about that and they usually… you know talk it through a bit more and it can bring them back down again. (Interview with assistant psychologists).

It was reported that many offender managers were reluctant to refer their clients due to the risk that they would be randomised out and not receive the treatment intervention, particularly in areas where there were no other treatments available.

Lead MBT therapist: Yeah, and also when somebody gets randomised out, the offender managers are probably going to be less likely to think about referring the next person because they've been through that process once, they've not really got any benefit from it for their person so in an environment where everyone's very stretched and very busy, I guess it's probably less likely to be something that they think of with future people. (MBT team interview, site 2).

Some sites were concerned at the lack of other therapeutic interventions available for men who did not get randomised to MBT.

MBT offender manager: I'm thinking hard like the let-down of when you've got someone, and they've attended these four/five sessions and you think they'd be really good for the group! And they really want to do it… and then they're randomised out.

MBT therapist: … obviously the kind of… slightly more ethical side of me would like them to have an alter… a proper alternative service just to make that seem fair, or like a waiting list-controlled group or… you know. (MBT team interview, site 2).

To mitigate disappointment, it was suggested that sites should be transparent about PAU options to the participants at the beginning of the assessment, and that

sometimes the assessment in itself could be therapeutic even if the person was then randomised to PAU.

Others felt that randomisation limited the rate of recruitment to the MBT group.

MBT therapist: Well, the… the obvious [challenge], the big one is getting enough people into the group because we lose people through randomisation. (MBT team interview, site 6).

6.3.4.2 Problems with licence conditions

Many members of the MBT teams felt uncertain about whether participants who had been randomised to MBT should be mandated to attend group treatment or were confused at the options regarding this issue that were permissible in the trial. These concerns particularly came up in the interview with the MBT offender managers.

MBT offender manager: Because it feels like a headache it's that oh MBT this feels like… it's not so clear. (umm) I've got to do a lot of work on engagement, do I enforce, don't I enforce… this is… it just feels like a headache. Whereas other programmes don't because the parameters are set. (Interview with MBT offender managers).

MBT offender manager: I think it's sort of… the nuances are just delivering to this group of people… like delivering this therapy to this group of people in the community… it's… it's such a challenge to… just to get that… those people in a room without some level of kind of coercion… (Interview with MBT offender managers).

A repeated anxiety was uncertainty about how to enforce the licence condition if the offender didn't comply by not attending the group. Although the trial guidance was that offenders should only receive warnings or be recalled if there was concern about his behaviour in general (e.g. missing other appointments, breaching hostel curfews, substance misuse, re-offending) and not just in relation to his attendance at the group, MBT teams remained concerned that the trial participants' offender managers would rigidly enforce attendance at MBT as a statutory intervention, as is the case with other mandatory probation treatment programmes, and not be able to address the issue flexibly.

MBT offender manager 1: …MBT isn't seen in the same way than other interventions are seen in terms of enforcement, it isn't as black and white, OMs have different views about it, SPOs have different views about it. … it's not as clear (umm) how (umm) how we are… what the enforcement strategy is, and I think there's an anxiety about ending up with recalling somebody to prison for not attending MBT. We don't want that to happen, we want to maintain that sort of therapeutic model and… and I think that leaves OMs and various other people in a greyer area about how they utilise the intervention in a way that they're not so concerned about… with things like the in-house stuff probation, where they know two misses and you're out and… so I think there's…

MBT offender manager 2: Yeah, the flexibility of MBT and (umm) in terms of the engagement side of it, allows us to tolerate actually the difficulties these guys face in terms of engagement, but I just think it's that grey area about how… I suppose… and that'll be sometimes how we communicate it. I wouldn't say that we communicate it as it should be, a statutory intervention. (Interview with MBT offender managers).

There were concerns that unclear guidance on the issue affected the willingness of offender managers to support the trial.

MBT offender manager 3: The thing is that… there's an added thing to it, the… the perceived sort of woolliness of (umm) the enforcement around MBT (umm) affects the OM's buy-in. (Interview with MBT offender managers).

Others, however, felt more confident about the benefits of enforcement.

Lead MBT therapist: I think it's a probation thing, we should do what probation do. Rather than from a health perspective, getting caught up in about 'Well you know choice' and… I'm always a bit… we're in the criminal justice system, choice is something that's a bit of a fantasy! So, if we think we're morally doing the right thing to reduce… you know to protect the public and… and help them, then I have no problem with using whatever! (laugh)

MBT offender manager: I know one of my cases, he was just so institutionalised and could not cope with the idea that he had choice! So it had to be because I was forcing him to do it, but even when told 'You don't have to', he would you know keep coming every week. So, I think it's dependent, isn't it? (MBT team interview, site 7).

6.3.5 Problems with the treatment intervention

Finally, several issues with the mentalizing-based treatment model and the way it was delivered were identified as obstacles to the implementation of the treatment arm of the trial.

6.3.5.1 Problems with the group format

The group format was difficult for some men to tolerate. Not being able to maintain groups of three or more participants were common experiences across sites, which not only meant that group processes could not fully develop and the treatment effect was potentially weakened, but this also caused some participants to drop out because they felt the group was too small, thus creating a vicious cycle in which it was very difficult to create a group with a sufficient number of men.

Assistant psychologist: The… I'll give you… the other one I've got I think is… that some of them had… bad experiences of groups, other groups. And then when they hear it's a group, they don't want to come as much. It's difficult to get them in. (MBT team interview, site 3).

6.3.5.2 Problems with the MBT model

Other problems specific to the MBT model cited were it not being formally an accredited treatment programme within the criminal justice system so offender managers were less likely to refer their clients to the trial; the MBT principles of treatment, and language used to describe these, were sometimes hard to understand; and the therapy was too unstructured, with unclear boundaries and less tangible compared to other psychological modalities.

MBT offender manager: …sometimes there's an issue of them wanting to get... but maybe they're more experienced in doing groups, other probation prison groups where it's more educational and they're... they might not be on the, yeah, therapeutic groups

and feeling that because they're... kind of not... or feeling that they want to kind of take something away and I guess... that they want to be able to feel that they're going through or getting some concrete... sometimes it feels like they want... they're bringing something up and they want a concrete kind of solution to their problem, they want it to be worked through...

Assistant psychologist: The unstructured nature of it as well is very... like in some ways the vagueness of not knowing what's to come in this group. (MBT team interview, site 11)

MBT therapist: I suppose you can understand this, it felt that they didn't know really what the… where the boundary was and they… we… we got feedback from a couple of people that it would be much better if we had very strict rules for their course, very strict so they knew where they stood and there were obvious consequences rather than the more kind of fluid way that we're trying to approach this!

MBT lead therapist: But they generally want very strict boundaries that apply to other people, but not necessarily… when applied to yourself. (MBT team interview, site 4)

6.3.5.3 Problems with the expert by experience

As mentioned previously, EbEs were male ex-offenders who had benefitted from previous group treatment, and whose role in the trial was to promote engagement of participants which included facilitating the group alongside the MBT therapists. Some sites were unable to find an appropriate person to take up this role; for others, their mental health trust was reluctant to employ or pay ex-offenders.

Lead MBT therapist: So, the expert by experience, I mean initially it was… we identified a couple of people, but (umm) and understandably there's systems to go through. But (umm) and it… originally this person was declined, but we sort of renegotiated an individual assessment and then they were accepted. So that didn't happen smoothly, smoothly and in addition to that I think there's things like payment of the expert by experience where there isn't a sort of standard process across the whole of the RCT. (Interview MBT team, site 13).

The boundaries of the EbE's role, particularly in relation to the participants in the group, were also sometimes unclear.

MBT therapist: But I think… but I think that in turn, so the (umm) that… the expert by experience, their needs and their life history and their ways of managing the world… I think actually their interpretation of the role and how they then… so actually… so and again because the area is so small and people know each other… there's… there's often blurring. And I think there still is with our new expert by experience, a bit of blurring between dual roles. Which I think actually we all have dual roles (umm) and our expert by experience is no different. He… he's our expert by experience, but he also works in a recruitment (umm) agency.

MBT offender manager: For recruiting offenders. So often he will have dual hats on, and halfway through a group will kind of make a mental note… you can see him get a bit of paper out and stick it on his knee ready for the end of group to… to give people information. So, there's… there's dual roles. (MBT team interview, site 7).

6.4 Discussion

6.4.1 The emotional impact of the work

Many of the impediments to carrying out the trial that were identified in the analysis of these interviews have been well described in the literature on the difficulties in implementing RCTs in criminal justice settings, such as attrition of participants, negative attitudes towards randomisation, organisational and systemic issues, and problems with the treatment intervention being evaluated. However, this study's main finding – that the most pervasive obstacle to emerge from the data was the emotional impact of being involved in the trial – is absent in the descriptions of the challenges encountered in published studies of RCTs or in papers focussing on such obstacles that arose in conducting specific trials or in RCTs in general. Although it has not been possible to conduct a systematic literature search of all RCTs conducted in criminal justice settings internationally, the literature review focussing on identifying all published RCTs that had taken place in the CJS in the UK, which is described in chapter 5, found that of those which highlighted some of the challenges of performing the trials, none explicitly mentioned emotional issues affecting the people involved.

However, although there appears to be no literature on the emotional toll of implementing an RCT due to poor staff morale, there is a substantial empirical literature, mainly based on studies in the US, examining stress and burnout in probation staff in their everyday work.

A review of the literature on occupational stress amongst probation and parole officers (Farester, 2016) showed that the consistent stressors reported were high caseloads, excessive paperwork, lack of promotional opportunities, inadequate salaries, leniency of judges/courts, lack of participation in decision making, expectations to do too much with too little time, lack of recognition for good work, inadequate support from management, lack of community resources for offenders, role ambiguity, and role conflict. Some of these factors - notably lack of support, time and resources; high caseloads; and feelings of lack of recognition of their work - were identified by the MBT teams in this current study as impediments to involvement in the trial in provoking negative emotional responses in themselves or in stress and sick leave in the wider probation staff with whom they were working. These in turn reflected the wider impact of austerity and privatisation on the culture and working practices in the UK probation service following the Transforming Rehabilitation restructuring where financial cuts, precarious working environments, unmanageable caseloads and staff shortages 'inflicted upon staff… a pervasive form of systemic workplace harm' (Walker et al., 2019 p. 113), resulting in mental health issues, work-related stress and professional dissatisfaction (Kirton & Guillaume, 2015, 2018; Logan & Ramsden 2015; Walker et al., 2019).

The timing of the planning, implementation and conduction of the RCT coincided almost exactly with the lifespan of TR. The initial planning for the trial commenced in 2013 and bids were invited for the new community MBT services in the OPD pathway which would become the clinical arms of the trial. Contracts were awarded in April 2014 and the services were set up in the 13 sites across England and Wales. The application for the funding of the RCT was submitted to the NIHR in 2015 and funding was confirmed at the end of that year. The RCT commenced in January 2016 with an end date planned for December 2020.

At the same, time in September 2013, competition for the CRCs were launched, in March 2014 all existing probation staff were allocated to the NPS or the CRCs, in June 2014 the probation service was formally split into the NPS and CRC, and the new providers started delivering the services in March 2015. By 2016, as recruitment and randomisation to the RCT was commencing, two government reports – the National Audit Office Report in April 2016 (National Audit Office, 2016) and the Probation Inspectors Report in May 2016 (HM Inspectorate of Probation, 2016c) - started to identify significant problems in TR. In September 2016, the Public Accounts Committee questioned the effectiveness of TR, and by December 2017 the Chief Probation Inspectors Annual Report found that TR was not working (HM Inspectorate of Probation, 2017). At the time of the interviews of the MBT teams in 2018, the overall staff vacancy rate of the NPS was 11%, and as high as 20% in London. There were more than 1,100 temporary staff, at the same time faced a shortfall of around 930 full-time equivalent staff (National Audit Office, 2019).

Many of the flurry of papers that have been published since TR was initiated contain emotive language with explicit mention of the emotional responses that TR had generated in the staff directly affected by the changes. These occur in statements such as:

- *The result has been at times unmanageable caseloads, giving rise to extreme stress and anxiety among probation staff and a general experience of deskilling and deprofessionalisation which has thrown many probation workers' professional identities into a state of existential crisis* (Walker, 2019, p.114).
- *While many aspects of TR have been welcomed, the split between NPS and CRC services has resulted in an exceptional level of upheaval and disruption. Whilst services will stabilise eventually, it is undeniable that uncertainty, stress, and low morale are having an impact on the openness and enthusiasm of OMs to ways of working differently with their high-risk PD clients.* (Logan & Ramsden, 2015, p. 174).
- *For senior managers contemplating moving into the CRC their sense of personal uncertainty was even more salient as a result of the frustration and resentment some harboured towards the underpinning principles of the reform programme and*

the deep anxieties they had about the future model of probation services built into the policy (Millings et al., 2019, p.63).

- *The failure of ministers to stand up for probation services made managers resentful, but just as hurtful for some was the perceived implication that only through innovation and private investment could service provision be improved* (Millings et al., 2019, p.64).
- *If the farce of diminishing the leadership was enough to impact on probation, it is a further tragedy that the organisational changes have wrought an existential crisis at the heart of the probation profession. …the warnings from voices rising above the parapet to reveal a sorry tale of the disestablishment of the Probation ideal. It can be summarised emotionally as confrontational, demoralising, and divisive* (Senior et al., 2016, p. 67).

The MBT staff also highlighted the emotional impact of specifically working with antisocial, mentally disordered, and violent men, many of whom were resistant to being part of the trial, making staff feel demoralised and less motivated themselves. Working with this population has also been identified as a factor in contributing to job stress in probation staff. For example, studies have shown that staff perceptions of the dangerousness of their work environment may influence workplace outcomes such as job stress (Hartley et al., 2013; Paoline et al., 2015); probation officers with more supervisees with mental health problems on their caseload reported significantly higher levels of depressive symptoms due to emotional exhaustion (Gayman et al., 2013); the pressures felt by probation staff in supervising a 'high-risk' caseload in the UK National Probation Service (Lee, 2017a; Logan & Ramsden, 2015; Philips et al., 2016); and vicarious traumatisation in probation practitioners following exposure to, and engagement with, their clients' trauma stories (Lee, 2017b).

The interviews of the different professionals involved in the RCT also revealed negative feelings of irritation, confusion, being criticised or being undervalued that were expressed in relation to each other. It is likely that these negative emotions were due to problems of communication and misunderstandings within the RCT treatment teams, the central project management team, the research team, and the research assistants, rather than deliberate attempts to undermine or annoy others. As described in chapter 5, difficulties of communication between the different individuals,

teams or institutions involved have been recognised as barriers to the smooth running of RCTs with the criminal justice system (Bowes et al, 2012, 2014; Newbury-Birch et al., 2009; 2014; Sherman et al., 2005; 2015).

6.4.2 Attrition

Unsurprisingly, attrition of men from the trial was found to be one of the main obstacles to its implementation in this study, which was attributed to the difficulties in engaging and maintaining men in both arms due to them being unstable, chaotic and paranoid; their attachment difficulties; and the practical difficulties of having to travel a long distance to probation offices, which in itself might be due to paranoid beliefs making them fearful of using public transport. Attrition of data is one of the most frequently cited obstacles in the literature regarding the difficulties in conducting RCTs within criminal justice settings (Farrington, 2013; Farrington & Welsh, 2005; Goldcamp et al., 2008; Labriola et al., 2010; Pearson et al., 2016; Sousa et al., 2016). This may pose a serious limitation to interpretation of the results of the trial, as non-engagement in the treatment arm may reduce the effect size of an intervention that is potentially effective, in this case MBT. Moreover, the results may be biased if the rate of attrition differs between the experimental and control groups (Farrington & Welsh, 2005). In these interviews, the staff were for the most part referring to their difficulties in engaging the trial participants in the treatment arm, as the MBT teams had no contact with men assigned to PAU, who were only in contact with the research assistants. This raises the question as to whether engagement in treatment, which is of course a prerequisite of a treatment being beneficial, may be related to the time spent with professionals rather than the effectiveness of the specific intervention.

One of the features of the ASPD participants in the trial that the MBT teams in this study cited in explaining the men's propensity for non-engagement was disturbance in their attachment systems. Interestingly, one of the RCTs identified in the systematic literature search of all RCTs conducted in the UK criminal justice system was evaluating an attachment-based group intervention designed specifically for mothers and babies in prison and aimed at improving the quality of the mother-infant relationship (Sleed et al., 2013). Incarcerated mothers have been found to have higher rates of insecure or unresolved attachment representations than community samples (Borelli et al., 2010). One of the shortcomings reported in the Sleed study was the high

rate of attrition. However, this was not attributed to the attachment difficulties of the women, but to the rapid turnover of women in the prisons as many women were on remand or unsentenced at the time of recruitment and were enrolled but released before they could be seen for follow-up.

As noted above, the staff interviewed in this study mainly attributed the difficulties in engaging and keeping the men in the trial to their problematic personality traits. However, the characteristics of the sample population which influences their participation in RCTs is barely mentioned in the literature. Exceptions include Goldcamp (2008) in his investigation of the causes of pre-assignment attrition in 13 experiments addressing problems of substance abuse in offenders in the US that he was involved in. He noted that those individuals who were cooperative with drug testing and monitoring may have represented the least challenging, least drug-involved portion of the target populations. Similarly, in his paper on longitudinal and experimental research in criminology, Farrington (2013) comments that those lost to follow up 'tend to be the most uncooperative, elusive, and antisocial' (Farrington, 2013, p. 504). Of all of the RCTs which have been conducted in the UK criminal justice system, attrition was the most common impediment to implementation cited (Bowes et al., 2012; 2014; Newbury-Birch et al., 2009; 2014; Pratt et al., 2015; Sheard et al., 2007; 2009a; Sherman 2005; 2015; Sleed et al., 2013; Watt et al., 2008), but this was often attributed to factors unrelated to the characteristics of the participants themselves, but due to resistances relating to staffing and settings, such as participants being unexpectedly transferred to other prisons (Howells et al., 2002), staff refusing to share information (Sheard et al, 2007; 2009), or not being able to offer financial incentives to encourage participation in the trial as senior police staff were unhappy with this approach (Addison et al. 2018; Birch et al. 2015). This latter trial, an RCT of alcohol screening and brief intervention in police custody suites to reduce heavy drinking and reoffending behavior in arrestees, also reported that many participants were lost to follow-up in the community due to them moving address, changing telephone numbers or erroneous contact details (Addison et al. 2018; Birch et al., 2015), but did not comment on how these obstacles might be related to particular features of their personality such as their tendency to be mistrustful of others and therefore evade detection.

There are few RCTs that have specifically evaluated treatments for men with ASPD. A Cochrane review of psychological treatments of ASPD (Gibbon et al., 2010) identified 11 prospective RCTs involving 471 individuals with ASPD, only 2 of which focused solely on an ASPD sample. Of these 11 trials only 3 mentioned any problems in their implementation, all of which were attrition (Ball et al., 2005; Huband et al., 2007; Marlowe et al., 2007), but none discussed on how participant drop-out might be due to the characteristics of the individuals within the study samples or offered recommendations of any strategies that could be employed to improve engagement. Given that many RCTs conducted in criminal justice settings will involve offenders with such difficulties this omission represents a significant gap in the literature on the challenges of implementing such trials. This may be symptomatic of one of the significant limitations of empirical research into psychological treatments for mental disorders in that many researchers are not clinicians, and papers focus on methodological issues rather than addressing clinical issues which may facilitate the transfer of the findings of trials of treatment efficacy into treatment effectiveness.

By contrast, the substantial body of knowledge concerning the management of antisocial offenders in general is replete with descriptions of the challenges of engaging these individuals in treatment. Individuals with ASPD are often treatment rejecting (Tyrer, 2003) and do not easily take on the traditional patient role (McGauley et al., 2008), resulting in behaviours such as lateness or missing therapy sessions altogether, becoming verbally aggressive and socially disruptive, frequent crises, and substance abuse (Dowsett & Craissati, 2008). Strategies frequently employed to address these issues, which may equally be used to reduce dropout in RCTs involving such individuals, include preparing patients carefully for treatment by giving practical advice, psychoeducation about their personality traits, explanation about the treatment model, fostering as collaborative a relationship as possible, help with travel difficulties and being proactive in the follow up of patients, such as calling the patient to remind him of appointments. These are all strategies that form part of the MBT model which was being evaluated in this trial.

6.4.3 Systemic issues

Staff shortages, staff turnover, high caseloads and time constraints within the MBT teams and wider probation service were factors identified as impediments to achieving

the optimal conduction of the trial as discussed above. The MBT teams interviewed also pinpointed other systemic challenges, such as poor communication between probation, office closures and poor IT systems all of which interfered with the processes of referrals, randomisation, delivery of MBT treatment and data collection. Such challenges related to the wider setting in which the trial is being carried out are well documented in the literature including in the publications of some of the previous RCTs that had been implemented in the UK criminal justice system. Thus, Wright et al. (2011), in their RCT comparing methadone and buprenorphine for opiate detoxification in prisoners, describe how data collection was slow due to access issues with key personnel at drug intervention programmes who had to prioritise their own workload before undertaking trial tasks. Newbury-Birch et al. (2009; 2014), in a cluster RCT randomising offender managers to three different screening and brief intervention groups aimed at reducing hazardous and harmful alcohol drinking in offenders describe the reluctance of some offender managers to participate in the study due to information overload and workload pressures. Meade et al. (2018), record the numerous systemic difficulties in their efforts to implement an RCT evaluating effectiveness of naloxone-on-release vs control in preventing fatality from opioid overdose in prisoners with a history of heroin use by injection, including delays in getting prison approval due to different methods of operation within each prison; lengthy processes to agree, obtain and issue research and development approval, appoint trial staff and obtain their security clearance, agree the pack prescription method and complete and collate trial accreditation documents; and slower than anticipated set-up time for new prisons.

However, some of the systemic resistances encountered by the MBT staff in this current RCT seemed less benign and were symptomatic of a more active anti-therapeutic culture within the CJS in which the rehabilitation of offenders was not prioritised. This was evident in the lack of support for the trial from senior management, prisons impeding access to trial participants who had been recalled to custody, and the failure to provide a welcoming environment where the therapy groups could take place. These more obstructive attitudes have also been documented in some of the RCTs carried out in prison, probation and police settings in the UK criminal justice system which preceded this trial. Thus Sheard et al. (2007; 2009) in an RCT comparing dihydrocodeine with buprenorphine for prisoners with opiate detoxification in

prisoners, found that collection was difficult when prisoners transferred to other prisons because some prison healthcare departments refused to share information for the purposes of the trial, leading to loss of follow up data; Craine et.al (2014), in their RCT of dried blood spot testing to improve the uptake of hepatitis C virus antibody testing within UK prisons encountered negative attitudes of prison health staff to the trial such that it wasn't clear whether they had offered the test to all prisoners; the reluctance of some offender managers to participate in a study on alcohol screening in offenders in probation due to their perceived lack of importance of alcohol misuse in their clients (Newbury-Birch et al., 2009; 2014); not being able to offer financial incentives to encourage participation in an RCT of alcohol screening and brief interventions in police custody suites to reduce heavy drinking and reoffending behavior in arrestees, as senior police staff were unhappy with the approach (Birch et al., 2015; Addison et al., 2018); negative attitudes of police towards research carried out in another police-based RCT testing an intervention intended to improve the public's perceptions of the police mentioned above (MacQueen & Bradford, 2015; 2017); and prison officers, who were responsible for delivering a tool designed to identify what help older prisoners needed to cope better with prison - the Older Prisoner Health and Social Care Assessment and Plan (OHSCAP) - in an RCT aimed at improving social care in older prisoners inadvertently describing how they did not believe that social care needed to be particularly important (Forsyth et al., 2017).

These unhelpful mindsets and behaviours of certain groups of staff within the system may be representative of a longstanding and harsh penal culture in which the prevailing approach is to punish rather rehabilitate offenders. However, such obstructive attitudes may also be in response to changes within the system that are instigated and imposed by their seniors, and which negatively impact on the staff working on the ground. Fears of recrimination may prevent their resulting feelings of resentment, lack of control and threats to their well-being being expressed towards those in charge and are instead directed towards their clients.

Even before its implementation, Transformation Rehabilitation was acknowledged by the government itself, albeit without envisaging the dire consequences, as effecting the most profound change in the structure of probation in the history of offender management services (Ministry of Justice, 2013). However, previous large-scale

organisational restructurings within the UK criminal justice service have impeded attempts to run RCTs within these settings.

In 2010, the coalition government introduced policies with the intention of reducing the full-time equivalence of staff across NOMS as a whole, which resulted in staff shortages and the reduction of specialist officer roles who had more expertise. This considerably hindered the implementation at that time of the RCT mentioned above which was evaluating an intervention aimed at improving the social care of older prisoners, as both prisoners and staff considered the prison system to be 'broken' as a result of a staffing crisis, resulting in concerns over safety, the basic needs of prisoners not being met, poor morale amongst staff, and an inability to share information and successfully collaborate with partner agencies within, and outside, of the prison (Forsyth et al., 2017).

The failings of the RCT testing the effect of 'procedurally just' modes of road policing on public perceptions of police to deliver the expected outcomes was in part attributed to wider organisational changes in Scottish policing during the trial's timeframe (MacQueen & Bradford, 2015; 2017). In 2013, 8 months before the trial started, eight police force areas were merged into a single national force, resulting in a transformation in management, governance, and accountability processes. Interestingly, these changes have been described as the biggest change to Scottish policing since the 19th Century (Terpstra and Fyfe 2015), echoing the rhetoric around TR, which was initiated in the same year. However, the police officers who were expected to participate in the trial experienced it as being imposed on them without sufficient explanation or justification to warrant changing their operational practice and expertise in the same way in which they felt the wider radical changes in Scottish policing were being forced on them. Thus, the trial compounded their pre-existing sense of organisational injustice, low morale, and lack of trust in senior management. Moreover, the intervention being tested in the trial was aimed at improving the public's trust and confidence in the police by altering officers' styles of interaction and communication by conveying dignity and respect, inviting citizen participation, and providing clear explanations during encounters with the public. Not feeling treated in a similar manner by the organisation may have made the participating officers interact

with the public in a less communicative and respectful way and this may have contributed to the negative outcome of the trial.

In a paper focused on the methodological and practical challenges encountered in another RCT undertaken in a police setting in the UK, evaluating the effectiveness of a training program for police officers in contact with people with mental health problems in reducing the number of incidents resulting in a police response, organisational issues were included as one of the most significant difficulties in implementing the trial (Scantlebury et al., 2017). During the period of the trial, the police introduced other initiatives - street triage and changes in how incidents were recorded - to assist their officers in dealing with the large number of contacts with mentally ill individuals. These changes interfered with the randomisation process as well as the trial's outcomes with the potential to dilute the effect of the intervention and undermine the trial's credibility.

Effective communication with staff within the organisational settings where the research takes place and with other stakeholders is key to addressing some of these obstacles that are contended with in conducting RCTs in the criminal justice service. Researchers may be unlikely to have any influence on policy making with regards to organisational changes at a national level but may be involved in discussions locally so that they can adjust the timing of the trial implementation or its design and methodology where necessary (Scantlebury et al., 2017). This may be achieved by ensuring that researchers attend relevant meetings and conversely that local staff are embedded within trial teams or attend regular trial meetings, which was the case with the MBT trial where the research team promoted the trial regularly in the local probation offices, and the MBT SOM was an integral member of the MBT team whose role was to liaise with probation staff who referred participants to the trial, and who could advise the rest of the team on any policy changes to the structure and functioning of the probation service, of which TR was the most significant.

In a recent multi-method study of healthcare provision for probation service clients in England which involved gathering data from a range of large criminal justice and health organisations, the researchers encountered more difficulties in gaining access to some organisations than others, which they found were due to the impact of impact of organisational resources, culture, responsibilities, change and objectives on

engagement with research (Sirdifield et al., 2019). They found that identifying and developing a rapport and negotiating with 'gateholders' was key in improving access to sites or staff. The initial gatekeeping level included the different organisations responsible for giving ethical approval and permissions to access data prior to the commencement of the trial; the second level of gatekeepers was comprised of divisional directors and chief executives within probation; and the third level were personal assistants or other administrative staff who asked for research information to be sent to them rather than directly to the directors or chief executives. They recommended developing a more personalised approach to contacting these gatekeepers, for example sending individualised information sheets and invitation letters; and that building rapport with a small number of higher-level organisational gatekeepers and engaging them at the project design stage, for example by inviting them to sit on the project steering group, was particularly important in under-resourced organisations undergoing change.

6.4.4 Trial methodology and delivery

6.4.4.1 Randomisation

Randomisation was identified as a significant obstacle to the rate of recruitment of participants in the MBT RCT. Some offender managers were described as reluctant to invite their clients to participate in the RCT due to the risk that they would be randomised out and not get the trial intervention, particularly in regions where there were few, if any, alternative therapeutic options. There were also worries voiced about how the offenders would become distressed, and more difficult to manage, when they were randomised to PAU.

Ethical objections to randomisation are frequently cited in the literature as one of the issues that hinders the successful implementation of RCTs (Boruch, 2000; Farrington & Jolliffe, 2002; Pearson et al., 2010; 2016; Weisburd, 2003) and are reflected in the accounts of the difficulties encountered in other RCTs conducted in the UK criminal justice system. These include a feasibility study of an RCT evaluating the effectiveness of an alcohol related violence intervention on reducing reconvictions in offenders, where some staff were unwilling to refer clients due to the risk of being allocated to TAU (Bowes et al., 2012; 2014); a prison based RCT evaluating the effectiveness of naloxone-on-release in preventing fatality from opioid overdose in

prisoners with a history of heroin use by injection failing to meet the accrual target due to a reticence to randomise remand prisoners (Meade et al., 2018); and an RCT evaluating a Enhanced Thinking Skills Programme versus a waiting list control group aimed at changing the self-reporting of offence-related thinking in adult male prisoners, where ethical concerns were raised about withholding treatment to those in the control group (McDougall et al., 2009). In this trial, these anxieties were overcome by providing a waiting list control group and the provision of a cohort group to fast-track priority offenders prior to random allocation. However, this resulted in a larger number of offenders than expected being included in the cohort group, potentially changing the characteristics of trial sample.

6.4.4.2 Licence conditions

Ethical concerns were also expressed in the MBT trial over the use of licence conditions. Licence conditions are the set of rules prisoners must follow if they are released with a remaining part of their sentence to serve in the community. The aim of a period on licence is to protect the public, to prevent re-offending, and to secure the successful reintegration of the individual into the community. They are not intended to be a form of punishment and must be proportionate, reasonable, and necessary. All licences contain a standard set of conditions which include good behaviour, not committing offences, keeping in touch with their offender manager, residing at an approved address and not travelling outside of the UK. Additional licence conditions may be imposed which are more specific, such as exclusion zones, curfews, and non-contact restrictions, and include 'participation in, or co-operation with, a programme or set of activities'. Offenders can have their licence revoked and be recalled to custody at any time during their licence period where the offender manager considers that they present a danger to the public.

As discussed above, one of the main challenges in the trial was engaging, motivating, and maintaining participants in the treatment arm. During the planning of the trial, it had been agreed that having MBT would be a voluntary choice for offenders and they should not be forced into receiving this treatment against their will. This was because of the assumption that participants would be less likely to be receptive to therapy if they did not possess internal motivation to change their behaviours.

However, during the implementation phase of the MBT community services, it became evident that many offenders who fulfilled the suitability criteria for referral to MBT either refused to engage in treatment at all or dropped out after they had started group therapy. These challenges led to the research team to revise their negative stance on mandatory treatment to advising the MBT teams, prior to the commencement of the trial, that eligible offenders could be mandated to attend the initial assessment for MBT. After the trial started and following intensive discussions with those involved, this advice was widened to allow MBT teams, if they thought it appropriate, and after the trial participant had been randomised to the treatment arm, to mandating him to attend not just the assessment, but the licence condition.as well, by making this a

This led to dissent and confusion amongst the MBT team and referring offender managers. Some MBT teams felt strongly that one of the positive features of MBT compared to most other treatment programmes in the CJS was its voluntary nature and that forcing offenders into treatment would be detrimental to the therapeutic relationship, disruptive for groups and lead to worse outcomes. Other teams were more open to considering mandating treatment but were confused on several accounts: firstly, in distinguishing the offender's choice in agreeing to participate in a research trial versus participating in treatment; and secondly, if mandating treatment was felt by the team to be the best option, who would be suitable and how that should be recorded as a condition on the offender's licence.

Any participant in any research trial has to give informed consent, and this rule clearly applied to the MBT trial where there was a formal process to obtain this from the offender. Participants in trials should additionally be remunerated for their participation, which may also act as incentives, in the case of the MBT trial being provided in the form of vouchers, but these should not act as levers for coercing participants to engage in the trial. However, it was decided that in the MBT trial, that if participants were randomised to receive MBT, they could then have attendance at the groups be made a licence condition, similar to most of the other treatment programmes available in probation. This stipulation did not equate to being mandated to remain in the trial. Participants were still at liberty to opt out of the research by declining to engage in the trial's assessments and follow-up interviews, but were still required to

continue treatment, which was now considered for them as separate from the trial. The distinction between these rules in relation to involvement in the trial and those relating to the treatment per se was experienced as confusing by both staff and offenders involved in the trial.

Moreover, the research team did not recommend that any offender who fulfilled criteria for inclusion in the trial should be required to comply with treatment, but only those who had mixed feelings about accessing psychological treatments. It was thought that these could sometimes be relieved if there was a clause in the licence conditions that endorsed their need for therapy. Some offenders have some insight into the problematic nature of their offending behaviour and are partially motivated to access help to change these, but may be ashamed to admit this, particularly to peers whom they perceive as denigrating any need for therapy. Being mandated to attend therapy may then be used as the ostensible reason for attendance and conceals the offender's own wishes to receive help, whilst reducing feelings of stigmatisation and maintaining the respect of his peers.

To enhance engagement of these individuals, the term 'assisted compliance' was chosen rather than the usual term 'licence condition'. Assisted compliance is a licence condition, however the difference is in how the probation officer enforces this. Assisted compliance reinforces the necessity for regular attendance and engagement but also includes a degree of flexibility around the inevitable difficulties personality disordered offenders have in social situations. The threat of automatic recall or breach of a licence condition around treatment is largely unhelpful to the therapy process, and if an offender failed to attend under assisted compliance this did not automatically lead to a warning letter or a recall. The offender would instead be expected to engage with his offender manager and the MBT team in order to work through their difficulties in engaging. Assisted compliance has similarities with 'desistance mandates' that have been introduced in drug and alcohol programmes in criminal justice settings in the US as an alternative to treatment mandates (Kleinman et al., 2016).

Assisted compliance is aimed at providing an external structure and sense of responsibility towards self-care that offenders can find difficult to provide for themselves. In the early phase of therapy assisted compliance could also be of use in

reinforcing the period when forming attachments with the therapists and group members is most difficult.

However, despite advice on structuring the wording of assisted compliance in the licence condition, some of the trial participants' offender managers struggled with the flexibility and lack of legal precision in the interpretation of when or when not to enforce a statutory intervention. The MBT team feared that this uncertainty put off some offender managers referring their clients, particularly those who found it difficult to operate within a grey area where the options were not strictly defined.

Conversely, other staff welcomed the opportunities in using assisted compliance, not just because mandated treatments were the norm within probation, but because they thought it was in the offenders' best interest to apply some external pressure to engage, particularly those who were institutionalised and found it difficult to make choices or decisions in general.

The premise of assistant compliance is in line with the research findings of the effectiveness of mandated treatments. The view that coercing offenders to attend correctional treatment has negative treatment outcomes is widely held and has been backed up by evidence. A meta-analysis to compare the effectiveness of mandated, coerced, and voluntary correctional treatment in reducing recidivism published in 2008 based on 129 studies found that mandated treatment was found to be ineffective, particularly when it was located in custodial settings, in contrast to voluntary treatment which showed significant treatment effect sizes regardless of setting (Parhar et al., 2008). However, a recent literature review of research assessing the effects of mandatory treatment on therapeutic process and outcome factors found that perceived coercion on the part of the offender or patient, rather than coercion per se, is linked to negative therapeutic processes and outcome compared to voluntary treatment (Hachtel et al., 2019).

Perceived coercion has been demonstrated not necessarily to be the result of involuntary treatment status but may also occur in non-mandatory treatments, in other words, both involuntary and voluntary clients have the potential to experience interventions as coercive (Newton-Howes & Mullen, 2011). This was evident in the

MBT trial where MBT teams reported some participants as saying they were forced to come despite being told this was not the case. The perception of coercion is determined by a variety of factors, many of which are linked to the quality of the relationship with the service provider (Newton-Howes & Mullen, 2011), including where the offender feels there is a lack of respect (Katsakou et al., 2011), which is one of the common triggers for violent behaviour (Gilligan, 1996).

Even where there is significant perceived coercion and lack of intrinsic motivation at the start of treatment, these may not determine negative outcomes as the treatment progresses (Snyder & Anderson, 2009). Evidence suggests that a therapeutic relationship that is experienced as caring, fair, and firm, but not authoritative or punitive, is more likely to result in changing clients' unwillingness to engage in treatment and better therapeutic outcomes (Skeem et al., 2007). Moreover, although mandated treatment relationships have been demonstrated to involve greater therapist control than in traditional therapeutic relationships, the predominant theme of these relationships is affiliative and autonomy- granting and consistent with the principles of healthy adult attachment (Skeem et al., 2014). These characteristics of therapy are consistent with the principles of MBT delivered within a mandatory treatment setting.

In contrast to the wealth of literature on the pros and cons of mandated treatment in general in criminal justice settings, any discussion of enforcing treatment to improve compliance within the treatment arms of RCTs taking place within criminal justice settings appears to be absent in relevant publications. This is a significant omission given that attrition of data due to participant's non-engagement in and drop-out from the treatment intervention(s) being evaluated in these trials is one of the most common challenges reported in their implementation.

6.4.5 Treatment intervention

The final theme regarding the obstacles to trial implementation that crystallised from the analysis of the interviews with the MBT teams encompassed their reservations about the treatment intervention - MBT – in its structure, content, and mode of delivery.

The group format was found to be problematic as the high rate of drop-out meant that it became difficult to sustain a minimum number of participants (three or four) to

constitute a potentially effective therapy group where dynamic group processes can be harnessed to provide a 'training ground' for interpersonal mentalizing (Bateman & Fonagy, 2016) to contribute to positive outcome. Small group numbers may constitute more of a problem for MBT treatment than for other treatment programmes in the criminal justice system, the majority of which are based on a cognitive behavioural model where group dynamics are not a focus of therapy. In a similar vein, the relatively unstructured nature of MBT, compared to CBT-based therapies, and its greater flexibility regarding the boundaries of therapy, for example in relation to lateness or non-attendance, were experienced by some, especially by the offender managers, as was the case with assisted compliance, as confusing for probation staff and offenders who were used to operating within a hierarchical criminal justice environment where activities are determined by clear cut statutory rules and regulations.

Concerns were also voiced in some sites in relation to how MBT was delivered by the expert by experience, who acted as a group facilitator alongside the MBT therapists. The EbEs were reported to be sometimes confused about their role in the group, or unfamiliar with the MBT principles of treatment, and as a result gave information and advice rather than offering interventions consistent with the MBT model or found it difficult to maintain appropriate boundaries with the participants, especially when they had been acquainted with them in a previous offending context.

Problems with the treatment interventions being tested in randomised studies in criminal justice settings are mentioned in the literature, mainly in relation to whether they are being delivered as intended (Farrington, 2013; Farrington & Welsh, 2005). Adherence to the treatment model in trials is reliant on adequate training and clinical supervision, and whilst this was delivered in an on-going basis to the MBT teams, the probation officers and EbEs may have found it more difficult to comprehend and apply MBT theory and practice compared to the MBT therapists, most of whom had had lengthy clinical trainings as psychologists, psychiatrists, or psychotherapists. In a trial evaluating a Risk-Need-Responsivity (RNR) CBT-based offender supervision program, Citizenship, delivered by offender managers for offenders on probation in the County Durham and Teeside regions in the UK found that the County Durham group had received more focus on staff training, and further sustained clinical follow-up in supervision sessions and in monitoring the use of Citizenship than the Teeside

group, which may have contributed to the former group's better outcomes (Pearson et al., 2016).

Correctly following the treatment protocol is not just dependent on sufficient training and supervision, but also on the beliefs, attitudes and motivations of the people tasked with delivering the treatment. Although there was no evidence from the interviews that the MBT teams were antagonistic to the MBT intervention, it is worth noting that there are several examples in RCTs carried out in UK where the staff's reluctance to participate in the trial negatively interfered with how they carried out the treatment intervention. As described above, some offender managers in the trial of treatments to reduce harmful alcohol consumption did not deliver the treatment as planned due to workload stress (Newbury-Birch et al., 2014); the researchers in the trial aimed at improving social care for older prisoners reported that deviations from the training and the intervention manual were likely to have negatively affected the results, especially where the prison officers, some of whom had admitted to not believing that social care needs were important, were the group facilitators rather than health care workers (Forsyth et al., 2017); and in the RCT evaluating procedurally just modes of road policing on public perceptions of police, the police officers related to the trial participants in a less, rather than more, facilitating manner as designated treatment protocol, due to their own feelings of being negatively treated within the organisation.

A final complication reported in the MBT team interviews was that some offender managers were reluctant to refer their clients as MBT was not a treatment programme that had been formally accredited by the Correctional Services Accreditation and Advice Panel (CSAAP), the advisory body for HMPPS which offers independent evidence-based advice on the development and implementation of effective criminal and social justice services and programmes. This is ironic given that many existing accredited programmes have not been subject to RCTs to demonstrate their effectiveness, and thus may lack a sufficiently robust empirical evidence base to justify their practice.

6.5 Limitations

As with any thematic analysis, there is inevitable overlap between the coding of the different themes.

It could be argued that the predominant superordinate theme 'Emotional impact of work' that came out of the analysis of the interviews in this study could be seen as an overarching theme encompassing the other four superordinate themes (attrition, organisational issues, methodological difficulties and problems with the treatment intervention) as the emotional reactions in the staff were elicited by many of the issues grouped under these four themes; in other words, some of the obstacles identified in the other four superordinate themes induced negative emotional responses, which became obstacles in themselves.

A second limitation is that I conducted the interviews, as well as the analysis, and had also been involved in the trial in being the lead for the development, delivery, and governance of the MBT community services which comprised the intervention arm of the trial. My analysis of the interviews, therefore, might have been biased by the selection of themes to fit with my pre-existing experiences of the challenges encountered in the implementation of the trial.

6.6 Conclusion

This qualitative study adds to existing research on the difficulties in conducting randomised controlled trials in criminal justice settings. Many of its findings were consistent with those described in the literature, in particular objections to randomisation, attrition of participants, and systemic issues which interfered with the trial's implementation. However, this study found two additional challenges that impacted on the staff involved in the trial who were interviewed which have not been explicitly described or discussed in previous published studies of RCTs taking place in criminal justice systems: the emotional effects of participation, which became an obstacle in itself, and the specific characteristics and personality difficulties of the participants which made them difficult to engage, and how to address these, which included the question as to whether the intervention being evaluated by the RCT should be mandated or voluntary.

Future RCTs of psychological interventions in criminal justice settings for offenders with complex psychopathology such as personality disorder should anticipate these

challenges and employ strategies to mitigate them, such as using well established methods to engage individuals with personality disorders in treatment as described above. Interventions to change the culture of the criminal justice system, and decrease the emotional impact of the systemic stresses on the staff who are more peripherally involved in the trial through their referrals and support of participants whilst they are engaged in the trial, will not, of course, be within the trial's remit; however, awareness of the shifting political forces and organisational changes within the system, and the strains this imposes on staff, should be anticipated by the research team and form part of their engagement strategies, particularly regarding effective communication between all involved in the trial. However, it may be possible to alleviate potential emotional strains in the staff directly involved in the trial – the research team, treatment teams and project management teams, such as the pressure of achieving recruitment targets, by being sensitive, responsive and encouraging non-judgmental, open and curious attitudes, which is entirely compatible with the fundamental therapeutic stance of MBT.

One of this study's strengths is that it had been a planned part of the MBT RCT from the start and was carried out whilst the trial was still on-going, thereby gaining contemporaneous data i.e., the participants' ongoing experiences of their involvement in the trial, rather than accounts of retrospective experiences which may have been less reliable. As noted in chapter 5, future RCTs in these settings should embed a qualitative component from the outset to identify and explore the more subjective experiences and views with all participants involved in the trial that might be missed with a quantitative investigation, but which may offer valuable information about contextual factors, including the emotional impact of interpersonal and systemic dynamics, that may influence the results of the trial.

Chapter 7: Evaluating the implementation of a randomised controlled trial of mentalizing-based treatment for antisocial personality disorder in the criminal justice system in England and Wales: Experience of the commissioners

7.1 introduction

Commissioning is the process of procuring health services. It is a continual and cyclical process involving assessing the needs of the individuals or population involved, planning services to meet those needs, procuring these services, and evaluating and monitoring their quality and outcome. This process is typically repeated on an annual basis. Commissioning is a complex process, with each stage of the cycle being comprised of many activities, requiring commissioners to use a wide range of knowledge and skills. Assessing the needs and planning services requires a familiarity of public health policy, population-based research, epidemiological studies, the design of services and a detailed knowledge of the local community via engagement with front line staff, both operational and clinical, and service users. The commissioner /provider relationship is both contractual, involving the co-production of service specifications and the negotiation of contracts, but also relational, requiring empathy for and trust of the population for whom they are commissioning. Effective commissioning involves problem solving and innovation to produce available, appropriate, high quality, and cost-effective services, to produce the desired outcomes for the population that they serve. Commissioners also need remain cognisant of government policy and strategy and what can be obtained within limited publicly funded budgets.

7.1.1 History of commissioning within the NHS and criminal justice system in the UK

The notion of the commissioning of health care as a formal process within the NHS dates from 1991, when the then UK Conservative government brought in legislation, following the 1989 White Paper ‘Working for Patients (HMSO, 1989), with the NHS and Community Care Act 1990 to create an internal market system to promote competition between health care providers. Prior to this, District Health Authorities, established in 1982, organised both the planning and the delivery of services for their

patients on behalf of the Department of Health, in other words, they acted as both purchaser and providers of healthcare. In 1991 the Conservative government split these functions so that the health authorities became the purchasers of care and were mandated to buy health services – hospitals, primary care services and other voluntary sector and private organisations – who fulfilled the provider role and who competed with each other for both contracts and patients. GP practices, either individually or as consortia, could act as commissioners as sub-committees of the health authorities, for non-urgent and community care services. This purchaser-provider system was aimed at increasing efficiency, quality, and patient satisfaction through economic market mechanisms.

The Labour government opposed these changes, arguing that the marketisation of health care had resulted in fragmentation and the loss of some essential service. However, following their success in the 1997 election, the 'New Labour' government introduced further market reforms by replacing 'purchasers' with 'commissioners' whose aim was to help patients choose the best provider, including private companies, for their health conditions. A 'payment by results' system was created to replace block contracts, whereby providers were rewarded for seeing and treating more patients and reducing waiting times. GP fundholding was abolished, and health authorities were replaced by primary care groups, which evolved into primary care trusts in 2001.

The Health and Social Care Act of 2012 introduced by the Conservative and Liberal Democrat Coalition government was aimed at increasing competition within the NHS by widening the criteria for qualification as a provider, allowing 'any willing provider', which included private companies, to compete for services. Primary Care Trusts were replaced by GP-led Clinical Commissioning Groups (CCGs) in 2013 which were responsible for purchasing services in their local areas. A new body, NHS England, was created in 2013 as a special health authority of the NHS to commission primary care services, and specialised services (treatments for rare conditions and secure mental health services, military and veteran health services, and some public health services). Some health services in the criminal justice system are also commissioned by NHS England, including in prisons, youth offending institutes, and diversion and liaison services. NHS England also sets the overall commissioning strategy and clinical priorities for the NHS.

The purchaser provider commissioning model is less well established within the criminal justice system. As described in chapter 2, the National Offender Management Service (NOMS) was created in 2004 following the review by Lord Carter, one of his recommendations being greater contestability via the marketisation of its functions, using providers of prison and probation from across the public, private and voluntary sectors. However, NOMS was both the purchaser and provider of some services, such as public sector prisons. In 2017, the formation of Her Majesty's Prison and Probation Services (HMPPS) resolved this conflict by transferring commissioning responsibility to the Ministry of Justice. HMPPS's responsibility is primarily operational delivery of prison and probation services including as new Youth Custody Service.

7.1.2 The OPD pathway: Co-commissioning

The OPD programme, described in full in chapter 2, is underpinned by principles of shared ownership, joint responsibility and joint operations (Burns et al, 2018). This involves a collaboration between the NHS and HMPPS to jointly deliver services and share responsibility for the individuals who meet the service criteria, i.e., high-risk personality disordered offenders. The OPD programme is also jointly commissioned and co-financed by these two organisations, involving both NHS and criminal justice commissioners in a process that is known as co-commissioning. Each of the four regions of England commissioned by NHS England plus Wales has two commissioners, one from the NHS and one from HMPPS, who together commission a range of services.

The commissioning of the OPD programme is broadly consistent with, but also differs in significant ways from the commissioning model in the NHS described above. Rather than cover a limited area of service provision, OPD commissioners are responsible for a whole pathway spanning custodial, in-patient settings and community services, and commissioning is more directly linked to high level government policy and strategy. OPD commissioners also need some knowledge of the population of high-risk personality disordered offenders who have complex needs and for whom services have historically been lacking, as well as the range of different organisations and agencies involved in the provision of different services in the pathway.

Moreover, such partnership working between NHS and HMPPS commissioners necessitates a mutual understanding of and respect for each other's organisation with their different legal frameworks, ethos, cultures, core tasks and priorities, and be able to develop a flexible approach with a shared philosophy which can withstand the pressures of financial constraints and structural changes within both organisations. The two main aims of the OPD programme are a reduction in offending and an increase in psychological well-being in the offenders it serves, reflecting the primary tasks of the criminal justice system and the NHS respectively, and tensions may arise over which aim should be prioritised. To avoid this, commissioners need to be aware that the two aims go hand in hand, in that offending behaviour is not just detrimental to the health of the victim, but also to that of the offender and improving his or her health will reduce the risk of offending. Negotiating such potential conflicts is part of the collaborative, relational, psychologically informed approach which enables commissioning from a team perspective, providing mutual support and the opportunity to model the expectations from providers (Burns et al., 2018).

7.2 Methodology

The setting for this study and ethical approval are detailed in chapter 5.

7.2.1 Participants

The participants in this analysis were the three commissioners of the MBT services which were being evaluated in the RCT. All three commissioners had been involved from the start of the MBT project when the services were being set up in 2014. Two of their roles changed in 2017 after the National Offender Manager Service joined with the HM Prison Service to become Her Majesty's Prison and Probation Service (HMPPS): the Joint Lead for NHS England for the Offender Personality Disorder Programme became Head of the Joint OPD pathway for both NHS England, and HMPPS; and the Senior Commissioning Manager, who was a national lead for NOMS, became a local lead, for the South of England and Wales, for HMPPS.

7.2.2 Data collection

Two of the interviews were carried out at the Portman Clinic and one at the Ministry of Justice, as the most convenient location for the commissioners respectively.

The interviews were semi-structured and involved me asking the commissioner what obstacles or challenges he or she had encountered during their involvement in the trial. I followed up with subsidiary questions to obtain more detail regarding the challenge identified where necessary. When the commissioner said they couldn't think of any more challenges, I pushed them further by asking them to think of any more challenges or anything else they wanted to say about the challenges they had already mentioned, until the commissioner said they couldn't think of anything else relevant to say.

The three interviews lasted 52 minutes, 43 minutes and 36 minutes respectively, and each was audio-recorded and transcribed verbatim (see Table 5 below).

Table 5: Interviews with commissioners

Commissioner	**Gender**	**Date and length of interview**	**Location of interview**	**Assigned code colour**
2014- Senior Commissioning Manager, NHS England	Female	16.09.2019 52 minutes	Portman Clinic	Red
2014 - NHS England Joint Lead, Offender Personality Disorder Programme From 2017 - Head of the Joint OPD pathway, NHS England, and HMPPS.	Female	31.10.2019 43 minutes	Ministry of Justice	Blue
2014 - Senior Commissioning Manager, National Offender Management Service From 2017 - Senior Commissioning Manager, South of England Her Majesty's Prison and Probation Service	Male	9.12.2019 36 minutes	Portman Clinic	Green

7.2.3 Data analysis

The data was analysed via thematic analysis, as described in the previous chapter.

Step 1: Become familiar with the data.

I read and re-read all transcripts of all of the interviews to become familiar with the entire body of data, and noted my initial impressions and ideas. For example, a prominent theme seemed to be about the cost of the trial; another was about the challenges of doing research in general in the criminal justice system.

Step 2: Generate initial codes

I then carefully re-read the interviews and identified all segments of data that were relevant to the research question to generate initial codes. Open coding was used in that there were not pre-set codes, but codes were chosen, developed and modified as the coding process proceeded. The length of chunks of text identified for each code varied between a sentence, and several paragraphs comprising 33 lines of text (see Table 6 below for examples). I highlighted the relevant chunks of text and put the initial codes in the margins. After systematically coding the entire transcripts, I collated all the codes as a single list, each code highlighted in the colour assigned to the commissioner. Given that there were only 3 commissioners interviewed, colour codes were necessary to see whether the themes that emerged were common to all three commissioners, two only, or just one.

Table 6: Examples of coding segments of text

Segments of text		Codes
Respondent:	The other challenge, I think was just the angst around, do we have the people within the project?	Challenge of are there enough men (participants) in the project?
Respondent:	Again, I think that's normal for probation. It's very rare that you have an Accredited Offender Behaviour Programme that keeps its maximum number for its entire duration, there's lot of attrition. That's nothing to do with MBT. That's to do with the fact that it's been based in the community and	Attrition problem for all programmes in community – not just for MBT

	so people don't have to come. Even if it's on their licence conditions they don't have to come.	
Interviewer:	So, that's another challenge then, that it's being implemented in the community rather than in prison?	
Respondent:	Yes, in prison you've got a captive audience obviously so it's much easier to hold on to people. I mean you still do get attrition in prisons but, yes, in the community people will leave. They'll walk especially if they don't have to do it. You get some traction if it's a licence condition but even that sometimes doesn't mean that people will come. People make a choice potentially or they don't weigh up the consequences. Some people actually want to be recalled.	
	…Prison Estates Transformation Programme. So, that's another big programme of work. Whether that would have had an impact on this I'm not sure but that's the whole sort of reception, resettlement, prison …	Explains Prisons Estates Transformation Project
Interviewer:	Can you say a bit more about that because I'm not sure I …	
Respondent:	Yeah, so for donkey's years the way the prison system is configured is that it would have a local prison, so somewhere like Pentonville, and that local prison, that met the needs of the court. So, that's where people would be remanded to or if they were recalled that's where they would go if they were recalled back into prison. And then you would have what we call training prisons where people go following sentence if they've got long enough they then go to a training prison which is either high security, Cat B, Cat C or open and local prisons were really just for managing that court traffic. So, places of utter chaos, lots of churn, lots of people coming and going, very difficult to manage so the population and Prison Estates Transformation Programme, what that's done is it's reduced the number of local prisons and has increased what they're calling the resettlement population to try and stabilise prisons.	

	So, you'll get places, Onley is a good example of it in Rugby, Onley is a resettlement prison for London. So, a lot of London prisoners who are sentenced to long enough would go to Onley to serve the majority of their sentence before then potentially back to London, they might come back into a local resettlement prison, like Brixton, and then be released from there or they might be released from Onley. So, that's still going on. All of that sort of changing the designations of different prisons we're still going through all of that work and it will lead to the change in function for some establishments. So, I'll try and give you an example, Onley again would be a good example, whereas before Onley was an ordinary Cat C trainer in Rugby it's now this resettlement prison for London. So, it officially now takes people from London and sends them back to London on release. So, before it would have always had a London population but it's like now formalised that that's it's function if that makes sense.	

Step 3: Search for themes

I then grouped these initial codes into a shorter list of codes, for example the following 7 initial codes from the interviews mentioning difficulties in recall are grouped under the overall code 'staff changes':

Staff changes

- Challenge of high staff turnover on the health side e.g., assistant psychologists
- Problems with changing staff
- Pressure to recruit probation officers
- Difficulty in demonstrating effectiveness of OPD when people involved at beginning move on
- Questions centrally as to whether good use of money, leadership changes, continually fighting battles you thought you'd won with new people coming in.
- Staffing shortages in prison also impacted on trial

- Holding on to participants problem – maybe due to staffing pressures in MBT teams

I then identified initial potential themes amongst these codes, gathering all codes relevant to each potential theme.

For example, the following codes were grouped under the theme 'Funding/allocation of resources':

- Challenge in London with splitting funding for 3 sites across 4
- If did it again would still go for 4 sites
- Money not always used by provider how commissioners wanted it allocated
- Would have preferred to have properly funded 4 sites by using the wider money in the system
- Challenge of how to address/deal with sites who are not using funding given to them for MBT
- Challenge of money coming via health, but project delivered in CJS and information governance issues took more time to resolve than anticipated.
- Didn't feel that money invested in project management should have gone to other projects once it was agreed
- But became challenge when concern arose that there weren't enough prison programmes vs community
- Challenge of delivering treatment and trial for not much funding
- Needs to be value for money
- Project is moderately resourced – efficient and lean model
- MBT programme lean on NHS side but expensive for CJS intervention as duration longer
- Would have been nice to have more sites but not enough money
- Good that shows trial can be done, especially if it shows positive outcome for MBT, and relatively cheaply

I ranked the themes firstly in groups according to the number of commissioners whose codes fit the theme in question i.e. the themes occurred in the interviews of all three commissioners, followed by the themes occurring in the interviews of just two of the

commissioners, followed by the themes occurring in the interviews of just one of the commissioners; and then secondly, I ranked within each group the themes in order of the number of codes per theme. Codes which I couldn't fit in any theme were put in the group 'miscellaneous'.

Summary of ranking of initial themes:

Themes	**Number of codes**
All three commissioners:	
• Challenges of doing research in CJS	15
• Funding and allocation of resources	14
• Emotions evoked	14
• Recruitment and retention	13
• Staff changes	7
• Organisational changes	7
• Getting buy-in from senior management	6
• Positive comments	5
• National vs local commissioners	3
Two commissioners:	
• Initial agreement for project to go ahead	15
• Harsh system	6
• Governance/IT	5
• Putting pressure on sites	3
• Randomisation	2
One commissioner:	
• Dynamics of group treatment	12
• Motivating MBT staff	4
• Diversity	3
• Diagnosis	2
Strengths of trial	7
Positive comments	5

Step 4: Reviewing themes; and Step 5: Defining and naming themes

I then spent some time reviewing, modifying, and reducing in number the preliminary themes identified in Step 3 above to see whether they worked in relation to the coded extracts. I tried to generate themes that were coherent and distinct from each other, by considering whether the themes made sense, whether they overlapped, was I trying to fit too much into a theme, and whether there were further themes that I had not identified. I then defined and named the themes. Because there were only three interviews and therefore a limited number of codes, I decided to have superordinate themes only, rather than each superordinate theme containing two or more subordinate themes.

The changes made were:

- Subsume ‘randomisation’ under ‘challenges of doing research in CJS’
- Subsume ‘staff changes’ under ‘organisational changes’
- Subsume most of ‘getting permission to go ahead’ under ‘funding/allocation of resources’
- Subsume ‘national vs local commissioners’ under ‘funding/allocation of resources’
- Subsume ‘governance/IT problems’ under ‘challenges of doing research in CJS’
- Subsume ‘harsh system’, ‘organisational changes’, and ‘getting buy-in from senior managers’ under new superordinate theme, ‘systemic issues’
- Shifting most of positive comments to ‘emotional impact of work’ as these were evidence of positive emotion expressed by the interviewees
- Subsuming the ‘strengths’ theme to ‘systemic issues’ as all four codes in the former related to working together
- Remove remaining themes mentioned by only two or one commissioners
- Remove comments which didn’t fit any of themes (‘miscellaneous’)

This resulted in the list of final themes below. This is also illustrated in a thematic map (See Figure 4).

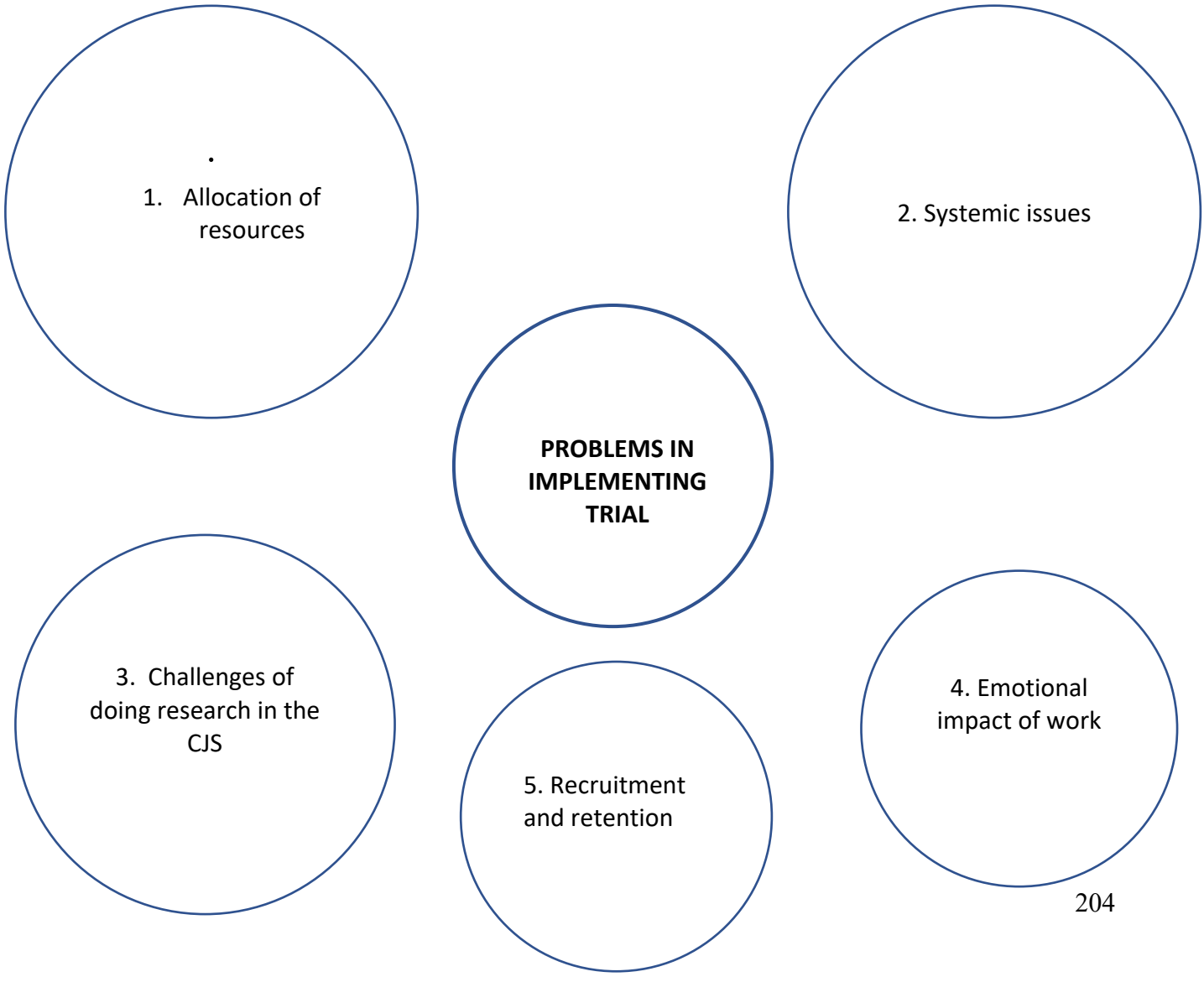
List of final themes:

Final themes	**Number of codes**
1. Funding/allocation of resources	30
2. Systemic issues	30
3. Challenges of doing research in the CJS	23
4. Emotional impact of the work	19
5. Recruitment and retention	13

Step 6: Producing the report

In the final phase of the analysis, I re-read the transcripts and collated data extracts, selected vivid extracts of text to illustrate each of the themes, and organized them into a coherent account, which was then written up in narrative form as follows.

Figure 4: Thematic map of obstacles encountered by the commissioners in implementing the trial



7.3 Results

The two main challenges experienced by the commissioners that emerged from the data with roughly equal weight were concerns around funding, and systemic issues that interfered with the implementation and delivery of the trial.

7.3.1 Funding/allocation of resources

So, we were thinking about the RCT, whether it was deliverable or not. And I think that was the second challenge for us was the risks associated with doing this because it was a lot of money from our point of view, over one million pounds a year, and we didn't really think it was deliverable, but actually … (Commissioner 3).

And that brings them back to what we said at the beginning and taking this project on, as a team, there were reservations around is this is the best use of over £1 million worth of investment over a few years? Could this be spent on other things? What's the pros what's the cons? (Commissioner 1).

One of the challenges in this regard that the interviewees came up against at the outset was persuading the Programme Board, comprised of commissioners and others from both NHS England and the Ministry of Justice, and who were responsible for the funding and oversight of the whole OPD pathway, to approve the project. Commissioner 3 had been involved in the original planning stage in 2013.

So, there's always stuff going on in the background. And that's really why it took a year from the initial conversation, to presenting the business case to the Board. And then X (the personality disorder lead for the Department of Health at the time) and I took that to the Programme Board, which then obviously got signed off by them. But I think it was signed off because they knew that there were stages where we could pull out particularly after the first year if we found that the sites just weren't able to do it. (Commissioner 3).

This included achieving a sense of shared ownership with those in charge both nationally and locally.

I'll go chronologically, so I think the original challenge was getting shared buy in and ownership of the project nationally within the group of commissioners and achieving that. (Commissioner 1).

So, if you're taking a step back and saying, well, what's the challenge then from an oversight perspective, and its back to this whole part around what we were discussing in our contract monitoring meeting about making these projects successful, you really do need buy in of the leaders and that's not only your own national level. It's at your local level, because they're the ones who are either going to be prioritizing this happening or not. And that goes for both a health angle and I also think the probation angle. (Commissioner 1).

There were concerns and uncertainty about the effectiveness of the MBT project in relation to that of other interventions available in the criminal justice system, where it would be viewed as expensive, and in the NHS, where this might not be the case. At the same time, it was acknowledged that the funding available for each site was relatively little for the number of staff and the time that was needed to deliver the clinical services.

Respondent: So, again this is about the difference in how these things are done on both sides of the fence.
Interviewer: So, within the NHS that would be relatively cheap then as an intervention?
Respondent: I think so. It looks lean. I wouldn't say cheap, I think it's lean on the NHS side, just my opinion, I might not be right. On the justice side it looks expensive. When you look at cost per place. (Commissioner 2).

And I think that's tied into another challenge, which is about what is the level of funding required to deliver this as a local level? Because we knew that it was very, very tight, you know, £75,000 per site. Yeah, that clearly was not very much money for what was expected of them, which is a huge effort around for them to be able to link in with all the other work they were doing, because there's only a small part of that time. And also, to then deliver the treatment and attend all the sort of the training that the supervision and all of that for a relatively small sum of money. But we knew that if it was more money than that, then it would appear as economically too expensive. And

that was a real tension that I don't think it was an unresolved tension really, isn't it? You know, what do we think is a legitimate amount of money per participants, for example, you know, because we know that when we compare it with other interventions, we know it's probably more expensive. (Commissioner 3).

7.3.2 Systemic issues

Like the MBT teams interviewed in the previous chapter, the commissioners cited the ever-shifting environment in which the trial was situated where pervasive systemic issues interfered with its delivery. The changes of leadership, staffing shortages, and a high turnover of staff generated by the major reorganisations which occurred during the duration of the trial, TR, the formation of HMPPS and a reorganisation and expansion of prisons called the Prison Estates Transformation Programme, generated turbulence, instability and lack of continuity resulting in uncertainty in the commissioners as to whether the trial could be successfully implemented as planned, or at worse, whether the MBT services might be decommissioned.

There's certainly been lots of questions centrally about whether we should continue with this or whether it was the best use of the money. And I think there have been occasions when there have been risks of it being closed down. Partly because people didn't understand what we were doing, but also competing priorities. So, I think every so often that's popped up. And that's because we get reorganized and other people become involved and our leadership changes and all those sorts of things. And people see things differently. I think, trying to deliver something over five years is really, really hard because you can't picture what things going to be like a few years into the future, and things, things change. So, you have to continually fight the battles you thought you'd won. So, arguments you thought you'd made a year or two earlier suddenly stopped coming up again. And that's a real surprise. You know, as new people could come in. (Commissioner 3).

…massive increase in the use of NPS which I think is probably not solely as a result of the staffing problems but the staffing problems have accelerated the decline, I think, because obviously if you haven't got the staff there you can't manage these things. (Commissioner 2).

So, you would have been affected by that then, the staffing shortages and of course the other bits and pieces on the prison side around the big sort of population, what do they call it, Prison Estates Transformation Programme. So, that's another big programme of work. (Commissioner 2).

Again, getting buy-in from senior management in both HMPPS and the NHS was essential to ensure the trial's continuity.

…challenge of getting buy-in from senior probation officers e.g., they were more likely to recommend an accredited programme rather than MBT. More of a challenge getting operational leads on the health side of the board than in probation as X (HMPPS Lead for mental health in London) was passionate about the project. (Commissioner 1).

Maintaining effective communication between the different parties involved was crucial, but time-consuming and exasperating.

The number of times we have to keep telling people and sending the ethical approval letters to prove that it's got ethical approval I've lost count because people change, and governors change, and in one particular establishment you may only have one person that a researcher needs to go and see. (Commissioner 2).

It was also emphasised how those leading the services locally needed to be respected and persuasive within the upper echelons of the wider organisation.

But there's been different problems in each site. I mean, (site X) has always been absolutely fine. And I think we learned a lot from them about the importance of the quality of the leadership. Yeah, and it's much more than having enthusiastic people. And they've got to be senior enough within the organization. There's no point having somebody brilliant, who's in charge, but who's actually not influential at a high level. You know, they just can't have the impact. (Commissioner 3).

The uncompromising, punitive, and dehumanising culture within some parts of the criminal justice system also interfered with the delivery of the trial and even led to a

temporary cessation of the trial to gain approval for participants to be renumerated for their participation in the trial.

And it has led to, as far as I can see it, the complete dismantling of any opportunity to have a relationship, to have that relational focus which we know is so critical for this particular client group. (Commissioner 2).

So, the rigidity of the system that we try and deliver our services in doesn't necessarily support or promote antisocial people who are generally not compliant, who might need sort of like the road smooth for them to become more engaged. And then we have a system that is quite rigid in itself and doesn't support their engagement. So, there is a wider structural issue that says, okay, what are we trying to do here, and the system and structures we're trying to do them in aren't necessarily conducive or helpful for maximizing engagement. (Commissioner 1).

Yes, you're right, now that was potentially a showstopper because we had to go up to Ministers for that didn't we? We had to get clearance from Ministers to allow payment which is a clash of cultures because of course the NHS or researchers will want to pay their participants, the Ministry of Justice will say people shouldn't be benefiting from crime. (Commissioner 2).

Finally, the commissioners were keen to stress that what they saw as one of the most powerful strengths of the trial was the sustained and successful collaboration between themselves, the research team, and the project management team.

I think that we've been lucky in that we've had a consistent group of people involved for a very long time. You know, there is a core of us who've been here since the beginning. And I wonder how things might have been different. Had we not been here throughout, you know, if I've moved on elsewhere, or you've moved on elsewhere? Who would have come in with their view, so it could quite easily, it may have kept going for five years, simply because we were here for five years. (Commissioner 3).

… I think, one of the strengths of the project as I see it is the way that everybody has worked together to, as I've said really, to tackle any of the problems that came up and not just within the OPD pathway and within the MBT Team. (Commissioner 2).

But actually, I think we've managed that really well here. That's, that was always one of the challenges as well. Could we actually work together effectively with the different responsibilities, but going towards the same goal? And I think we learned that we can have fun. I think that's absolutely unique in research. It has basically never been done before in this country, not in the forensic world. (Commissioner 3).

7.3.3 Challenge of doing research in the CJS

The third most commonly mentioned theme from all three commissioners was how hard it was to conduct formal research in criminal justice settings. Their experience was that, despite the availability of research expertise within the criminal justice system, it didn't have the financial resources to prioritise research.

Interviewer: And do you feel that part of this problem is that people in the criminal justice system, have less understanding of research, of empirical research?

Respondent: No, I don't think that's the case, well it depends who you're asking. So, governors and probation officers, they wouldn't necessarily understand the methodological issues behind all of this because that's not part of their job, but psychologists, the researchers here, you've got a very sophisticated analysis team in HMPPS that fully understand all of this. Some of the problem is resource as well because they're expensive, RCTs, and the Ministry of Justice doesn't have money for that. It doesn't have money to evaluate stuff full stop let alone do an RCT. … There might be other bits of research that are ongoing that I'm not aware of but as a general rule Ministry of Justice and prisons and probation have very little resource to do what we might call proper research. (Commissioner 2).

Randomisation was viewed as an obstacle in being an ethical dilemma by denying half of the randomised sample the available intervention.

But yes, RCTs, generally speaking in the justice sector, they're not really seen as being the thing that you can do both from a process point of view, i.e. how do you do it, how do you enable it, well I think this has shown that you can do it but also from that ethical point of view that withholding treatment or pulling people, I mean this must be a very familiar thing for NHS chaps as well, it's because of the public protection. It's like the third party. So, it's not just the person themselves that is consenting to be randomised, that then potentially has an implication on other people. (Commissioner 2).

The impatience of the system to obtain the results of trials as rapidly as possible limited the commissioning of methodologically robust research.

*So, things around performance then get used and how they are important, but sometimes you have to stay with it in order to complete the research. And I think it's linked to wider research challenges whereby we are always pushed to get evaluation results quickly. And the consequence, and I think this is my view of the whole going back to the early days of DSPD, is you implement research or you commission research too early, things aren't settled enough, and then people want results too quickly, and then they wonder why the research isn't particular high quality, or there's problems with the data. (*Commissioner 3).

A further challenge was negotiating the complexities of information sharing and clinical governance between the Ministry of Justice and the NHS.

I think the only problem from my memory was the information sharing issues that we had to work quite carefully, didn't we, to get information sharing protocols in place and also, again my memory fails me, but there were issues about the videoing of stuff wasn't there and you had to, we had to come up with a solution for how you could get access to the materials for supervision if I remember rightly. (Commissioner 2).

7.3.4 The emotional impact of the work

In the course of the interviews, all of the commissioners touched on emotional responses, both positive and negative, that they themselves had experienced, or had witnessed others experience, in relation to the trial. Again, these were predominantly

linked to a perception of limited resources that were not sufficient to fund existing services, let alone new initiatives, and which created competition and conflict between different parts of the system.

But there was more than one person in the room who was anxious around the money. But ultimately, people did sort of see the benefits of progressiveness…(Commissioner 1).

It is my perception that there is a greater expression now of jealousy and envy then perhaps there was a few years ago. And it's brought about I think because yeah, there were very significant cuts in the prison and probation service over the last three or four years and people struggle with those and yet we've managed to retain our money [for the OPD programme] *and to keep going, to keep growing, and why wouldn't anybody be jealous and envious of that? We do the opposite to what everybody else is doing. And I think over time, those things got stronger and stronger and stronger. You know, people thinking, well, why can't we have some funds and also the consequences that we start to accrue staff from them because our work is seamless, more exciting, more challenging, developmentally, much, much better people being better supported. So, the advantages of it all are huge. And that hasn't gone away in five years, six years. And now we continue to maintain that developmental momentum. But I think as a consequence, as things got more difficult for other people, they become more envious, more envious of the program to the extent of saying, well, maybe we can do it better, maybe we should take over releasing out a slice of our cake.* (Commissioner 3).

One of the commissioners described trying to put her emotions to one side in order to come to a fair decision about whether to fund the project at the start.

This is why I actually think the money could be spent in other ways, and for me, it was really useful putting my emotion out of it; this is the argument for doing what we're doing. What I meant by that was that I knew even my- I'm thinking it through, that actually a lot of what I've just been saying here, I'm giving you my thought waves but it was also emotionally triggering me in a negative way towards MBT because I was just thinking but you've got this, you've got this, you've got this and then, wow, what else could we do with a quarter of million pounds? So, that was that. So, that's my

emotion element of my work and thinking going like, okay, I wholeheartedly could see the reason for having an evidence-based trial. The benefits of it, …it's going to give us something good. My emotion bit was, why can't we find someone else to pay for the project management? (Commissioner 1).

Frustration about working through some of the governance requirements was also expressed.

And while I've also had complete amnesia, on the challenge of getting the video recording and stuff for- that one time I remember, I nearly did lose the will to live. Remember, it was X and myself and we were meeting with the NOMS Data Controller person. And remember it was the whole part about how do we - you are now going to be bringing up for trauma for me! I was in a really honeymoon phase of this. No, that was really difficult. (Commissioner 1).

At the same time, for all three commissioners the expression of enjoyment and excitement in what had been achieved in the face of so many challenges were palpable in their narratives, and that even if the results of the trial were not favourable in terms of treatment outcome, they felt it would still have been worth doing the trial.

Well, I mean I think it has been a fantastic collaboration and a very exciting one, pushing the boundaries really in terms of what's achievable and certainly pushing back against the sort of HMPPS rhetoric which is you can't do RCTs in this context. (Commissioner 2).

I still can't believe we achieved as much as we did. To be honest, I think that's incredible, I mean, 313 people I'd never believe for a moment we'd get even close to that. So, I think looking back, it was hugely painful. It was an absolute nightmare. Really, really difficult but absolutely. But they did sign up to it. (Commissioner 3).

Interviewer: And do you think if we don't show a treatment effect that if we can show that actually we've implemented a trial, do you think that would still be useful?
Respondent: Absolutely, that will be useful. I think it will be very disappointing if we don't show an effect but if we don't, we don't. We're dealing with very difficult

participants with entrenched difficulties, but I think, yes, just having been able to do an RCT in that fashion is important. (Commissioner 2).

7.3.5 Recruitment and retention

The commissioners were very aware that the survival of the trial was incumbent upon maintaining a steady flow of suitable referrals to ensure that enough participants were recruited to reach the required target number for randomisation. However, there was also a risk that the struggle to achieve this would overshadow the equally important work of engaging and retaining participants in treatment.

I think the first set of challenges would have been making sure we had enough referrals from the different probation teams in order to make the MBT programmes worth, actually viable and obviously for the randomisation. So, a lot of work was done by everybody, I mean all I did really was write a few letters but a lot of work was done by everybody to make sure that probation knew that this was happening and therefore they needed to recruit, they needed to take part in recruitment. (Commissioner 2).

But in terms of the feedback from the sites, that was more about how do you first of all, get people in, have enough critical mass to deal with the high rates of dropout. (Commissioner 1).

And I suspect that when we look back, we may find that that's the biggest weakness of it all, is we haven't had enough people retained in treatment for long enough. I mean, that is what some of the sites reported that they felt that their focus was so much on recruiting into the trial that they sort of lost, you know, that. (Commissioner 3).

7.4 Discussion

Not surprisingly, in their role as commissioners, the most common challenge encountered by all three concerned the cost of the delivering the clinical intervention which would be evaluated by trial and whether carrying out a research project was a fair use of the overall monies available to the OPD programme as a whole, or funding should be used for other, less expensive, services directly available to offenders. In

relation to other services and interventions commissioned within the programme, the MBT services were among the costliest. The initial challenge for all of them was to persuade their colleagues on the Programme Board who were responsible on behalf of the government for the entire budget of the OPD programme, of the benefits of investing in a psychological intervention, MBT, that was not already established as a treatment in the criminal justice system so that it could be robustly evaluated by an RCT. This task was made doubly difficult as they had to put aside their own doubts about the project's value and success, as described by Commissioner 1, in order to facilitate a presentation of the pros and cons that was as objective as possible to allow for fair and transparent decision-making. Moreover, the commissioners appeared confused about the cost of delivering the MBT services compared to that of other programmes. Although one of the key aims of the trial was to determine the cost effectiveness of MBT, before that would be known, the commissioners seemed to need to justify, but were uncertain of, the cost per participant and how this compared to the costs of other treatments in the NHS and in the criminal justice system.

Even after the initial decision had been made to give the go-ahead for the services to be set up, there remained three further challenges in relation to funding – firstly, to keep on board the regional commissioners, senior management staff and other key stakeholders, some of whom changed during the course of the trial; secondly, supporting the MBT teams themselves to deliver demanding, difficult and time-consuming work on a limited budget; and thirdly, having to agree to dedicate money to setting up the MBT services without knowing that funding would be granted from the National Institute of Health Research to actually be able to carry out the trial.

Like the MBT teams, the commissioners raised the many challenges that had arisen from the major reorganisations that had taken place in probation during the lifetime of the trial. As well as highlighting the havoc caused by TR and the formation of HMPPS which resulted in high staff turnover and shortage of staff, poor morale, and a significantly increased volume of work for probation officers, Commissioner 2 also mentioned another reorganisation that she thought would have impacted negatively on the trial, the Prison Estates Transformation Programme, initiated in 2015, a programme aimed at improving the condition and suitability of prison accommodation by creating 10,000 new-for-old prison places and reconfiguring the estate to better

meet the needs of prisoners. However, a recent report from the National Audit Office concluded that its plans to achieve this were failing, in that it had not been able to provide enough prison places, in the right type of prisons, and at the right time, to meet demand, and outsourcing prison facilities management had not delivered expected efficiencies (National Audit Office, 2020).

The commissioners also highlighted an inflexible, callous, and penalising culture within the criminal justice system which was felt to be the antithesis of the ethos of the OPD programme. This was illustrated by an unforeseen complication in February 2016, shortly after the trial had commenced, when NOMS discovered that the trial participants were being given vouchers to thank them for giving up their time to take part in a research project, as would be the case in any research trial. NOMS objected to this on the basis that Ministry of Justice guidance states offenders under supervision from the National Probation Service cannot receive payment in any form. This resulted in the trial being temporarily suspended for three months whilst the commissioners appealed and sought ministerial approval that an exception could be made for this trial, during which time recruitment and randomisation had to be ceased, which caused a loss of momentum, reduction in referrals and disruption of groups.

As with the MBT teams, the commissioners mentioned recruitment, randomisation, and governance issues as specific problems with implementing the trial, but they also took a wider view of a criminal justice system that was insufficiently resourced to perform its core functions, let alone programme evaluations or more formal research compared to the NHS. Commissioner 2 highlighted that there wasn't an equivalent grant-giving body for criminology research akin to the National Institute of Health Research. Unlike the MBT teams, commissioners also raised the unrealistic expectation to produce results within short timescales, perhaps because they felt the pressure more directly from senior leaders within NHSE and HMPPS, who were anxious to report progress before the next change of government advisors, ministers, and policy.

The emotional impact of the work was not the most prominent theme to materialise from the analysis as it was with the MBT teams, but was nevertheless interwoven in their narratives and evident in the interviews in which they appeared to me to be

excited, and even proud of what had been achieved, whilst at the same time talking about more negative emotions they had felt earlier in the course of the trial, or that they had observed in others. Commissioner 3 spoke of the emotional conflicts he had experienced within the wider system, again in relation to funding, involving powerful affects of envy and jealousy towards the OPD programme which was perceived by other parts of the criminal justice system as being preferentially resourced. This was in contrast to the commissioners' anxieties about the limited funding of the MBT project and how its survival felt precarious, but perhaps illustrates how easily the emotions elicited in individuals under pressure become amplified and projected within a fragmented system, and the risk that decision making can then become distorted and biased, as Commissioner 1 was aware of when she feared her own subjective feelings about what should be funded would prevent her from making a fair appraisal of the options.

7.5 Conclusion

The main limitation of this analysis is that it was based on only three individual interviews due to the small sample of only three commissioners involved in the study. However, it highlights the crucial role that commissioners may play in the success or failure of implementing RCTs conducted in the criminal justice system. In their view, what seemed key to the achievements to date was working collaboratively with the research and project management teams and developing a sense of shared ownership of the project that persisted over time facilitated by the continued involvement of the central people in the trial from its beginning. This experience reflects the principles and ethos of the OPD programme as a whole – the importance of partnership working, continuity and attachment – which can mitigate, at least to some degree, some of the many obstacles to innovative working in criminal justice settings.

Chapter 8: Evaluating the implementation of a randomised controlled trial of mentalizing-based treatment for antisocial personality disorder in the criminal justice system in England and Wales: Experience of the experts by experience

8.1 Introduction

8.1.1 Peer support and service user involvement in mental health services

Service user involvement in health services evolved out of peer support, which may be broadly defined as mutual support provided by people with similar life experiences as they encounter different situations (Repper & Carter, 2010). Peer support within mental health involves people with 'lived experience' of mental health difficulties and distress providing support to each other, which may be social, emotional and/or practical and is based on shared personal experience, trust, respect, empathy, and agreement of what is helpful (King, et al., 2018; Lawton-Smith, 2013). Peer support work is modelled on naturally occurring peer relationships, where personal growth and change is fostered by understanding and challenging their own and others' views and relational patterns. Mutuality and reciprocity within the peer relationship are widely thought to be key factors in the efficacy of peer support (King et al., 2018).

Peer support in mental health settings can be traced back to the earliest asylums (Shaw, 2014) but became more organised and structured in the 1970s and 1980s with the creation of networks of self-help groups for people suffering from specific mental health conditions (Pitt et al., 2013) and the pioneering of peer-run services and the formal employment of peer support workers in Australia, Canada, Europe, New Zealand and the USA (Lawton-Smith, 2013; Watson, 2017). In the UK, peer support work initially arose from the efforts of radical activists and small groups of people, who, influenced by the international peer support movement, objected to the medicalisation of mental distress, and using their own experience, began campaigning, lobbying, and working with 'the establishment' to transform and improve its services and the national mental health agenda (Beales & Wilson, 2015).

Various models of peer work have emerged as its identity has evolved, with a growing distinction between peer-delivered services and peer support (Davidson et al., 2006). Three categories of peer work can be broadly delineated: informal support amongst service users, separate from healthcare staff; more organised but unpaid work by volunteers acting in roles such as 'mentors' or 'peer buddies'; and paid work, where peer support workers are formally employed as part of a team contracted to deliver mental health services (Lawton-Smith, 2013). As peer support workers have become more formally involved in existing mental health services, having had first-hand experience of them as patients, there has been a shift, at least in the UK, towards referring to them as 'service users' although they are also variously called ex-service users, service user consultants, consumer providers and experts by experience.

In the UK, service users have gradually become active in the design, commissioning, delivery, and evaluation of services of mental health services since the 1990s, leading to its enshrinement in national policies (Department of Health, 1999; 2001) following legislation requiring its involvement in the UK Health and Social Care Act 2001 (Pitt et al., 2013). In the last decade the recovery movement, and the personalisation of mental health care where patients are given more choice and control of their treatment has empowered service users' involvement in mental health services (Department of Health, 2010a; Jeffcote et al., 2018). The concept of 'co-production' which has been defined as 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families, and their neighbours' (Boyle et al., 2010) has gained increasing traction since its introduction in the statutory guidance of the Care Act 2014. The Stepping Forward to 2020/21 (HEE, 2017) mental health workforce plan proposed 8000 new non-traditionally qualified jobs which will include the development of new peer worker roles.

Many benefits of peer support and service user involvement have been widely reported in the literature (King & Simmons, 2018; Repper & Carter, 2010), including increased feelings of empowerment, self-efficacy, self-esteem and hope, as well as decreases in hospital admissions, length of stay in hospital, risk of relapse, and symptoms in the recipients of peer support; and increases in confidence, sense of value, ability to cope with their own mental health difficulties and employment opportunities in the peer support workers themselves (Lawton-Smith, 2013). However,

systematic reviews and meta-analyses of RCTs of effectiveness of peer support have not demonstrated consistent positive clinical outcomes due to variations in programmes offered, a wide range of different outcome measures used in the studies, and a lack of adequate descriptions of what the peer workers do which is different from what other mental health workers are doing (Bellamy et al., 2017; Gillard, 2019; King & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al., 2013).

Moreover, it is also not clear what aspects or mechanisms of peer work effect change. Suggested active ingredients of peer support include self-disclosure, role-modelling, building trusting relationships, and engaging individuals in services (Davidson et al., 2012; Gillard et al., 2014; Marino et al., 2016). A recent literature review regarding the process of peer support and its underpinning processes and mechanisms to better understand how and why it works found that five mechanisms underpinned peer support relationships (Watson, 2019). These were: lived experience, in which peer support workers explicitly share their experiences and implicitly draw on their experiences of what works and what does not; 'love labour', defined as emotionally engaged work that has as its principle goal the survival, development and/or wellbeing of the other (Lynch, 2007, p.557); the 'liminal position' of the peer worker (Scott et al., 2011) where they occupy a 'liminal space' between two distinct identities - the role of service user and the role of mental health worker; strengths-focussed social and practical support, such as help with accessing suitable benefits, attending appointments and managing medication, and support with shopping or laundry; and the helper role, in which the peer support worker feels he or she is useful to others by the adoption of a helper role including reducing internal stigma, feeling looked up to and the requirement to shift focus away from oneself onto others.

8.1.2 Service user involvement in criminal justice settings

Service user involvement in criminal justice settings originated in prisons in the 1950s and 1960s in the US when researchers became interested in using ex-prisoners to help rehabilitate other offenders (Lebel et al., 2014). Prevailing theories at the time as to why this might be helpful were the 'retroflexive reformation' process (Cressey, 1955) whereby the offender positively identifies with the ex-offender on the basis of the latter's anticriminal behaviour; and the 'helper therapy principle' (Reissman, 1965) which emphasises how the helper i.e., the ex-offender, is himself helped in the process

of helping others. These ideas were implemented in several initiatives in the 1960s such as the New Careers Movement (Grant & Grant, 1975) where former prisoners could be trained to have formal helping roles in prisons and social services helping others who had similar needs as they had experienced (Lebel et al., 2014).

The New Careers Movement has largely disappeared but provided the impetus for the growth of peer support workers in the US, which has grown in the last 20 years with the creation of 'forensic peer specialists', individuals who use their own experiences of the criminal justice system and mental health difficulties to engage others with psychiatric disabilities who have had contact with the criminal justice system (Adams & Lincoln, 2020; Baron, 2011). Forensic peer specialists include 'peer re-entry specialists' who help prisoners re-enter society and settle in the community post-release, often focussing on abstinence for those offenders with substance misuse, and acting as their mentors (Reingle et al., 2019).

In the UK, the Listeners scheme, run by the Samaritans, was one of the earliest peer support services to be implemented in prisons in the UK. The Samaritans is a charity started in the 1950s to 'befriend the suicidal and despairing' and the first Listeners Scheme was set up in 1991 at HMP Swansea and has since become established in almost every prison in England, Scotland, and Wales. Samaritans volunteers select, train and support prisoners to provide emotional support to their fellow inmates who are struggling to cope (https://www.samaritans.org/how-we-can-help/prisons/listener-scheme/).

Peer mentoring is now common in prisons in the UK, particularly helping with literacy problems and substance misuse. User councils have also been developed in some prisons, supported by a user-led charity, User Voice, where prisoner representatives sit on the council and are involved in decision making (Jeffcote et al., 2018)

However, despite these activities, service user involvement remains less well developed in criminal justice settings than within health and social care services in both the US and UK (Barrenger et al., 2018; Jeffcote et al., 2018). This may be due to a number of factors, such as the fear that collaborating with offenders increases rather than mitigates risk in custodial settings where the emphasis is on behavioural management and procedural and physical security rather than on individual prisoner's

states of mind; offenders viewed as not having any right to voice their opinions due to their crimes; and undermining the value of offenders' views due to beliefs that there is something inherently wrong with them (Jeffcote et al., 2018).

Based on the 'helper therapy principle' mentioned above, and the desistance literature, which suggests that the most significant factors contributing to not re-offending are developing a non-offender identity, having a social role and building positive relationships (Maruna, 2005), there have been a few studies demonstrating the positive effects of ex-offenders' helping other offenders has on the former, including a reduction in recidivism, abstinence from alcohol and increases in self-esteem and self-efficacy (Heideman et al., 2016). There have also been a number of qualitative studies of the views of forensic peer workers on what they think is effective about their role, most prominently having lived shared experiences (Barrenger et al., 2019; Reingel et al., 2019).

However, there have been few robust empirical studies evaluating the effectiveness of peer support or service user involvement in criminal justice settings. A meta-analysis of studies on the impact of mentoring on reoffending rates indicated that mentoring was associated with a small reduction in reoffending on average (Jolliffe & Farrington, 2007). Another meta-analytic review of 39 studies published between 1970 and 2005, found a moderately positive effect of mentoring programmes in addressing offending and aggression (Tolan et al., 2008). However, specific information regarding what constituted mentoring was lacking.

Of the published literature reviews of peer support in the last ten years (Bellamy et al., 2017; Brett et al., 2014; Chinman et al., 2014; Davidson et al., 2012; King et al., 2018; Lloyd-Evans et al, 2014; Repper & Carter, 2011; Watson, 2019), there is only one study that demonstrated the effectiveness of peer workers on offenders with criminal justice histories (Rowe et al., 2007) which had been mentioned in three of the reviews (Davidson et al., 2012; King et al. 2018; Lloyd-Evans et al., 2014). This study was an RCT comparing the effectiveness of two interventions in reducing alcohol use, drug use, and criminal justice charges for persons with severe mental illnesses: first, a community group intervention with citizenship training and peer support combined with standard clinical treatment, including jail diversion services; and second, standard clinical treatment with jail diversion services alone. The experimental group showed

significantly reduced alcohol use in comparison with the control group, but there was no difference between the two groups on drug use and criminal justice charges, which decreased significantly in both groups. Moreover, the intervention took place within a community health setting, not a setting within the criminal justice system.

8.1.3 Service user involvement in the OPD pathway

From its inception, the OPD pathway adopted a whole systems approach which included the experiences and perceptions of offenders and staff at the different stages of the pathway (Joseph & Benefield, 2012), and service user involvement has subsequently become embedded in four key areas: planning and developing the structure of the organisation; review and evaluation of services; day-to-day practices and processes; and creating an organisational ethos and culture (Jeffcote et al., 2018). Service user involvement in the pathway has been most extensively developed and coordinated in the London area of the OPD delivered by the London Pathways Partnership (LPP), and organised via a stepped model, with three levels of participation: participation without an active development role (e.g., participating in feedback sessions, focus groups, shared social and recreational activities); participation with an active service development role (e.g., facilitating groups, carrying out service evaluation research, delivering training); and active involvement in projects with outside agencies, with support from our services (e.g., involvement in recruitment and presentations). Specific activities and initiatives developed within prisons include prisoners working collaboratively with staff in developing formulations and risk assessments; buddying programmes; being co-facilitators in psychoeducational and skills groups; and taking on roles and responsibilities, such as chairing meetings, organizing activities, acting as representatives in decision-making work groups and working in partnership with staff at formal meetings and running open days. In the community, LPP has established a service user forum to oversee all user involvement projects and ideas. Community activities include peer support and mentoring prisoners being released into the community; training for staff to better understand the experiences of service users; involvement in service evaluation; and consultation to staff teams.

8.1.4 Service user involvement in the OPD MBT services

In line with the principles of service user involvement in the OPD programme, each MBT team included, in addition to the MBT therapists and specialist offender manager, a service user, or expert by experience, (EbE), to promote engagement of participants into the trial and sustain those randomised to the intervention arm in treatment.

To qualify as an EbE for the MBT services, the person needed to have: a previous history of offending, direct lived experience of ASPD or difficulties, previous involvement with the criminal justice system; completed a reasonably intensive group treatment – MBT where possible, but otherwise any intervention that involved self-reflection and active engagement with other group members; demonstrated a period of community stability in relation to offending, substance use and health; and an awareness of the challenges of the role in relation to confidentiality, boundaries and containment.

The EbEs were identified and recruited from three main sources, which varied in different parts of the country. The first route was from an established forensic service user organisation, such as UserVoice, or the London Pathways User Forum. However, these organisations are mostly based in in London, and many areas of the country do not have such organisations locally. In these areas probation officers put forward for consideration men who were still under the supervision of the NPS, but who had not offended for at least 2 years. The third option was to recruit the EbE from the MBT groups themselves where the participant had completed the year of MBT treatment. This option wasn't available at the start of the trial and was only possible after the MBT groups were firmly established.

The EbE was usually employed in the MBT team on a trial basis for a few weeks to give adequate time for him to be further assessed to ensure that he had the experience and skills necessary to carry out the role in relation to participant support, collaborative working, and service development. As the role involved exposure to potentially sensitive and emotive information the EbE needed to be able to maintain confidentiality within the group, share any relevant risk information and utilise supervision to reflect on their responses to the work. Regular supervision was provided

from the MBT team regarding their performance in the role, and in some sites the EbE also attended the monthly clinical supervisions to the MBT team provided by their Anna Freud Centre clinical supervisor. The EbEs were not formally trained in MBT but attended national training days delivered by the Anna Freud Centre three times a year, where they received some basic training in MBT principles and skills, as well as sharing and learning from each other's experiences. The role was paid, and depending on the site, some EbEs were employed by the mental health trust, and others directly by the NPS.

Initially, the EbEs were envisaged as being involved in the assessment phase, offering contact to men on the waiting list, being available to participants at risk of disengaging from treatment, following up DNAs alongside staff and getting feedback from men who had dropped out. However, at the first national training day organised by the Anna Freud Centre, the EbEs were vocal in wanting to co-facilitate the groups (some sites were allowing them to attend intermittently), as they felt that this would provide the best opportunity to get to know the participants and their difficulties and to be involved directly in the treatment process. Some of the MBT staff initially had reservations about an ex-offender being a co-therapist of the group, but this initiative was implemented and gained widespread enthusiasm and acceptance.

8.2 Methodology

The setting for this study and ethical approval are detailed in chapter 6.

8.2.1 Participants

The participants in this study were EbEs who participated in three separate group interviews. Two of the interviews took place at the Anna Freud Centre, and one at the Portman Clinic, all as part of the EbE training days that were held two to three times per year. The MBT training days, facilitated by Anthony Bateman, MBT Training and Supervision Lead for the RCT and Jessica Yakeley, MBT Project Director and the interviewer in this study, presented opportunities for the EbEs from the different sites to come together, share experiences in their respective sites, receive on-going training regarding MBT and their roles as EbEs, and about the progress of the trial.

8.2.2 Data collection

In total, 8 different EbEs, from 7 different sites (Bristol, Devon, East London, Lancashire, Lincoln, Nottingham and Wales) participated in the 3 interviews. The EbEs from East London, Lincoln, and Wales participated in 2 of the three interviews. The EbE from Bristol who had attended the first interview had left the project by the time of the third interview, which was attended by his replacement as EbE for the Bristol site.

The interviews were semi-structured and involved the interviewer asking the men about their experiences and roles as EbEs in the trial and what obstacles or challenges they had encountered. The first two interviews were shorter, lasting 42 minutes and 29 minutes respectively. The third interview was longer at 2 hours and 8 minutes. Each was audio-recorded and transcribed verbatim (see Table 7).

Table 7: Interviews with EbEs

Experts by Experience	18.7.17 29 minutes	Anna Freud Centre, London	EbE East London EbE Lincoln EbE Nottingham site EbE Wales site
Experts by Experience	30.4.18 42 minutes	Anna Freud Centre, London	EbE Bristol site EbE Devon site EbE Lincoln site EbE Wales
Experts by Experience	24.2.20 2 hours 8 minutes	Portman Clinic, Tavistock and Portman NHS Foundation Trust, London	EbE Bristol site EbE Devon site EbE East London EbE Lancashire site

8.2.3 Data analysis

The data was analysed via thematic analysis, as described in the previous chapter.

Step 1: Become familiar with the data.

I read and re-read all of the transcripts of all of the interviews, to become familiar with the entire body of data, and noted my initial impressions and ideas. For example, a prominent theme seemed to be about their identity as EbEs; another was about difficulties in keeping the MBT participants engaged in the groups.

Step 2: Generate initial codes

I then carefully re-read the interviews and identified all segments of data that were relevant to the research question to generate initial codes. Open coding was used in that there were not pre-set codes, but codes were chosen, developed, and modified as the coding process proceeded. I highlighted the relevant chunks of text and put the initial codes in the margins. After systematically coding the entire transcripts, I collated all the codes as a single list, each code highlighted in the colour assigned particular group.

Step 3: Search for themes

I then grouped these initial codes into a list of initial themes:

- Continuity
- Involuntary attendance
- Confidentiality
- Diagnosis of PD
- Problems with MBT
- Identity and what they should be called
- Effecting change
- How to learn to be an EbE
- Boundaries
- Disclosure
- Sacrifices
- Positives
- Miscellaneous

For example, the following 7 initial codes from the interviews are grouped under the theme ‘Boundaries’:

- Problem with one man in group who knows EbE from prison and keeps coming to his house
- A met someone on bus who said she knew someone on MBT group
- Difficulties with men in the group who know you from before
- Man in group taking advantage of EbE due to past association and common experiences e.g., did drugs, in prison. Man feels EbE is keeping him in group. EbE feels he’s threatening
- Don’t know people in group personally, wouldn’t want to know them
- Difficult if they already know you or work out where you live. Not to get into feuds. A says he has his own tools so as not to end up back in prison
- If B has problems he can go to MBT team for support. A can’t do this as X used to be his therapist

Step 4: Reviewing themes; and Step 5: Defining and naming themes
I then spent some time reviewing, modifying, and reducing in number the preliminary themes identified in Step 3 above to see whether they worked in relation to the coded extracts. I tried to generate themes that were coherent and distinct from each other, by considering whether the themes made sense, whether they overlapped, was I trying to fit too much into a theme, and whether there were further themes that I had not identified. I then defined and named the themes.

The changes made were:
‘Involuntary attendance’ subsumed under ‘Continuity’
‘Confidentiality’ subsumed under ‘Boundaries’
‘Disclosure’ subsumed under ‘Boundaries’
‘Diagnosis of personality disorder’ subsumed under ‘Identity’
‘Sacrifices’ subsumed under ‘Learning to be an EbE’
‘Positives’ subsumed under ‘Identity’
Remove ‘Miscellaneous’

This resulted in five final themes listed in decreasing order of number of inclusive coded extracts:

Becoming an EbE	25
Identity	23
Boundaries	20
Continuity	18
Effecting change	10

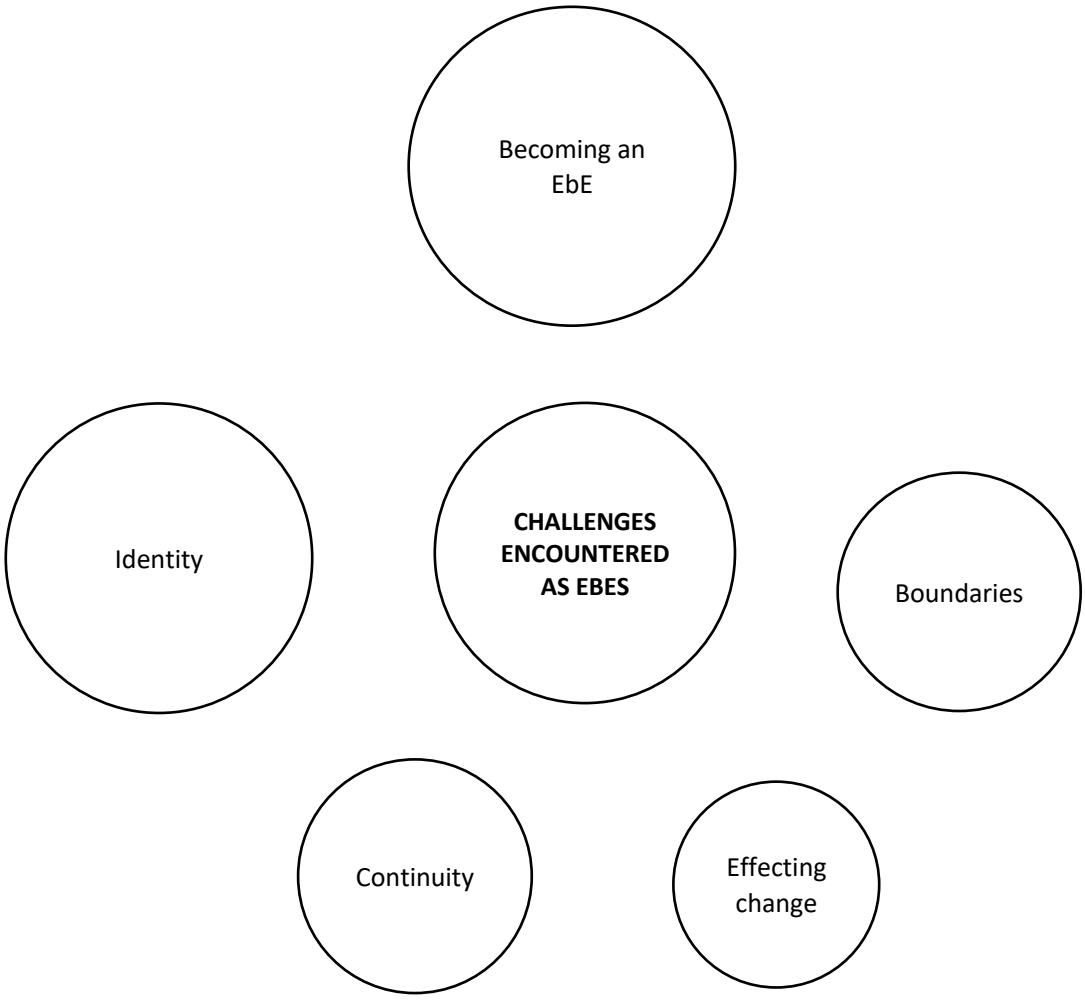
Step 6: Producing the report

In the final phase of the analysis, I re-read the transcripts and collated data extracts, selected vivid extracts of text to illustrate each of the themes, and organized them into a coherent account, which was then written up in narrative form.

8.3 Results

The qualitative analysis of the 3 interviews produced the following five themes presented in a thematic map (Figure 5).

Figure 5: Thematic map of challenges encountered by the EbEs in the trial



It was striking that most of the EbEs knew very little about the trial, with one person being unaware that there was one at all. This lack of awareness may have been partly due their main involvement in delivering MBT rather than in other aspects of the RCT such as helping with recruitment, and they had little contact with the research team. The discussions in the interviews centred around their experiences in working with the trial participants who had been randomised to receive MBT, their understanding of their role as EbEs and how this had developed, and how they enabled the participants to engage in and benefit from treatment.

8.3.1 Becoming an EbE

The most predominant topic that was discussed in the three interviews was their experiences of becoming an EbE, and what had motivated them to take up this role.

Participant 1: *Yes, then I shadowed the team the year before, yes. … It was something that I wanted to get into, with everything I saw. I looked at my own position over the years from the past, and I thought what would really have helped me was someone maybe meeting you at the gate or something, someone a bit like myself being able to, not like preachy, but someone-*

Participant 2: *Someone who's been, where they are.*

Participant 3: *Someone that you can relate to, which is what I do when I go to the prison. I'm the only bloke in there they can actually relate to within there.*

(EbE interview February 2020)

They described their anxiety and uncertainty when starting in the role and how their confidence developed by being present in the groups, observing the MBT therapists' style and interventions, and how the men responded to them.

Participant 2: *Well yeah, I… I certainly didn't, wasn't sure about what I was meant to be doing so I sat back a lot and watched and listened.*

And as I found my feet, I sort of participated more. But to begin with yeah, it was like what is this? What do I do now because it was very different to what I'd experienced at [previous service where he had been EbE] *for example? (I mean the last group was a very difficult group! (Laugh) You know they come in with their phones, eating food and they were really antisocial and didn't want to be there. You know, hard work (sigh). This group's a lot easier, thankfully!*

Participant 3: *I sort of did mine voluntary sort of from week to week, until it sort of became official. Then you sort of grow the more times you sit in… the easier… probably quiet for two or three weeks so… until you get used to things being… and also how the facilitators worked. Especially when they were going to change and everything. I was sort of like one constant and then the clients had to engage with you and then it's sort of a two-way stretcher.*

Participant 2: *It's been… yeah, it's an ongoing journey and yeah, I like it. And I… I mean I'd… I would happily do it on a voluntary basis.*

(EbE interview July 2018)

They stressed the importance of being able to relate to the men in the group due to their own experiences of the criminal justice system, but also how these prior experiences were continuously being expanded and elaborated by their experiences as an EbE in the group and learning from the trial participants.

Participant 1: *So, we're all different and we all think differently, but we've had the prison experience of the people that are there.*

Participant 4: *It's like a book of short stories, isn't it?*

Participant 1: *Yeah. So, what ways that you can talk to people, you know how to talk to them, its… it is a separate, you've got to have two heads.*

Participant 4: *I was a firm believer in the past of saying 'I've heard it all before, I've heard it, me!' But I learnt something that somebody told me once, it doesn't matter how old the book is, it can be the shittiest cover in the world, if you haven't read the book it's brand new. And that's how I see this kind of stuff now. And I don't… you know if you wrote a chapter and you wrote a chapter and you… and then I read it, I'd think well this is good, I can do this and I can relate this now to these guys. Know what I mean. For the bits that I didn't know.*

(EbE interview April 2019)

Whether their own individual experiences allowed them to qualify as an EbE and work with others who may have had different experiences was a topic of debate.

Participant 4: *But then you see that's the reason I don't want to use myself as expert by experience, because alright, I got experience in some ways, but I'm not an expert in that way because I haven't been taught anything. So, I can't class myself as 'by experience' against yourself like because you've been in a lot longer than I have. So how can I be classed as a person who supposed to look that part if they've done more time than I have?*

Participant 1: *I don't think it's all based on how much time you've done.*

Participant 2: *No, I don't think so.*

Participant 1: *It's about just… I think it's about whole life experience as a whole.*

Participant 2: *Yeah.*

Participant 4: *Right.*

Participant 1: *So, I mean like (umm) we've all been through bad things in our life haven't we?*

Participant 2: *Yeah.*

Participant 1: *I mean like bereavement, like death, losing people and stuff, time in prison, good times, bad times, everything, I think just… that's what I class it as. Do you see what I mean? Its experience as a whole. I've experienced a wide range of things and emotions so that's what I class it as.*

[GENERAL AGREEMENT]

Interviewer: *Yeah, because you're never going to all have identical experiences, but I suppose like you say you have got… you are…*

Participant 2: *We've got one thing in common as we said earlier, we're…*

Participant 1: *We've got life experience, haven't we?*

Participant 4: *And been caught*

(EbE interview July 2018)

One of the EbEs described the difficulties encountered and efforts he had made since being released from prison and the on-going support that he needed to keep him in the role.

Participant 4: *I know what you're saying, but I'm just thinking about, it's a 12-month rolling programme. I've been out nearly eight years now and it's taken me that long to get to where I am, and if we think back to when we began, I still struggle to mentalize, I still make mistakes.*

I think I've had a lot of support along the way as well. Really, a huge amount of support from various people, and I get supervision when I go to my MBT supervision, but yes, I've had a lot of support. I still see the psychiatrist every six to eight weeks [and the] psychologist.

(EbE interview February 2020)

The EbEs cited factors that facilitated their development in the role, including being part of their MBT team's supervision, attending the EbE training days, and being given feedback on their performance by the MBT therapist.

Participant 4: *I suppose… now which was like now you get a little bit more feedback because (umm) as I said from my end I was the first one to join it so I didn't know… I didn't have a clue what I was supposed to be doing. I could only go by what I learnt myself in the group so (umm) hopefully now that we're starting to get feedback off what I've actually done in the last year, and they look back at the cameras and… and they can see like well I could have done better, but obviously it's a learning curve. So rather done it anyway…*

(EbE interview July 2018)

Becoming an EbE made them also aware of some of the sacrifices this might entail which included the time taken to get to the group and incurring unexpected taxes despite not being paid much for their work.

Participant 3: *So, it was just stop-start, stop-start, and I was getting a little frustrated because before Christmas, I had to consider a few times during the year just financially because it's minimum wage really. It's not like you're paid a lot, and I had troubles with expenses and stuff like that because they said I was classed as local.*

Then I've got a big bill that I find from the Inland Revenue over a grand because what happened was my expenses, I think, were being paid in a lump sum because I was paying in my money for quite a long time. My account wasn't set up. They paid me in a lump sum, and then obviously my account bill, a letter from…I was just thinking, God, this job's more trouble than it's worth.

Interviewer: *You already sorted that out-*

Participant 3: *Yes. Normally, I'd fight something like that, but X just said, look, just squash that, just pay him. I fought it for so long. It was going on for nearly a year, and I just thought, in the end, it just caused some stress I might as well just pay it and then forget about it.*

Participant 4: *I get that, not to that degree, but occasionally, because I do MBT, I work in the Aylesbury NHS. So, occasionally, maybe a three- or four-week period, it'll build up, and then bang, I get a lump sum maybe £300, £400. I think yes, if the DWP asked for my bank account, I'm in trouble, but I just think what can you do?*

(EbE interview February 2020)

8.3.2 Identity

Closely linked to the theme of becoming an EbE was that of developing their identity as an EbE as distinct on the one hand, from the trial participants - offenders under the supervision of probation, and on the other hand, from the professionals with whom they worked. This meant occupying what was felt at times as an uneasy position between the two where they felt pulled in both directions and not appreciated nor recognised by either.

Participant 1: *I do actually resent having to wear it [his name badge]*

Participant 2: *You can take it off if you want.*

Participant 1: *No, no, but I brought it today because I wanted to talk about it. That's the only reason I'm wearing it now, but it's like when I went to the prison, I had to be escorted everywhere until I presented with keys. In my head, I was like, no, they're never going to let me have the keys, but they did.*

Participant 2: *You can get a key for your door.*

Participant 1: *Yes, I don't know. It's about wherever I am on my journey and benchmarks, if you like. So, I said, oh yes, this is important to me because I did resent having to sign in as a guest and then be a member of staff.*

Participant 2: *That's a friendly environment where you work, you're known there, but if you came outside of that and did your same job perhaps in another county, if you'd gone to visit another county [as an] EbE wherever, the people on that group might look at you and think who are you because straight away, they're going to say, oh well, because I still don't see you as an EbE now. You've got the experience, but now you've crossed over.*

(EbE interview February 2020)

Participant 2: *That's the thing. And because obviously as I say explained for me, I'm actually sitting on their type of desk and then I'm also sitting on your side as well.*

Interviewer: *Yeah.*

Participant 1: *So you're in the middle?*

Participant 2: *Yeah. So it's hard being pulled…*

(EbE interview April 2019)

Situating their identity in a middle ground, which facilitated rather than constrained their role, was felt to be important in order to be accepted by both the trial participants and the MBT staff.

Interviewer: *It's funny you say you see it from the other side because you would think they're maybe saying something about he's gone to the other side.*

Participant 1: *No, I don't see myself as that. I see myself as a bit of a bridge, I suppose. I don't see myself sitting on the fence. I did worry when I first joined how the other people in the group would perceive me because I'm not like an undercover, sort of KGB star in here. Morning, everyone. I'm just ready to tell people, because I do bump into people on the street, and I was quite fortunate really because I don't live in the area.*

Yes, well, I suppose at first when I joined, how the staff would perceive me, but that went away and I just thought it is what it is at the end of the day, and I just saw myself as wanting to be a bit like a guide, I suppose. Not necessarily nudging people into bad practices, but I think mentoring really.

(EbE interview February 2020)

Participant 3: *I'm a comfort zone for them and for me, I'm kind of in the middle.*

(EbE interview February 2020)

Their struggle in establishing their identity was reflected in ambivalence about what they called themselves, with particular discomfort in using the term 'expert by experience,'.

Participant 3: *I always try to say I'm not an expert.*

Participant 2: *Yeah.*

[LAUGHTER]

Participant 2: *Well I don't… I never use that word you know, I say …*

Participant 4: *I think the name's been changed a few times anyway like (umm) I didn't like the word (umm) what was the first one that we used? A 'Server' was it?*

Interviewer: *Service user.*

Participant 4: *Service User.*

Participant 1: *Service user, yeah.*

Participant 4: *Because it always made me (umm) think of ourselves as a user.*

Interviewer: *Oh right.*

Participant 4: *But I've always thought of like the word we came up with last time – 'Consultant' was a very… it looks more professional.*

Participant 2: *I mean I normally say I'm an ex-offender and that's it.*

Participant 4: *MBT professional I class myself as because I'm working with MBT and working with psychologists and (umm) I mean I haven't got the degree obviously, but I'm learning on the way.*

Participant 2: *That's often the best way.*

Participant 4: *Yeah. I mean obviously I'd like to put myself forward to do something in a couple of years, but I could never do it. So.*

(EbE interview July 2018)

Participant 2: *I've got the same issue with being called service user and expert by experience, because the service user… it sounds like as if you're a user as in on drugs and needles! Service is basically provided for that… but not really now because we're not in that same boat.*

Participant 3: *I don't know anything about drugs!*

Participant 2: *And expert by experience, who can say who's an expert and who's got the experience because somebody does like say a year in jail or one does twenty-five years. Who's more expert there?*

Interviewer: *So, what kind of thing?*

Participant 2: *I don't like… do… I've never viewed myself as an expert which means I don't like that word and I… I'd rather be called a mentor.*

Interviewer: *Mentor, ok.*

Participant 3: *When I went to the police station the other day they said 'Who are you here to see?' I said '[X]' and they said 'And which company are you with?' I said 'Actually I'm an expert by experience, and I felt so fucking stupid by saying that. I thought man, this woman… this is a policewoman, she has got no idea what… she's a receptionist and I… I don't understand what I'm saying to her either! Expert by experience? I thought just slip me into the group, I don't have to be called anything, you don't have to introduce yourselves expert by experience, and all that. Because I'm not an expert by experience, because I'm not an expert… that word*

'expert' is… is in… it's saying I know everything and I don't know… like I said he's talking about drugs there, I don't know much about drugs and… and what goes wrong with people's brains after drugs.

(EbE interview April 2019)

There was particular sensitivity around having a diagnosis of personality disorder, and whether this was necessary for the role as EbE.

Participant 3: *I would say that is a very, very good point because a lot of people that would… could actually have seen as negative when your record… if you were seen as having a personality disorder, that can… that can hold you back, you think oh I don't want that on my (umm) on my file because that can have a negative…*

Participant 2: *The thing with this is that we are experts, are we an expert in personality disorders?*

Participant 3: *Yeah, well I always…*

Participant 2: *Or have we got…*

Participant 3: *Yeah.*

Participant 2: *The biggest personality disorder out of the whole group?*

Participant 3: *Yeah.*

(EbE interview April 2019)

8.3.3 Boundaries

Maintaining appropriate boundaries regarding issues of confidentiality, disclosure of personal difficulties and how to manage interactions with the trial participants external

to the group were challenges that the EbEs struggled to negotiate, leading in some instances to disagreements with the MBT therapists as to what was permitted.

Interviewer: *But it is difficult in smaller places, isn't it, that you might know them or you've been in prison with them and how you managed that.*

Participant 3: *But we needed that rapport about prisons initially at the beginning of the year to break the ice because they needed to know what prisons I've been in because that can generally tell a story.*

(EbE Interview February 2020)

Participant 4: *To balance that up, I've had supervision where the person supervising me said you might care to think a little bit about what you want to disclose and how much information you tell people and not so much personal stuff to balance what you're saying because it doesn't bother me. I'm quite happy to disclose stuff about my personal life. I'm not bothered about people looking me up on Facebook or anything like that. So, yes, just to add a little bit of contrast to what you say.*

(EbE interview February 2020)

Participant 3: *You might come to the table with a problem, and really, at the end of the day, I am not supposed to come to the table with a problem. If I have got a problem, I can probably go and talk to someone else, but not MBT. I can't go there with a problem because it is for them. It is their hour.*

(EbE interview February 2020)

It was agreed that giving some detail about their own offending behaviour or recent experiences might be helpful.

Participant 3: *I wouldn't go into too much detail about personal things, but I just think I would give as much as it took to help them. And that is a little bit of what I do, without turning every little thing. When I go to the prison, I do it as well. I say listen, problems don't stop when you get out the gate, they carry on. Because I think they respect that and they're like oh, okay. And that is all I would do.*

Interviewer: *That sounds fine and that sounds quite vague.*

Participant 3: *Like I will give you examples as well. That is all I would be doing on the MBT group is saying well, actually, I can relate to that because something similar, and I might give them a sort of a rough outline of what happened, happened to me recently.*

(EbE interview February 2020)

Particular difficulties arose when the EbEs had encountered any of the trial participants in the past when they had been involved in the criminal justice system, for example whilst they were in prison.

Participant 3 *If somebody knows you, there's not much you can do about it. If you've made the approach to them, that's different, but because he knows you then there's fuck all you can do about it, but you've just got to be very … That's how little, stupid feuds get started, and they can have different outcomes. So, you've got to be careful with that.*

(EbE interview February 2020)

Participant 2: *What he tries to come across is he's done a long time, I've done a long time, he does the landings, I know the landings. So, he's playing a game now. He's trying to play a game where he's trying to get information off his back, he's trying to get off the course at times, like I am keeping him there.*

Participant 4: *It's not compulsory though.*

Participant 2: *No, it's not compulsory. I know what he's here for, and…It comes off difficult, his arsy behaviours or the room which becomes a danger to certain people in public, and this is how bad it is. So, I said, I said you'll have to keep away from me.*

(EbE interview February 2020)

A further area of concern which the EbEs felt needed further clarification was around the limits of confidentiality in how much the trial participants could disclose in the group without this being reported to their offender managers.

Participant 3: *I am glad you mentioned it because on the last cohort, probably a year and a half ago, I forget his name, there were young kids. Social Services were involved, and he came and disclosed to the group that he was drinking, I don't know, eight or nine cans of strong lager a day. Immediately, they didn't have a choice, they had to do something about that, because his kids were at risk.*

Participant 4: *They're going to do that, aren't they because he has said then he is taking the medication. I call alcohol the medication, he is taking that kind of medication, drinking, but that leads to other things. Do you know what I mean?*

Participant 3: *It did. They had no choice but to tell his probation officer because the kids were at risk. He ended up losing the kids anyway. Social services were already involved. He'd come in sometimes stinking of cannabis and skunk and stuff like that. But we now make a point of saying to the people, 'Look, unless you're going to talk about harming yourself or somebody else, basically everything else is okay.'*

(EbE interview February 2020)

8.3.4 Continuity

A sense of continuity and stability in the group was agreed to be an important element of effective treatment. In this respect, frustration was expressed in relation to the inconsistent attendance of the MBT therapists in some sites.

Participant 3: *Well I think the one [challenge] in [location of group] is the continuity and the inconsistency of the number of the people that attend.*

Participant 2: *You're not alone!*

Participant 3 *And because the facilitators change every week, it's hard to get a stream or to carry something on from the previous week. I know [the assistant psychologist] sorts out the rotas and she normally tries to have one person from the previous week on the next. But unless you get the same clients turning up from week to week to week, then there's no… it's always a stop/start and you're always… it's re-explaining the rules and questions about the confidentiality bits and things. So, it's hard to be consistent.*

Interviewer: *And is there anything that could make that better?*

Participant 3: *No, because it's voluntary. So, the clients can turn up when they want because quite a lot of them still class it as a tick in the box. If they don't turn up, the probation will find out and it's a black mark against their names. So.* *(umm)*

(EbE interview July 2018)

Participant 3: *Last week, we had a group on the Tuesday, and [A and B], two brand-new girls just started, managed to get three fucking sessions under their belt before they both took leave. I thought*

don't come back because the two that took over were the regulars [MBT therapists C and D] and they're old-school, if you like, on the job. One of the guys said to me the other day I told you, every time he was asked the question, C, [MBT therapist], put this on me, and this was after the group, a little chit-chat. She said I noticed that every time I asked the member a question or A asked the member a question, the member would turn around to me and answer the question but wouldn't give eye contact to either of the females.

I didn't notice myself, but I thought yes, because C [MBT therapist], at the beginning, wanted to do catch-up for not just the last week but last couple of fucking weeks, of course, all this year, she hasn't sat in the group. The last one she sat on was the 7th of January. That was the one where the training that came in at 11h00 until 15h00. That was the last one she was on.

So, she hasn't been there, and we've just got two brand-new guys. One's a fixed sentence but high risk, and the other's one IPP, just finished 11 years. But I've got used to them and I can talk to them, and they can talk to them because we have a chit-chat before we get on the group because we're in the same waiting area

(EbE interview February 2020)

The theme of continuity was also raised in relation to the outcome of the group participants after they had finished treatment and what further support they could access so as to sustain gains achieved during treatment.

Participant 2: *Another thing I can think of, slightly off that path is… when somebody does go through a whole year, and they must express their feelings in the group… what happens to them then actually after they leave? What help have they got? If they're thinking…*

sometimes it's a break for them to get out of the house, just to speak what's on their mind, oh I've had a really shit week, so-and-so… and when that comes to an end, they're back in the square thinking… they're like a hermit again, back in the house, they… and nobody to speak to anymore.

(EbE interview April 2019)

8.3.5 Effecting change

The final theme that crystallised from the interviews concerned the EbEs' theories on how they facilitated the trial participants to engage in the group, to recognise and modify their problematic attitudes and behaviours, and to move away from a life of crime.

Gaining the men's trust was recognised as the first step in the process.

Participant 2: *Six weeks ago, which was the first one I'd had and I've been doing it for a long time. One of the guys thought… he didn't know which… what my full role was because it wasn't quite explained to the round robin thing. And then he thought… which was in some ways it was like being a grass!*

Participant 1: *Yeah!*

Participant 2: *It was a horrible feeling and it made me feel like shit, I used to be that… well they just sit there, exactly where you are, and I didn't think of anyone as being… because I'm obviously the first one that's to do this mental thing.*

Participant 4: *Yeah.*

Participant 2: *But now it's just like when it was explained, it was just try to get somebody's trust.*

(EbE interview April 2019)

This involved at times speaking in a more direct and confronting manner than the therapists.

Participant 2: *I think we can often say stuff that the clinicians might feel reluctant to say. Whereas we can say it and not necessarily get away with it, but get heard, get listened to.*

Participant 3: *Yeah.*

Participant 2: *Because they know we're not coming from a point of authority, you know and we've been where they are so… so ok, listen.*

Participant 4: *I think we'd have been heard more because we've also been through the mill. So (umm) sometimes like with professionalism, they don't know how it feels to be in the situation of the ex-offender or whatever it is. So (umm) that's… I suppose with this I suppose people can trust us a bit more.*

Participant 2: *We haven't got an extra guide.*

Participant 4: *Why would we bullshit by it, because at the end of the day we've actually done it!*

(EbE interview July 2018)

Being able to shift between recognising the mindset of the criminal and that of the professional enabled the EbEs to detect when the trial participants were being evasive or insincere and encourage them to consider that the viewpoints and motivations of their offender managers might be in their best interests.

Participant 3: *We know the questions to ask, I am not a stupid person and I have been in crime and criminology and all the rest of it. I know*

the questions to ask just to get a little bit of reaction. And I don't need to give anything of me. I know what it is, I know the question, I know what happened on the last six groups and just use that, not against them, but I use it as boundaries because something that they perhaps talked about five, six weeks ago.

Because when I get home, I write everything down. I fucking do. That's why I have got pads. I have got four or five pads now just A4s, and it is nothing personal, I just put initials and subjects. And how I felt they conveyed themselves and whether or not I believe them and there haven't been any liars yet. So, because as much as they are giving, I could also tell if they are bullshitting because that's the beauty of it.

Interviewer: *So, you can tune in, can you?*

Participant 3: *And that's why I said to X last time, I never ever stopped being criminally minded. I am not a criminal, but I can get out of that what you're thinking, because that is how I have done it for 40 years. So, it is part of the mould I came out of.*

Participant 1: *That's what makes you good at what you do.*

Participant 3: *Exactly. As much as we help other people, we can also check out the bullshitters, the ones that are not doing it. And at the moment, we have got two that are good, and the last year, we had one of them that was good. And none of them have gone back to prison.*

(EbE interview February 2020)

Participant 1: *Yes, and I try to get it from both points of view. The staff, I try and get it from their point of view, and also when the lads are obviously*

in the room as well, I always say, look, the staff are actually not too bad, they're only doing their job at the end of the day.

Participant 3: *How do they take that?*

Participant 1: *No, I just say, look, you're making it difficult for them because at the end of the day, one staff member, it was really good to see a good probation officer, but I had a dilemma. If they do something on my watch, then it's on me, but then if I give them a chance, which I want to do, then this person's completely pushing it and pushing it and pushing it, what do I do?*

I thought if I put myself in their shoes for a minute and that person was to go out and do something really bad to someone, how would you- At a point when I heard that, I thought do you know what, could I make that call then and there if I've got loads of people on my book to see that day.

It's what I try and say to them [the trial participants]. I said to them, look, they've got a job to do, and if you're actively out there, then the public protection bit will come into it. But if you give yourself a little bit of room and try and do positive things, they won't put hurdles in front of you. I said if you do really well, they would probably go out of their way.

(EbE interview February 2020)

Being present in the group and communicating with the trial participants in a way that they understood fostered a sense of curiosity - of the fundamental aspects of mentalizing - initiated a process of positive development that could be built upon.

Participant 1: *It's great. Some of the lads that have come in, because they've seen me there, just seeing me there, I think, automatically has made them curious straight away-*

Participant 4: *And that's what it's all about, being curious.*

Participant 3: *Yes, that's right. It starts that seed of change if they can do it-*

Participant 4: *And once you start talking their language, there is a language-*

Participant 1: *That's it, that's what the group is there for.*

(EbE interview February 2020)

8.4 Discussion

Few studies have looked at the experiences of forensic peer support workers or service users in the criminal justice system, and although there are some studies of the perspectives of peer workers supporting the treatment of borderline personality disorder (Barr et al., 2020) to my knowledge there are no published studies of the experiences of peer working with an offender population with a diagnosis of ASPD.

8.4.1 Developing an identity

The two most prominent themes in the interviews, which were closely related, were the process of becoming an EbE, and what being an EbE meant in terms of their identity. The EbEs recalled how difficult it was for them coming out of prison and how to cope with life on the outside, and how much they would have valued someone in the role that they now occupied to help them. Although the primary task of the EbEs in this trial was to engage the men in treatment rather than specifically support offenders' reintegration into the community, they could identify with many of the men in the group who had been recently released from prison. Several studies in the US show the benefits that forensic peer mentors or 'peer navigators' (Portillo et al., 2017) can offer in re-entry programmes which assist the transition of formerly incarcerated persons to the community (LeBel et al., 2015; Matthews et al., 2020; Portillo, 2017).

The EbEs stressed the importance on-going training, supervision, and feedback from the MBT team for them to become confident in their work, factors which have been

identified as facilitators in adoption of the role of a forensic peer support worker (Barrenger et al., 2020; Gillard et al, 2013). Observing how the MBT therapists intervened in the group and the participants' responses, and regularly attending supervision of the MBT team enabled them to learn about the treatment model.

The significance and value of shared experiences between the EbEs and the offenders provoked lively discussion. This was discussed in relation to both their development as EbEs and what they thought was effective in engaging the men in treatment. The literature on service user involvement in mental health settings indicates that one of the key mechanisms underpinning peer support relationships was lived experience (Watson, 2019). 2 recent qualitative studies of the views of peer specialists in the US criminal justice system found that having and sharing lived experience formed the basis of their work (Barrenger et al., 2018; Reingel et al, 2019). The EbEs in this study recognised that lived experiences were not static but continued to evolve throughout their lives, and what was useful in gaining the trust of the offenders was not just their shared knowledge of the criminal justice system but experiences from their life as a whole.

Moreover, the role offered new experience, not as an ex-offender, but as someone who was considered sufficiently qualified by their existing experience to work alongside trained clinicians in delivering treatment. This required an ability to take different perspectives, to imagine the intentions and motivations, and associated thoughts and feelings, in other words to mentalize both the offenders and the professionals in the team. However, this fluctuation between taking up the identity of the offender and taking up that of the therapist made it difficult for the EbEs to find a distinct identity of their own. Of particular concern was the fear that the offenders with whom they worked would perceive them as traitors, that they'd 'crossed over' and gone to the other side. At the same time, they did not always feel accepted as legitimate members of staff, describing how they were not trusted to have their own keys when doing work in prison, or having to sign in as guests. This highlights the power dynamics which can hinder effective peer working (Greenacre & Paez, 2019). The structure of the criminal justice system is inherently hierarchical, where professionals have real control in making life-changing decisions for offenders. This replicates and reinforces the model of relationships which have been internalised at

an early age from their abusive childhoods and/or the criminal subculture which many experienced where the paradigm for relationships is one of dominance and submission (Jeffcote, 2018). Moreover, formalising peer support by offering payment and titles can create perceived power differences (Repper & Carter, 2011; Mead, 2001), which may be resented. Whilst recognising that these power differentials are inevitable, within more reciprocal relationships, such as those promoted in the OPD pathway, power can become empowerment by working together in a mutually respectful way. However, where peer workers are neither enabled nor supported to bring these relational values to their work peer support is weakened or corroded (Gillard et al., 2015b; 2019; Schmidt et al., 2008).

To withstand being pulled too much in either direction the EbEs described finding their identity in a 'middle ground', where they would feel authentic and have the confidence to act as a bridge of communication with both sides. In the literature on peer support workers in mental health, this has been described as the 'third position' of an EbE, who recognises the expertise and vulnerability of both patient and professional (Lees et al., 2019) or the 'liminal position' between the two distinct identities of service user and mental health worker, or more widely between those who are included within society or those who are stigmatised and marginalised (Watson, 2019).

Their uncertainty as to where to situate themselves was linked to their reluctance to be referred to as experts – they felt that although they had learned from their experience and could impart some of that knowledge to others, this did not give them a special status. Their ambivalence as to what they should be called is reflected in the literature where such roles are variously designated as 'service user consultant', 'lived experience practitioner', 'forensic peer specialist', 'peer support worker' or 'mentor', often with no clear differentiation of the meaning between the different terms. In mental health, more agentic terms such as client, consumer or service user have been used to replace less agentic terms such as patient, in an attempt to reduce stigma (Fischer et al., 2020).

The EbEs were well aware of the stigma of having a diagnosis of personality disorder, both for themselves and for the trial participants with whom they were working. The EbEs in this study were all ex-offenders who had suffered from mental health problems themselves, some of whom had been given a formal diagnosis of ASPD. Some

continued to struggle with mental health issues which needed on-going psychiatric or psychological support, but they also described how their personality difficulties had improved, at least to some extent. This is consistent with studies that show that forensic peer support specialists with mental health and criminal justice backgrounds find that their work contributes to their own recovery process (Barrenger, et al., 2020; Lebel, 2007; Lebel et al., 2015), as well as their personal and professional development (Hodgson et al, 2019). Nevertheless, clinicians should be sensitive to exacerbations of their mental state, such as low mood or general emotional instability, which may interfere with their involvement and commitment to the work (Jeffcote, 2018).

8.4.2 Boundaries

Individuals with ASPD frequently break boundaries, and the EbEs in this study were aware of the importance of maintaining safe boundaries in their relationships with the trial participants, but there was confusion and divergence of opinion between themselves, and with the MBT team, as to what was reasonable and appropriate. Boundary issues are widely reported in the literature on the challenges of service user involvement and peer support work in mental health services (Gillard et al., 2014; Miyamoto & Sono, 2012; Repper & Carter, 2011; Watson, 2019) and more recently in the criminal justice system (Barrenger et al., 2018; Jeffcote, 2018).

One of the key issues was how much the EbEs should disclose to the trial participants about their personal experiences, with some wanting to talk in more detail in the MBT groups about their offending history than the MBT team thought was appropriate. Sharing experiences is a hallmark of peer support services in general (Barrenger et al., 2018), and more flexible boundaries allow for more egalitarian and meaningful relationships and may avoid the negative effects of the power imbalances of traditional professional relationships (Mead et al., 2001). However, within forensic settings, peer specialists with criminal histories may risk becoming over-exposed and even put themselves at risk by disclosing too much, especially if some of the offenders they are working with were former acquaintances or associates, or are still involved in criminal activities, as was the case for some of the EbEs in this study. Linked to this, there was also confusion regarding how much the trial participants themselves could disclose about their offending behaviour without being reported to their offender

managers. These complexities highlight the importance of regular supervision from the team and clear guidance regarding the limits of disclosure and the rationale for these decisions.

8.4.3 Attachment, mentalizing, epistemic trust, and desistance

The dissatisfaction expressed by the EbEs in relation to how the turnover of MBT therapists in some sites disrupted the group process, and their worries about the lack of support available to participants once they were discharged from the group, highlighted how important continuity of care is to individuals with ASPD whose attachment difficulties stem from childhoods in which continuity of care was absent and those who should have given care were abusive or neglectful. Such adversities interfere with normal psychosocial development and produce an internal world which is fragmented and conflictual, a state of mind that may be mirrored by the harsh and fractured nature of the criminal justice system in which they find themselves, a retraumatising repetition of their childhood experiences. Although the personal histories of the EbEs were not discussed within the MBT teams or groups, it is likely that they also had suffered similar childhood experiences and identified with the group participants' struggles in developing trusting relationships and a sense of stability, which were not facilitated when the same therapists were not consistently present.

Desistance is the process by which someone stops offending, and it is interesting to examine how attachment might contribute to the causal connections that promote desistance in some offenders but not others. Early theories of desistance stemmed from the seminal longitudinal research of juvenile delinquents by the criminologists Glueck and Glueck (Glueck & Glueck, 1937), who challenged the early 20th century beliefs that criminal behaviour was genetically determined by emphasising the environmental as well as biological factors involved. Laub and Sampson further developed the Gluecks' theories by giving emphasis to sociological influences and highlighting how attachments and social bonds with significant others, such as marriage, served as a 'turning point' in the trajectory of a criminal's life (Laub et al., 1998; Sampson & Laub, 1990; 1992; 1993). Giardino and colleagues built on this theory by bringing in personal agency as a significant factor and that events like marriage and employment acted as 'hooks for change' rather than turning points in the

journey of desistance which promoted the cognitive transformation necessary for a sustained abstinence from involvement in crime (Giardino et al, 2002).

Fonagy and colleagues have integrated these accounts into their mentalizing-based approach to violence and crime, as well as their general theory of therapeutic change, based in attachment research and social learning theory, in which the concept of epistemic trust is central. As discussed in chapter 2, epistemic trust refers to the trust in the value of social knowledge that a teacher may offer the learner where the teacher is felt to be a trusted source of that knowledge, and where the knowledge is communicated in a way that seems personally relevant to the learner and will motivate changes in self-identity and social perception (Fonagy & Allison, 2014; Fonagy et al., 2015; Fonagy et al., 2019). The matching between the instructor's image of the learner, often based on their shared experiences, and the learner's self-image, allows the learner to receive and process the instructor's message in sufficient depth to permit the effective transfer of information from one mind to another, representing a process of cognitive transformation. However, individuals, such as those with ASPD, who have experienced early adversity and attachment disruptions, are trapped in a state of 'epistemic hypervigilance' where their mistrust of those around them hinders the efficient communication of knowledge (Fonagy et al., 2019; Fonagy et al., 2020). Treatment will only be effective if the therapist is a trusted giver of such knowledge.

In forensic peer support relationships, the offender wanting to reform trusts the knowledge being taught by the reformed ex-offender due to the shared understanding of experiences more than that of professionals who are not fellow offenders, and moreover may be experienced as persecutory parental or authority figures. In this study, helping the trial participants develop trust was one of the key elements identified by the EbEs in initiating change. The men's trust was engendered through feeling better understood by the EbEs than by the therapists due to their shared experiences of offending and the criminal justice system. Via epistemic trust, peer workers may therefore facilitate those with whom they work to be more open to learning, promoting engaging in and willingness to benefit from therapy.

In MBT, the group setting allows for attachments to form between group members, which may enhance epistemic trust, but these bonds in themselves are not the drivers

of change. Mentalizing promotes the capacity to envisage the lives of others, such as are modelled by the EbEs, and see these as relevant to their own lives, enabling them to gradually adopt a new identity and new ways of thinking less dominated by cognitive distortions. In this study, the EbEs' views that their ability to put themselves in the offenders' shoes, offer alternative views and fostering curiosity, aptly captured the active mechanisms operant in the process of this cognitive shift. The EbEs also felt that they could be more challenging than the MBT therapists due to their ability to shift between the 'criminal mindset' and the mind of the professional, and their ability to detect when the trial participants were being avoidant or dishonest, which one might hypothesise exerted a further push in their change of identity.

The social learning within the group can eventually be expanded to cause positive changes in their external lives, with the growth of more supportive and prosocial relationships. Fonagy and colleagues' theory of change is in line with Giordano and colleagues' (Giordano et al., 2002) theory of cognitive transformation which stresses the influence of social processes as generating a motivation to change through the modification of self-structures which lead to self-improvement, as well as with other theorists of identity who stress that a fundamental and intentional shift in the offender's sense of identity or personal narrative is essential for desistance to become sustained (Farrall, 2005; Maruna, 2004; Paternoster & Bushway, 2009). The EbEs' accounts in this study of finding their identity as peer support workers and role models as described above may be examples of this on-going process of reformation.

8.5 Conclusion

This study is limited by being based on interviews with a small number of EbEs who were involved in engaging participants in the treatment arm of an RCT of the effectiveness of MBT, and its specific findings may not be generalisable to EbEs or peer workers in different roles or settings. Nevertheless, the EbEs' experiences and opinions in this study correlate with those of other forensic peer workers reported in the literature, particularly in relation to the value of shared experience, the conflicts between their former identities as criminals and their new ones as paid workers and boundary issues. Moreover, their ideas about how they assisted positive change in the trial participants with whom they worked, in particular by sharing experience, increasing trust, and being able to identify with the participants' mindset so as to better

challenge their existing thoughts and beliefs, are in line with theories of desistance that focus on the prominent role of developing a non-criminal identity to produce the cognitive transformation to sustain a non-offending life-style, and with Fonagy and colleagues' development of these theories to include the concept of epistemic trust and the role of mentalization in promoting desistance. What is also notable is that in the interviews, the EbEs' descriptions of what they thought was important in effecting change are examples of good mentalizing, such as putting themselves in the trial participants' shoes, offering different points of view and promoting curiosity.

The personal strain and toll of such work should not be underestimated. The EbEs described on-going experiences of rejection by criminal justice services despite their designated peer worker roles, difficulties with claiming benefits and time spent in travelling for which they were not financially reimbursed. The emotional burden of working with personality disordered offenders was also evident, especially for those EbEs who suffered from mental health or personality difficulties themselves. The EbEs in this study were clear that they wanted on-going supervision and support in their role; this is a fundamental requirement of any peer support work.

This study highlights the relational foundation of forensic peer support work in which the development of trust, understanding of and respect for the offenders' experiences, and an ability to offer different perspectives. These qualities reflect key elements of all OPD pathway services, in which meaningful service user involvement is integral to their structure, function and delivery.

Chapter 9: Interpretation of the findings on the emotional impact of the trial within different theoretical models

9.1 Introduction

The unexpected theme that emerged from the interviews of all the groups of professionals involved in the trial - MBT therapists, research assistants, probation officers and commissioners - was that the most prominent obstacle encountered in implementing the trial was found to be its emotional impact. Although there was not the opportunity to do follow up interviews with the participants in this study to explore this topic further, it is nevertheless of interest to consider how these findings might be meaningfully interpreted within each of the two theoretical models of organisational dynamics described in chapter 3, namely psychoanalytic and mentalizing, and the limitations of these models in making sense of the data.

This chapter will examine how the emotional effects of implementing the trial can be understood and contextualised within each of these two models, the limitations of these models in interpreting the entirety of the findings, and whether other theoretical models of emotions within criminology may provide a better conceptual fit or enhance such understanding. Exploration of different explanatory frameworks is important as it widens the scope of potential remedies to prevent and/or lessen the emotional toll of implementing these types of trial.

9.2 Preliminary interpretation of the findings

9.2.1 Psychoanalytic organisational framework

In viewing the findings of the interviews through the prism of a psychoanalytic organisational perspective the emphasis is on the unconscious conflicts, defence mechanisms and fantasies operant in the dynamic relationships between the staff and offenders, between the staff and the organisation, and in their relationships with each other. Within a psychoanalytic organisational framework, the central point is that the disturbed emotional states of the offenders become projected into the institution and the staff group, resulting in pathological defensive reactions to defend against intolerable anxieties. In this, predominantly Kleinian, psychoanalytic framework, it is

not just the projection of affects, and their associated unconscious fantasies that the person cannot process or tolerate, but also the projection of primitive defence mechanisms, such that the mental states consciously experienced by the staff reflect a complex interplay of unconscious affects, defences and fantasies. Thus, the negative feelings of frustration, disappointment and detachment which the MBT staff reported consciously experiencing may defend against more intense emotions, such as anger, terror or despair that are less acceptable to admit into consciousness and reflect (or are the projection of) the unbearable emotions that are aroused in the offenders in reaction to their current and historical adverse experiences.

From such a standpoint, feelings of belittlement that the research assistants reported may, at least in part, not have been based in reality, but rather reflected persecutory anxieties resulting from the projection of the trial participants' feelings of rejection, humiliation and disrespect, which are so commonly reported as being experienced by violent and antisocial individuals. Similarly, the research assistants' feelings of being split off from the rest of the team may reflect a projection of the fragmentation of the offenders' own states of minds, where primitive defence mechanisms of projection, projective identification and splitting prevail.

At the same time, more positive emotions were reported by the MBT team. They described feeling like a family, a sense of solidarity, a 'gang' along with the other regional sites and their supervisors. These feelings may reflect their authentic interest, curiosity and hope in a project aimed at improving the lives of men who have been neglected by their families and society but may also be the manifestation of unconscious defences against splitting and fragmentation, the 'gang' metaphor reflecting the more insular, rigid and hierarchical mind sets of the offenders, many of whom were, or had been, the member of gangs in their external lives.

The interviews also suggested that primitive affects and collective defences against these existed within the dynamics of the criminal justice system within which the trial was embedded. As mentioned earlier, one of the commissioners thought that parts of the system were envious of the well-resourced and exciting work of the OPD. Both envy and excitement are classified psychoanalytically as primitive or pre-oedipal affects, characteristic of Klein's (1946) paranoid schizoid position, affects which are narcissistically centred and provoked by frustration and deprivation, feelings which in

turn were reported by the interviewees and attributed to their colleagues who felt overworked, unappreciated and mistreated in an underfunded criminal justice system. Similarly, the reluctance of another commissioner to report her feelings of hostility to funding this project may reflect a primitive persecutory anxiety of being attacked within a culture that sanctions punishment and revenge for aggression as opposed to understanding, reparation and conciliation, which are attributes of Klein's (1935, 1946) depressive position.

9.2.2 Mentalizing framework

The results of the analysis of the interviews of staff involved in implementing the trial can also be interpreted within a mentalizing model. The non-mentalizing nature of the criminal justice setting in which they were embedded was clearly communicated within their narratives. They spoke of a system which was not based on attention to mental states but on action. The solution to the constant turnover of staff was to immediately replace them with new staff in a mode of psychic equivalence rather than reflect on their emotional states and needs produced by the adverse work conditions which were the drivers of their exodus. Offenders were defined by and punished for their behaviours, with no curiosity in their minds. Recall was a common obstacle to recruitment into the trial, which was sometimes thought by the MBT team not to be a proportionate response but rather a rigid interpretation of official guidance by some probation officers, which can be seen as a teleological response to offenders' antisocial actions at the expense of considering the individual's internal affective states and motivations for his crimes.

Although individuals within the MBT teams clearly had significant capacities for mentalizing given that they were trained in and delivering a mentalizing intervention, nevertheless, working within such a non-mentalizing system their mentalizing abilities could be compromised, particularly when they felt emotionally overwhelmed by the anxieties of working with risky, non-compliant, and aggressive men or when they experienced hostility or resistance towards the trial from some of the probation officers. It is therefore possible that the criticism and disapproval that the MBT team felt was directed towards them from the research team, which they inferred from the tone or frequency of the emails they received, was in reality not present in the minds of the researchers, but that the MBT team were operating in teleological mode by making an

assumption about the intention of the other by their interpretation of the meaning a physical action (sending the emails) without actually knowing what the research team meant to communicate. This also illustrates an imbalance in the poles of mentalizing – too much of an external focus within the internal/external dimension, in focussing on the overt manifestations of the other's behaviour rather than considering the other's internal state. This can then lead to too much automatic (implicit) rather than controlled (explicit) thinking and being too far towards the emotional end of the emotion/cognitive dimension in a paranoid affective state; and in the context of a persecutory, punitive environment, the person can become hypervigilant and constantly looking out for threats. These deficits in mentalizing, of course, are characteristic of the mindsets of many of the offenders with ASPD who were participants in the trial, and whilst it is not implied that the staff implementing the trial had limited capacity to mentalize in general, it is an illustration of how a non-mentalizing system can reduce mentalizing in those individuals within it, which may lead to a vicious circle perpetuating non-mentalizing modes of relating in the system.

The splits described by the interviewees that they felt existed within themselves and the system - within the MBT team, between the MBT team and the researchers, between the MBT team/research team and the rest of probation, and within the commissioner group - may also have been the result of non-mentalizing attitudes and states of mind in those involved. As noted previously, the criminal justice system is founded on a binary paradigm of being found guilty or not guilty, a model which facilitates psychic equivalence ways of thinking where opinions become rapidly polarised, dogmatic or black and white in their nature, with no nuanced thinking or compromise possible. This type of relating may have been played out to some extent within the staff involved in the trial, for example the research assistants' experiences of feeling belittled by others in the MBT team may have been in part due to a regression to a two-dimensional victim/perpetrator paradigm of relating, again typical of the way many individuals with ASPD experience the world. This highlights the absence of a sense of 'we-ness' (Fonagy et al., 2021), that is, the development within a couple or group of individuals of joint intentionality and togetherness that is necessary to engage socially with others. This involves the capacity to coordinate perspectives and appreciate the distinction between the subjective (one's own viewpoint) and objective (external reality) and coordinate these with another person's

mental state. There is joint attention on a common object but with different perspectives. This shared process involving the joining of minds in collaboration with others is an essential ingredient of social mentalizing.

9.2.3 Limitations of these models

Although both psychoanalytic organisational and mentalizing models provide useful and complimentary ways of interpreting the findings, nevertheless, limitations may be identified, in that several relevant topics are lacking within these two frameworks.

First, there is no exploration of the legitimacy of emotions within the workplace i.e., how much the organisational culture condones or disapproves of emotional expression and the tension between what staff believe they are permitted to show as professionals within the work setting and the emotions that they actually experience internally.

Secondly, there is no discussion of the pre-existing emotional capacities of staff within the criminal justice system, how these are affected by a hostile environment, and how emotional sensitivity to others may be enhanced and honed to strengthen their engagement with offenders and increase emotional resilience to working in these challenging settings.

Thirdly, there is little empirical research focussing on the emotions experienced by offenders and how these are affected by the emotional culture of the organisation.

And finally, the psychoanalytic and mentalizing literature on emotionality lack studies on the emotions experienced specifically in criminology researchers and how they manage these in their work within the criminal justice system.

These four areas have been addressed within a growing literature on emotions in criminological studies, specifically in relation to the concepts of emotional labour, emotional literacy, and affective and moral climate respectively, and how they are played out in the emotionality of criminological researchers. I will now review these areas of study within criminology and see how they might enhance understanding of the findings of this thesis beyond the psychoanalytic organisational and mentalizing frameworks and delineate the overlaps between these different theoretical models.

9.3 Emotions in criminology

Traditionally, criminology has been wary of emotions. The discipline emerged out of the Enlightenment in the late eighteenth century and was established within modern liberal democracies as a science with concomitant principles of reason and rational discourse. Public expressions of emotions were viewed with suspicion by criminologists and the role of criminal justice was tasked with curbing such emotions for fear they would be manipulated by the media to influence politicians and other law and policy makers to fulfil irrational and unjust populist demands (Karstedt et al., 2011). Penal law, jurisprudence and criminal justice positioned themselves as limiting the intrusion of emotions into law to uphold reason by making emotions more 'reasonable' – fear of sanctions instils compliance with the law, and vengeance is channelled by legal procedures (Elster, 1999) - choosing to ignore how powerful emotions continue to pervade crime, law and justice.

Since the mid 1990s, there has been a revival of interest in emotions in criminology, corresponding with a 're-emotionalisation' of criminal justice and the law (Laster & O'Malley, 1996). This manifested in several trends within society and the legal arena: the return of shame in humiliating public punishments, first in the US (e.g., sex offender registers; judges ordering convicted offenders to wear signs in public exposing their crimes); and subsequently in the UK (e.g., electronic tagging; the media exposing, naming and shaming paedophiles); citizens and politicians' fear of crime, driven by a highly emotional, mostly punitive, public discourse on crime and justice; and the victim movement with a focus on their emotional needs, with their presence in the courts and at executions in the US (Kardstedt, 2011). These movements harnessed and capitalised on the more negative and destructive aspects of affects that characterise the moral indignation of penal populism such as anger, disgust, contempt, shame, and vengeance, which overshadow the more hopeful potential of emotions such as forgiveness, empathy, guilt, grief, and love. These more positive emotions provide the emotional foundation of the development in recent years of restorative justice, which aims to transform the negative emotions of both victims and perpetrators into emotions that enhance social bonds (Sherman & Strang, 2011). Within a psychoanalytic framework this may be seen as the conversion of the primitive emotions of the paranoid-schizoid position into the more mature emotions of the depressive position

(Klein, 1935; 1946), a reparative development which includes increasing conscious awareness of previously unconscious processes, and reflecting a view within criminology that societies can more fairly control crime and punish offenders by acknowledging rather than suppressing the central role of emotions in establishing law and order (Loader, 2011).

At a more global level, criminologists have also turned their interest to dealing with collective emotions in the quest for a more peaceful justice via reconciliation and conflict resolution of violence within community and international relations, taking account of the legacy of nations' historical traumas and experiences of humiliation which are perpetuated through generations of on-going warfare (Brewer, 2011; Scheff, 2011). This has also been explored within the psychoanalytic literature, for example in the writings of Alderdice (2017a; 2017b), and Volkan (1988; 2006) who have written about the Northern Ireland conflict and about the conflicts in Afghanistan, the Balkans, and the Middle East, respectively.

However, this emotional revival within some areas of criminology and the law has been offset by policies, practice and environments within the criminal justice system which minimise or exclude any recognition of the role of emotions. This trend has been influenced by the rise of managerialism and its emphasis on quantitative rather than qualitative measures of success - its focus on the concrete in favour of the 'ineffable' (Knight et al., 2016). Nevertheless, the recognition that emotions continue to brim beneath the surface of the edifice of criminal justice institutions - within prisons, probation services, police forces and court rooms, in the offenders managed by the system, in the personnel and professionals who manage them, and in the relationships between them, has resulted in a growing literature on emotions in criminology. However, this is for the most part embedded within a sociological framework, with few references to psychological approaches in general, let alone psychanalytic or mentalizing perspectives. Where psychological theories are referred to, these are usually based on a cognitive-behavioural model, for example, Gross' cognitive appraisal model of emotional regulation (Gross, 2015) has been utilised in research on how prisoners manage their emotional states (Laws, 2018; Laws & Crewe, 2016). Within criminology there are three predominant and interrelated areas of research on emotions in criminology and their application within the criminal justice settings of

prisons, probation and police: emotional labour, emotional literacy, and affective and moral climate. Pertinent to this thesis, these three concepts have also been applied to the study of the emotionality of researchers themselves in the criminology discipline, an area which is lacking in the literature on psychoanalytic and mentalizing approaches to organisations.

9.3.1 Emotional labour

Discussions of the emotional state of staff working within the criminal justice system has centred around the concept of emotional labour. This concept originated in the field of sociology in the 1980s and was first articulated by the sociologist Arlie Russell Hochschild in her pioneering book *The Managed Heart* (Hochschild, 1983). She proposed that in the new economy of service, consumption and material commodities, work was aimed at the production and management of positive feelings in the customers and clients at the expense of those of the worker, in whom the emotions that they were supposed to have were not actually those they felt. Hochschild defined emotional labour as 'the management of a way of feeling to create a publicly observable facial and bodily display…which is for a wage' (Hochschild, 1983, p. 7). Hochschild originally studied flight attendants, where making passengers feel positive about their flights was an important commercial aim of airline companies, even though they might be experiencing negative feelings, for example towards difficult customers. Hochschild contrasted this work with that of debt collectors who, instead of having to suppress negative feelings, were expected to suppress positive feelings in their work, such as feeling sympathetic to people who owed money to the debt collectors' employers. In emotional labour, employees had to put on a calculated emotional performance demonstrated by their facial expressions, bodily actions, vocalisations, and other observable behaviours. Moreover, the employer exerted a degree of control over the emotional behaviours of their employees, which they instilled via training and supervision.

The emotions that the employee is required to show are determined by what Hochschild called 'feeling rules' (Hochschild, 1983). These are the rules or norms regarding the expectations for which feelings are judged appropriate to the job. Some researchers prefer to use the term 'display rules', which refer to the public show of feelings of the employee, rather than their internal feelings, as the former are easier

to observe and research. Feeling or display rules may be stated explicitly in selection and training materials, or more implicitly known by the observation of co-workers (Grandey, 2000). Feeling and display rules may be further categorised into three subtypes: societal display rules, which guide interpersonal behaviour in all cultures and provide general guidelines about how feelings should be expressed in work environment; organisational display rules, the purpose of which is to achieve the organisation's aims and objectives; and occupational display rules, which derive from groups of workers engaged in the same type of work and who share a common set of values, norms and perspectives (Ashforth & Humphrey, 1993; Rafaeli & Sutton, 1987; Van Maanen & Barley, 1984).

Hochschild's work stemmed from the ideas of Erving Goffman (1959), a sociologist who highlighted the dramaturgical dimension of human social interactions where an individual will attempt to control the impression s/he gives to others by adapting her/his appearance and behaviour, which Goffman likened to a theatrical performance. In the theatre of commercial transactions, the customer is the audience, the employee is the actor, and the workplace is the stage (Goffman, 1959; Grove & Fisk, 1989). In a theatrical performance, there is a front region where the actors are on stage in front of the audiences, and a back region, where actors can prepare for their role. Hochschild applied her concept of feeling rules to this theatrical framework, in which 'surface acting' corresponded to being frontstage, where the person displays an emotion to others whilst suppressing their true internal feelings; and 'deep acting' is likened to backstage, where the person alters one's self by invoking these emotions through experience or via a trained imagination so that their inner feelings are aligned with their emotional expectations. With both types of acting, the employee is expected to manage their emotions as well as those of the recipient of their emotional display, and moreover, the feelings that are shown are more for the organisation rather than the self. Workers may also express 'genuine emotional responses' where there is an existing alignment between their genuine feelings and the emotional expectations of the organisation. Although such displays are more genuine, emotional labour is still needed because the emotional response will require regulating in order to be appropriately displayed (Phillips et al., 2020).

Following Hochschild's work, a large body of research has accumulated exploring and applying the concept of emotional labour in various fields, including sociology, psychology, organizational behaviour, and nursing (Grandey et al., 2013). Emotional labour is particularly central to professions or organisations where the work is difficult and demanding, such as in health and social care, teaching, and the service industry, and has been linked to a range of occupational hazards and negative health outcomes including burnout, workplace violence, job stress and dissatisfaction, loss of memory, depression, depersonalization, hypertension and heart disease (Jeung & Chang, 2021; Jeung et al, 2018). Some studies have looked at the differential outcomes between the effects of surface versus deep acting. Hochschild (1983) proposed that 'surface acting' may lead to cynicism and alienation, whereas 'deep acting' may lead to stress and exhaustion; however, studies have shown that surface acting is more likely to cause emotional exhaustion (Brotheridge & Grandey, 2002; Brotheridge & Lee, 2002; Cheung et al., 2011; Grandey, 2003; Grandey et al., 2012; Kim, 2008; Pisaniello et al., 2012; Totterdell & Holman, 2003; Yagil et al., 2008; Yagil, 2012), whereas the relationship between emotional exhaustion and burnout is less clear. Some studies have found a positive link between deep acting and emotional exhaustion, although weaker than the link between surface acting and emotional exhaustion (Bono & Vey, 2005; Grandey, 2003; Holman et al., 2008; Kim, 2008; Pisaniello et al., 2012; Totterdell & Holman, 2003); whereas others have found a negative association (Johnson & Spector, 2007; Näring et al., 2012; Philipp & Schüpbach, 2010; Whiting et al., 2011) and some studies have found deep acting to be positively related to job satisfaction and a sense of personal accomplishment (Bolton and Boyd, 2003; Hulsheger & Schewe, 2011; Kruml and Geddes, 2000).

To date, within criminal justice settings, emotional labour has been mostly researched in prison staff (Bruhn, 2013; Bruhn et al., 2017; Crawley, 2004a; Crawley, 2004b; Norman et al., 2020; Nylander et al., 2011; Tracey, 2005; Walsh, 2009; Ward et al., 2018) and in police officers (Bakker & Heuven, 2006; Kwak et al., 2018; Lumsden & Black, 2018; Schaible & Gecas, 2010; Schaible & Six, 2016; Ward et al., 2018). It has been researched to a lesser extent in probation practice and has also been studied in the voluntary penal system (Quinn & Tomczak, 2021) and the legal profession (Westaby & Subryan, 2021).

Here I will focus on summarising the small, but growing, literature on emotional labour in probation in the UK, which is pertinent to understanding some of the emotional responses of the researchers and MBT team involved in implementing the MBT RCT in the National Probation Service.

9.3.2 Emotional labour in probation

Westaby, Phillips and Fowler have researched over a number of years the performance of emotional labour in probation through interviews with probation workers in the UK, building on Knight's work on emotions and emotional literacy in probation (Knight, 2012; 2014; 2016; Knight & Modi, 2014). They found that although the role of emotions and working relationally with offenders had been neglected over recent years in probation policy, recruitment, training and staff supervision in the modern era of the managerialism and marketising of public services (Fowler et al., 2020; Knight et al., 2016), emotional skills were still valued by probation officers and were used regularly in their work to manage their own emotions and those of their clients (Westaby et al., 2020). However, different emotional displays were used to achieve the different, and sometimes competing aims of probation, which encompass public protection, rehabilitation, and risk management.

Showing empathy was the most commonly cited example of emotional labour done by probation staff, which aligned with the occupational display rules that showing positive emotions are key to pro-social modelling, developing relationships with clients, and rehabilitation. However, displaying and maintaining such attitudes of empathy involved complex emotional labour of deep acting in having to develop clear boundaries with their clients, being honest, remaining emotionally detached and suppressing emotions such as disappointment and frustration, which could result in stress and burnout (Fowler et al., 2017). Deep acting was also used for negative emotions, for example probation officers would sometimes use their feelings of anger or disappointment to convey their disapproval of their client's behaviour, or to demonstrate humanity in showing the service user that they were a person as well (Westaby et al., 2019).

Surface acting was also prevalent, for example, hiding feelings of disappointment when a client was non-compliant, or suppressing negative feelings to appear neutral in order to obtain information about an offender's risk. The negative effects of such

acting were evident in practitioners' accounts of the work with high-risk offenders being 'relentless' (Phillips et al, 2016), of how their work affected their personal lives in making them more suspicious or parenting their children in different ways and becoming desensitised to the work or hyper-sensitised when dealing with sex offenders, especially when the practitioner had children (Westaby et al., 2016).

Tidmarsh's (2019) ethnographic study of a probation office led by a Community Rehabilitation Company explores how probation staff experienced the Transformation Rehabilitation (TR) reforms, the privatisation of part of probation services in the UK as described in chapter 2, and how performing emotional labour was important for their professional identity. This is relevant to this study as the RCT evaluating MBT commenced at the time when TR was being implemented and concluded just when the UK government decided that privatisation had been detrimental, and that probation should be nationalised again. Tidmarsh found that despite the considerable upheavals of TR's organisational changes to probation practice, including reduced practitioner autonomy, increased administrative pressures and the exacerbation of long-term trends of increasing use of information technologies rather than directly working with people, probation staff continued to hold on to the relationship-oriented values of their work, such as being non-judgemental, empathic, and understanding of their offender clients, whilst at the same time having sympathy with the victims. To achieve these standards in the face of the increased pressures of the work, the officers often had to perform considerable emotional labour, which nevertheless included the genuine expression of emotion, drawing on their internal sense of eagerness to work with clients and establish relationships which was integral to their sense of self. However, the stresses of the job forced them at times to resort to surface acting where, in order to meet organisational performance targets, they became dissociated from the genuine expression of their internal feelings of wishing to relate meaningfully to their clients, and instead felt alienated from the work, or that they were just 'going through the motions' to outwardly demonstrate care, with the risk of developing sickness and burnout. These findings resonate with those that emerged from the analysis of the qualitative interviews with staff involved in the MBT trial in that turbulence of the system, and its emotional impact, were identified as major factors impeding its implementation.

9.3.3 Emotional intelligence and emotional literacy

The second field of study within criminology that is relevant to the findings of this thesis is that of emotional literacy. The theory of emotional literacy is based on that of emotional intelligence. Emotional intelligence originally stems from the idea that intelligence was more than a narrow range of cognitive capacities and that there was more than one form of intelligence (Gardner, 1984). The concept of emotional intelligence was first developed in psychology in the 1980s and 90s (Payne 1985, cited in Howe 2008, p 11; Salovey & Mayer, 1990) and was then popularised and extended to the world of business (Goleman, 1995;1996;1998; Goleman et al., 2002) and continues to evolve in the fields of business, management, marketing, psychology, psychotherapy, education, and social work (Knight, 2012). Mayer and Salovey's model of emotional intelligence has been influential and involves four broad domains: perceiving and expressing emotion, accessing and assimilating emotion in thought, understanding and analysing emotion, and regulating emotion (Mayer et al, 2001; Salovey & Mayer, 1990; Mayer & Salovey, 1995). Different models of emotional intelligence have been proposed (e.g., Goleman, 1996, 1998; Steiner, 1997; Higgs & Dulewicz, 1999), but they share broad agreement around common themes: self-awareness of one's emotional state, self-regulation of one's emotions, the ability to motivate oneself to achieve one's goals, empathy, and social competence (the interpersonal and social skills needed to relate to others, including managing strong feelings in others) (Killick, 2006). Emotional intelligence is closely related to mentalizing, although it is restricted to mentalizing emotional states, rather than the full range of mental states that mentalizing encompasses (Allen et al., 2008). Emotional intelligence is also related to emotional labour in being one of the factors in the individual person that influences the performance of emotional labour (Grandee, 2000).

Sherman (2003) pioneered the idea of emotional intelligence in criminology in a call to reinvent justice around the emotions of victims, offenders, and society. He proposed that the state should try to make its officials control their own emotions so as to be able to adopt a rational stance to emotional offenders, as well as victims and the wider public, to persuade citizens to comply with the law. This new paradigm formed the basis of restorative justice.

The concept of emotional literacy is similar to emotional intelligence but has been researched and applied more in the fields of education and learning (Killick, 2006), and there is more of an emphasis on self-awareness and sensitivity to others as an activity or skill that can be used to engage and build relationships with others (Knight, 2012).

Knight introduced the concept of emotional literacy into criminal justice studies, specifically within probation practice as a model for understanding how probation practitioners work with their own and others' emotions (Knight, 2012; 2014; 2016; Knight & Modi, 2014). This is of interest to the understanding of the impact of conducting the MBT trial in that probation officers were directly involved as part of the MBT team, but also indirectly in referring offenders to the research team as well as managing those participating in the RCT. Knight defines emotional literacy as 'a skill in probation practice [that} requires knowledge of our own emotions and the ability to recognise and respond empathically to the emotions of others. It includes an awareness of the causes, triggers and expression of emotions in ourselves and in others, and requires an underpinning value base of respect, positive regard and a non-judgmental approach towards offenders' (Knight, 2014 p.194). She emphasises the 'soft skills' of emotional literacy that are concealed by a discourse based on 'hard' instrumental and managerial processes within probation and the wider criminal justice system (Knight, 2012).

In her qualitative study interviewing probation officers working with sex offenders and perpetrators of domestic violence, asking them to define what they understood by the concept of 'emotions' and how they managed their emotional lives in the context of their work with offenders, Knight found that some of the participants showed evidence of the five core elements of emotional literacy – motivation, self-awareness, self-regulation, empathy and social competence – in their interactions with offenders (Knight, 2014; Knight & Modi, 2014). This was demonstrated in their ability to use emotional skills to form trusting relationships with their clients with the potential for change and getting alongside the offenders in trying to understand their mindset, motivations and why they had committed their crimes. They were able to deal with offenders' challenging behaviour by being able to recognise the anxiety behind their anger and that they also may have been victims of historical abuse.

However, there was also evidence of practitioners who were unable to manage or control some of their own feelings, for example expressing disgust at the account of a sex offender, as well as concerns expressed by respondents of observing colleagues use collusive, manipulative, or repressive means of control of offenders. Gender differences were also noted with some female participants feeling poorly supported by their male colleagues around the emotional impact caused by their work with male offenders.

9.3.4 Social, moral and affective climate

The third key area of criminological studies which explores the topic of emotionality within the criminal justice system is that of the prison research carried out by Alison Liebling and her colleagues at the Institute of Criminology in Cambridge. In contrast to the concepts of emotional labour and emotional literacy, which focus on the nature and role of emotions in workers, Liebling's work is primarily in relation to the emotional states of prisoners. Nevertheless, this research is relevant to the experiences and impact of conducting research within the criminal justice system in its exploration of how a harsh and punitive environment negatively impacts on prisoners' emotional states and behaviours, which in turn exert a heavy burden on the experience of researchers.

Liebling has explored the quality of prison life and its impact on the welfare and recidivism of prisoners through her focus on the 'moral climate' of prisons. The concept of moral climate builds on that of social climate which was originally defined by Moos (1989) in his study of psychiatric environments in the US as 'the material, social, and emotional conditions of a given unit and the interaction between such factors' (Moos, 1989). Social climate is a multi-dimensional construct and its application in forensic institutions and prisons comprises features such as the degree of safety from aggression and violence that patients/ prisoners and staff feel, how therapeutic the unit is perceived to be, whether the physical and psychological needs of residents are supported, and whether the unit provides opportunities to learn new skills and promote prosocial behaviour (Tonkin, 2016). Social climate and its effects on prisoner wellbeing and behaviour have been extensively researched, and a number of measures have

been developed to this end (Tonkin, 2016). More positive prison social climates have been linked to less disturbed behaviour, lower rates of violence, higher levels of motivation, better engagement in treatment, more positive therapeutic alliances with staff, greater prisoner satisfaction, and perceptions of safety (Bressington, et al., 2011; Friis & Helldin, 1994; Long et al., 2011); whereas negative social climates characterised by strict rules and inexperienced workers have been correlated with more disruptive behaviour, stress and sickness in prisoners, poor relationships with staff and low levels of staff (Van der Helm, et al. 2009; Wright, 1993).

Liebling and colleagues developed the concept of social climate to include the moral and emotional aspects of a prison's environment which make the prisoner's experience less dehumanising and painful. These moral and emotional dimensions include decency, fairness, humanity, relationships with staff, and the use of authority (Auty & Liebling, 2020), and when these are lacking this may lead to depression, suicide, anger, frustration, and violence (Liebling, 2011). Liebling and colleagues developed a specific 'ethnography-led measurement' of moral climate – Measuring the Quality of Prison Life (MQPL) – which uses both qualitative and quantitative methodology to measure the moral, social, and relational qualities of prison life as experienced by prisoners (Liebling, 2004). An extensive survey conducted between 2009 and 2013 using the MQPL of all prisons in England and Wales showed that those prisons where the moral quality of life experienced by inmates was higher had lower rates of prisoners reoffending on release, suggesting that a more positive moral climate supports better outcomes for prisoners (Auty & Liebling, 2020).

More in-depth studies of individual prisons using the MQPL have teased out the associations between some of the distinct components of the moral climate of a prison and the experiences, which include the emotional experiences of prisoners, in particular in relation to differences in staff culture. Crewe et al. (2015) carried out an in-depth study of the cultures of five public sector and two privately funded prisons in England and Wales using the MQPL, as well as interviews with prisoners, uniformed staff, and managers, observations of management meetings, adjudications, and staff-prisoner interactions to compare and explain three key domains of prison culture and quality: relationships between frontline staff and prisoners, levels of staff professionalism (or 'jailcraft'), and prisoners' experience of state authority. Overall, the

public sector prisons generally outperformed their private sector comparators on prisoners' perceived quality of life, but these results were not readily explained by the publicly funded prisons performing better on all three aforementioned domains. In fact, staff prisoner relationships were more positive in the private sector prisons where prisoners were less likely than those in public-sector prisons to report feeling that staff looked down on them, judged them adversely and deliberately made their lives harder; whereas in the public sector prisons officers were much more likely to express punitive and cynical views than their counterparts in the privatised prisons. However, prisoners in the private prisons were more likely to report a lack of staff professionalism, which had a negative impact on their experiences, and which they attributed mainly to high staff turnover and poor-quality training and support. By contrast, in the public sector prison staff were perceived by prisoners as more knowledgeable, experienced, and skilled, and even though they were considered less friendly and informal than private sector staff, prisoners felt that their competence offset their negative attitudes towards prisoners. In their experience of the staff's use of state authority, prisoners in the public sector prisons felt that staff were better at creating a controlled environment which made them feel safer, compared to prisoners in the private sector prisons who often complained about both the underuse and overuse of power – that the regime could be either too strict or not strict enough.

The researchers explained these results by differentiating between staff cultures in terms of two dimensions - their relative 'weight' – whether they were 'heavy' or 'light' - and the 'absence' or 'presence' of staff power (Crewe, et al, 2014; Crewe & Liebling, 2017). Staff cultures that are heavy reflect a sense of prisoners that their conditions are bearing down on them due to prison staff believing inmates are undeserving of respect, morally inferior and deserving of prolonged punishment; whereas those that are light promote more relaxed conditions such as more time spent unlocked, ownership of cell telephones and wearing personal clothing, and an overall less oppressive atmosphere. The power dimension has polarities of absence and presence: 'absence' is characterised by diminished staff authority and control, where there are fewer and/or less experienced staff and prisoners fear the power of their peers to assault them or develop drug economies; whereas 'presence' refers to environments where staff exerted more confident and consistent authority and policing. Emotions are intricately linked to power dynamics, and the over- or under-

uses of power in staff-prisoner relationships produce emotions in prisoners which significantly contribute to the explanations for variations in distress and suicide in individual prisons (Liebling, 2014; Liebling et al., 2005).

In their study comparing private sector and public sector prisons, the former were characterised as 'light-absent' and the latter as 'heavy-present'. Although the latter performed better on scores of the quality of prisoners' life, both types of regimes were relationally withdrawn, where their model of order was not based on the formation of deep relationships with prisoners. The 'gold standard' of prison management is 'light-present' where staff exert power and authority, but this is not intrusive or oppressive, and staff have developed deep relationships with prisoners and adjust their authority through knowing the needs, moods, and motivators of their prisoners. These relationships are close but not collusive and have clear boundaries and expectations. Prisoners have high levels of autonomy but are held responsible for their behaviour by peers and staff. Liebling notes that although such prison cultures are rare, they are most likely to exist in well-staffed therapeutic communities, PIPEs and small drug detoxification units (Crewe & Liebling, 2015). Indeed, a recent study using the MQPL of a prison in England, Warren Hill, which is part of the OPD pathway hosting a therapeutic community and a PIPE unit, found this prison to be situated in the 'light-present' quadrant of their styles of penal order matrix, and found it to be inspirational in its ethos, relationships, and mission (Liebling et al., 2019). However, although prisoners described very positive experiences in prison, these were lost once they were released as they received little resettlement support, emphasising the need for a continuation of a positive moral climate for offenders in the community.

Liebling's ideas about the moral climate of prisons have led to further research on emotions in custody, such as that of the criminologists Ben Crewe and Ben Laws who have more explicitly examined emotions in prison life in exploring how space shapes penal experience in mapping out the 'emotional geography' of prison experience (Crewe et al., 2014; Laws, 2018; 2019).

9.3.5 Emotionality in criminological researchers

Of particular relevance to this thesis is the growing body of literature on the emotionality of conducting research in criminology, particularly in qualitative

ethnographic prison research where the culture of the prison and experiences of the staff and prisoners are the focus of study. This brings together some of the aforementioned researchers studying emotional labour in the workforce, emotional literacy in staff and offenders, and the emotional climate and geography of prisons.

In a landmark paper, Liebling (1999) challenged the lack of 'pain' in quantitative research accounts of prison life and argued that doing research in any human environment, especially a prison, without subjective feeling was impossible. She described her emotionally exhausting and harrowing experiences of interviewing prisoners who expressed powerfully negative emotions such as anger, hostility, resentment, and suspiciousness. She portrayed prisons as raw, and at times, desperate places where both extremes of human nature – its capacity for good and evil - could be seen in their starkest form. Whilst her research, which involved interviewing hundreds of staff and prisoners across five prisons, had robust quantitative foundations, and generated quantifiable interview results and objective data, the qualitative component which guided the focus of the analysis was 'complex, messy and 'deep'. Describing the processes and methodology of the study as 'data gathering' or 'observation' did not capture the intense immersion in the work; rather, the enterprise was better designated as a wholehearted commitment of 'doing fieldwork' in which the researchers were active participants and their inner lives interplayed with the lives of the interviewees. It was at times difficult to bear emotional intensity and to refrain from action and participation, for example, to give advice, assistance, or opinions to staff as a way of avoiding disturbing feelings. Like many of the prison staff they interviewed who were exposed daily to prisoners' violence, pain and suffering, Liebling and her fellow researchers also found that on returning to their lives outside of the prison they experienced feelings of detachment and disorientation, and difficulties in articulating these feelings to others and avoiding the temptations to drink, smoke, drive too fast, or 'let off steam' in other ways. Returning to do further ethnographic research in one of the high secure prisons 12 years later, Liebling described prison research as constituting emotional 'edgework' – studies which were organised and structured but at the same time deep, vivid, immersed, and intrusive (Liebling, 2013; 2014).

After living through these early experiences as a young researcher, Liebling proposed that there is an essential moral dimension of social research which requires sensitivity to the inner states of others. Moreover, emotional responses in researchers should not be ignored but seen as valuable sources of data to inform and guide research. Qualitative and quantitative methods should be used in tandem, with checks of experience and emotion on the one hand complementing the structure and measurement, and on the other to create deeper understanding of the research findings. However, doing such research needs to be carefully planned with built in structures for emotional support and debriefing.

In the decade following Liebling's cri de coeur for more attention to be paid to the emotional aspects of prison research, a trickle of criminological ethnographic researchers followed suit. Thus, Hill (2004) adopted a collaborative approach to exploring the experiences of women offenders accessing community-based health and social care services by setting up an advisory group of 'expert advisers/knowers'. She stressed the need to recognise that emotional involvement or identification on the part of the researchers was an essential part of the research, and how this approach was based on reciprocity, mutual disclosure, and 'role reversal' where researchers may experience the emotions of the offender-researchers such as feeling powerless and abandoned in the relationship. In another study involving prisoners as researchers, Bosworth et al. (2005), in a paper co-authored by a researcher and four prisoners in a US prison, stressed the experience of the interviewer, rather than those being interviewed, drawing particular attention to the emotional nature of being part of a study and how a researcher gains participants' trust. Both of these studies were approached from a feminist perspective reflecting their views that studies encompassing the researcher's subjectivity and emotional experience were more the domain of female researchers than their male counterparts who were more likely to stress the primacy of objective empirical research where the researcher was an impartial observer. This gendered account, however, has been challenged in a later paper by Crewe (2014) who cites papers by male researchers of prisons who have acknowledged and explored their emotional responses, and describes his own emotional experiences and how these were entwined with discourses of masculinity and class to shape the research process.

Nevertheless, a central tenet of feminist methodology is the process of self-reflection/reflexivity and the use of emotionally sensed data as a key source of knowledge that is difficult to access through other data sources, and this approach became more accepted in a growing body outside of prison studies (Drake & Sloane, 2013). Reflexive understanding involves a 'turning back on oneself' where the researchers recognise that they are centrally implicated in their observations, the topics they have selected for study and the analysis of the research (Phillips & Earle, 2010). Research diaries are central to the reflexive process, allowing a 'reflexive discussion' with the research team of findings and ongoing research strategies (Drake & Sloane, 2013). This methodology has been slowly gaining ground within criminological research and is not solely confined to feminist studies.

Thus, in their ethnographic research of a medium security adult male prison and a young offenders' institution, Phillips and Earle (2010) recognised that the study of prisoners' identities could not be separated form their own subjectivities, personalities and biographies, including the influences of race, ethnicity, class and gender, and proposed that a reflexive methodological approach, where the researchers engaged with their own identities and emotions, was necessary in making sense of their findings.

Yuen (2011), in a reflexive-practice study of Aboriginal female offenders in a federal prison, proposed that researchers' emotions as analytic tools are particularly relevant when working with marginalized or oppressed groups. Her own experience of feeling paralysed with an overwhelming sense of despair, hopelessness and vulnerability, and the subsequent discovery of 'safe spaces' where she could discuss, reflect, and process her emotions with trusted colleagues, ultimately allowed her to empathise with and understand the experiences of incarceration of her research subjects.

Drawing on her personal experiences of interviewing of offenders, Jewkes (2012) was struck by the feelings these encounters elicited in her – not only negative affects but also positive, sometimes life affirming experiences where prisoners shared stories and emotions that they had not revealed to anyone before. She stressed that emotion has epistemological significance - that knowledge was not something objective and separate from our bodies, experiences and emotions but is created as a sensuous and affective activity through our experiences of the world. Liebling echoed this view

that attention to the researcher's physiology could yield important data: 'when our bodies do the work for us, detecting cues, recognising danger, sensing tension, or sharing frustration' (Liebling, 2013, p.23). The role of the physiological as well as the emotional within the research process was also highlighted by Drake's experience of conducting research in high secure prison settings where she developed a number of physiological symptoms (colds, flus, ulcers, and serious throat and bronchial infections) which she later understood as resulting from the impact of emotional experiences which she was unable to adequately process (Sloan & Drake, 2013). Gariglio (2018) also recognises the bodily component of such carceral research in his accounts of prison officers' threats of the use of force in an Italian prison, describing his methodology as autoethnographic: 'an approach that unpacks the relationships between the researcher's experience and embodied experience, on the one hand, and culture and cultural practices, on the other' (Gariglio, 2018, p.209). He uses the tool of 'emotional recall' (Ellis, 1999) in constructing his autoethnographic account, in which he imagined being back in the scenes of his fieldwork emotionally and physically, in addition to what he had written, photographed, and video-recorded contemporaneously.

Emotionality in criminological researchers has also been examined through the lens of emotional labour theory. Drake and Harvey (2014) incorporate ideas from Goffman's dramaturgical theory of social interactions into their consideration of the role of the ethnographic prison researcher. They argue that to connect with their study participants, the researcher needs to engage in impression management (Goffman, 1959), in other words attempt to influence the prisoners' and prison officers' perceptions of them by performing different identities in accordance with the different micro-cultures within and between prison environments. For example, this might entail the adoption of the role the 'empathic listener', whose identity must shift according to the divergent stories, views, opinions, and beliefs of the research subjects which may be very different to those of the researcher. Drake and Harvey found that although such impression management supported the development of a sense of mastery, it also exerted a significant and on-going affective toll, specifically feelings of meaninglessness and fragmentation as a result of the rapid shifting of identity positions. The authors note that such feelings seem to echo aspects of the prisoner experience but are cautious in assuming aetiological links.

Testament to the resurgence of interest in emotions in criminology, the emotional labour of researchers in prisons and other areas of criminal justice has been the focus of a recent special issue of the journal *Methodological Innovations*. Several of the papers in this volume are of pertinence to this thesis.

Based on thematic analysis of semi-structured interviews, Waters et al. (2020) looked at the emotional labour performed by 30 doctoral researchers in the UK within a range of criminal justice settings and related fields including police, prisons, probation, youth justice, victims and victimology, people with convictions, drugs and alcohol, hate crime, terrorism, restorative justice, violence and green criminology. Similar to the findings of Drake and Harvey's (2014) study, they found that these researchers were concerned with how they should present themselves to their subjects. For example, on the one hand they felt the need to display empathy, but on the other to conform to the portrayal of the 'competent detached researcher'. Some of the researchers appeared to experience genuine emotional responses where their inner emotional states matched the external displays of empathy or sympathy shown to the research participants they were interviewing. Others, however, engaged in surface acting, where feelings such as anger, resentment, hurt and sadness, but also at times more positive emotions such as elation and excitement at the possibility of gaining new insights were suppressed in an effort to maintain a professional relationship with their subjects. This led to many experiencing 'imposter syndrome' where they felt incompetent, ill-equipped and a sense of dread at being 'found out'. Some of the researchers were able to engage in deep-acting, such as resisting feelings of disgust and horror when working with sex offenders, but at times the effort to do so was too great and the researchers resorted to detaching themselves from emotion altogether. The emotional consequences of engaging in such emotional labour were considerable. All the researchers felt overwhelmed at some point during their studies, experiencing symptoms of emotional exhaustion, depression, burn out, or numbness. They described developing several specific coping mechanisms, which the authors categorised as 'self-care', 'space-creation', 'shedding rituals' and 'communities of coping'. Self-care included activities such as taking a shower, changing their clothes, reading, swimming, reflective writing, keeping a research diary, going to the gym, talking to their partner, seeing a counsellor and clinical supervision. 'Space creation' was how researchers shaped and occupied physical and mental space way from their

research, including commuting between their homes and research sites, and keeping home and work life separate. Mental space creation comprised taking breaks from studying or researching, and/or escapism, which included less healthy ways of coping such as consuming alcohol or playing violent video games. 'Shedding rituals' incorporated space creation with elements of self-care, for example washing and changing their clothes in a ritualised way to promote self-care and make space between themselves and the field. 'Communities of coping' (Korczynski, 2003) referred to engaging in, often informal, networks including peers, other PhD students and/or supervisors in-person, online via social media (e.g., Facebook, Twitter), or across both.

Based on their own research conducted in prisons, and the emotions this generated, for which they were unprepared, Garrihey and Watters (2020) explore how criminological researchers employ 'emotional agency' – using their emotions actively to produce the desired effects - when confronted with the emotionality of their work. The authors argue that emotional agency requires researchers to acknowledge that emotionality is a legitimate part of the research process and data, and that they need to be emotionally literate, as described by Knight (2014) above. Furthermore, emotional agency is an active process - experiencing emotions is not a passive encounter, but continues over time, even after the research has finished. Embracing the emotionality of the research process allows researchers to harness their emotions as a tool for data collection, analysis, and dissemination. Positionality is also inherent in emotional agency in actively recognising that the researcher's point of view, as well as their biography, influences their research. The authors propose an integrative methodology for criminological research where emotional agency and emotional reflexivity intersect with more traditional approaches to qualitative and quantitative research, and researchers are taught a systematic approach to the emotionality of such research from the outset.

9.4 Secondary interpretation of the findings

To what degree is do the concepts of emotional labour, emotional literacy and moral and affective climate further our understanding of the findings of this study beyond their interpretation within the psychoanalytic and mentalizing models? This section will

address this question and tease out areas of conceptual overlap between, on the one hand, psychoanalytic and mentalizing models, and on the other hand, emotional labour, emotional literacy and moral and affective climate models respectively.

9.4.1 Emotional labour

One key difference between the psychoanalytic organisational framework and the emotional labour construct is that in the former the central point is the disturbed emotional states of the offenders which become projected into the institution and the staff group, whereas in emotional labour theory the focus on emotion is located at the outset in the professional or staff member.

We might speculate that the work of the different groups of staff implementing the trial involved significant emotional labour. Many of those interviewed spoke about the considerable stresses they were under due to both a shortage of staff and lack of time to complete the tasks. They complained of the high turnover in staff within both the MBT teams and the local probation services where each team was based, as well as vacant posts because they could not recruit to the role. Within probation there were accounts of probation staff having high caseloads, staff absences due to sickness and burnout, and vacancies being filled with unqualified staff, all of which made it less likely for probation staff to find the time or willingness to find, refer, and facilitate the participation of offenders in the trial. In the face of these pressures staff would still have been expected to act professionally according to the codes of their respective professional bodies as well as the implicit rules of the work environment and culture - outwardly feeling obliged to presenting a calm, agreeable and willing attitudes to their colleagues, i.e., engaging in surface acting whilst concealing their genuine feelings for example of anxiety, resentment, guilt or anger, that were being evoked in them by the work. A further tension that may have added to the strain of emotional labour may have been differences in the display rules between the different organisations - the NHS and the criminal justice system. Thus, the organisational display rules of the NHS might be to maintain a caring, compassionate, and empathic role towards patients at all times and to distance oneself from negative feelings such as disgust or anger. By contrast, the organisational display rules of the criminal justice system, in line with a more punitive and harsher culture, another prominent theme that emerged from the interviews with the staff implementing the trial, whilst more explicitly promoting an

empathic stance towards offenders, might more implicitly expect staff to engage in surface acting to present themselves as firmer, more authoritarian in establishing boundaries, and more disapproving of antisocial behaviour, but having to supress more positive feelings of sympathy with offender's plight. The organisational display rules of the criminal justice system may also promote deep acting in trying to harness more negative genuine feelings of anger or disappointment to come across as disapproving of their antisocial behaviour, whilst at the same time feeling guilt at having to adopt a punitive line, for example, recalling a trial participant.

These differences in display rules and the emotional labour that staff were expected to perform between the two organisations may have accounted for some of the tensions between the MBT team and the staff in probation upon whom they were dependent for referrals. Probation staff may have been envious of the health team's licence to behave sympathetically towards offenders whilst they felt obliged to appear more distant and dispassionate. Envy was one of the emotions mentioned in the interviews with one of the commissioners who thought that some staff from other services within HMPPS of were envious of the OPD programme because it was exciting, better funded, and could poach enthusiastic staff from them.

More complexity is added if one considers differences not just in organisational display rules but in occupational display rules, which may have accounted for some of the conflicts within the MBT team, and between the MBT team and the research team, that were reported in some of the interviews. As previously described, occupational display rules derive from a particular group of workers engaged in the same type of work and who share a common set of values, norms, and perspectives. Although both worked in the same organisation, the MBT therapists spoke about feeling criticised by the research team in what they perceived as their negative tone of communications, lack of support for not reaching recruitment targets, and the imposition of confusing changes in guidance through the course of the trial. At the same time, they had to employ surface acting so as not to display these negative feelings to remain on good terms with the researchers, who themselves, one might imagine, were performing another type of surface acting – feeling they needed to be strict and apply pressure on the MBT teams to achieve the research goals within the strict trial time limits, which may have been at odds with internal feelings of hesitation, anxiety, or guilt. Within the

MBT team itself, the research assistants spoke of experiencing additional pressures from the MBT therapists to engage offenders in groups, believing they did not appreciate the difficulties inherent to their role in travelling long distances, offenders missing appointments, difficulties accessing emails remotely, being given no food expenses, and feeling disjointed from the rest of the team. The strain of maintaining feeling rules of professionalism in acting as competent, calm, and empathic researchers in the face of these obstacles may have been particularly acute due to them being the least qualified and experienced of the team. Indeed, they reported feeling belittled and not taken seriously by both the staff and the trial participants due to their youth and lack of experience.

In the interviews with the commissioners, one of them seemed markedly aware of performing emotional labour in relating her conscious effort to put the emotions evoked in her involvement in commissioning the MBT services to one side so as not to allow these to influence the other commissioners. She recalled feelings of injustice that offenders who were not randomised to the treatment arm would be excluded from the intervention and that the money would be more usefully spent on service provision directly rather than central project management, but actively suppressed these feelings in order to 'tease out the emotional from the rational parts of the decision making'.

Thus, an emotional labour framework adds to the understanding of the emotional impact of implementing the trial in highlighting the distress generated in staff by their efforts to display socially condoned emotions at the expense of their true emotions. However, there are also areas of conceptual intersection between the psychoanalytic and mentalizing models and the emotional labour model. As within the criminological discipline, there appear to be very few explorations of psychoanalytic conceptualisations within the literature on emotional labour. In a pragmatic literature search of psychoanalysis and emotional labour I could only find 2 papers (Price, 2001; Rustin, 2003) which applied psychoanalytic understanding to Hochschild's ideas.

In a study of emotional labour in teachers, Price (2001) links Hochschild's concept of emotional labour to a Kleinian psychoanalytic model of the internal unconscious psychic work of mourning. She suggested that emotional labour represents the efforts of the depressive position (Klein, 1935) where the individual is required to

unconsciously curb aggressive desires and impulses towards others because of the damage these could do to loved others and the self. In another paper comparing the psychoanalytic 'Tavistock model' of organisational dynamics and the sociological concept of emotional labour as applied to emotional learning, Rustin (2003) notes the presence of unconscious processes in the work of emotional labour in that Hochschild's research subjects were largely unaware of the efforts of surface acting and deep acting and how this shaped their behaviour and thinking in ways which were not fully recognizable to them.

Similarly, I could find only one paper on emotional labour which referred to mentalizing. A study of emotional labour in a crisis resolution home treatment team in Norway (Sjolie et al., 2017) found that the feeling rules of the team both allowed and encouraged the expression of a range of feelings, including vulnerable feelings, and where expression of such feelings was met with validation and support by other team members, this support seemed to increase the mentalizing of emotions, which they defined as identifying emotions and what they meant, modulating them, and then expressing them in an appropriate manner.

Viewed through a psychoanalytic lens, I propose that the work of emotional labour involves the use of defence mechanisms which may be conscious or unconscious depending on the resilience or ego strength of the individual, i.e., their capacity to tolerate frustration, stress, and internal conflicts. Thus, those with healthier ego functioning, surface acting and deep acting may involve the employment of the more mature defence mechanism of suppression, where attention to emotions may be consciously or semi-consciously minimised or postponed. When the display emotions are consciously acknowledged as being discordant with the person's authentic internal emotions of Hochschild's model, they may generate some anxiety or discomfort, but the person has sufficient ego strength to bear this with little impact on their overall functioning. However, people with a more fragile sense of self may not be able to tolerate the anxiety provoked by the conscious awareness of less positive emotions that might undermine the positive emotional expressions, gestures, and responses they are expected to demonstrate to the outside world, and therefore resort to the use of repression or other more primitive defence mechanisms to keep these feelings out of consciousness. These defence mechanisms would include denial (avoiding

awareness of painful aspects of external reality), splitting (the compartmentalisation and lack of integration between incompatible experiences of polarised aspects of the self and others to prevent conflict), and reaction formation (transforming an unacceptable wish, anxiety or impulse into its opposite). However, the psychic effort involved in emotional labour may become too great such that these defences break down to cause overt anxiety and depression which are recognised consequences of emotional labour. In more disturbed cases where such negative emotions cannot be held in consciousness, individuals may present with burnout or psychosomatic symptoms by unconsciously employing the primitive defence mechanisms of somatisation (converting emotional pain or other affect states into bodily symptoms and focussing concern on somatic rather than psychic manifestations) or dissociation (temporary loss of identity, memory, consciousness, or perception as way of retaining an illusion of psychological control in the face of helplessness or loss of control). An example of this is an auto-ethnographic study of the disembodied experience of a novice researcher doing qualitative cancer research who experienced a range of symptoms including dissociation and bodily symptoms, including pain and nausea, which mimicked the symptoms experienced by the participants in her study who were suffering from cancer (Benoot & Bilsen, 2016). This highlights the added emotional strains of staff working within health care or criminal justice settings with clients or patients who themselves are experiencing emotional and/or physical distress, often related to previous trauma, and where the member of staff unconsciously overidentifies with their plights and experiences physical and emotional responses that parallel those of the participants. This is particularly more likely to occur in younger researchers, being variously described in the literature as 'research student syndrome' (Malacrida, 2007), 'medical student syndrome', or 'compassion stress' (Pickett et al., 1994).

Aspects of the deep acting processes operant in emotional labour as described by Hochschild may also bear resemblance to Winnicott's (1965) concept of the false self, and other related theories proposed by different psychoanalysts e.g. Helene Deutsch's 'as if' personalities (Deutsch, 1934), Michael Balint's 'basic fault' (Balint, 1969) and the work of Heinz Kohut (1971), Alexander Lowen (1984), James Masterson (1988), and others in describing true and false selves in people with pathological narcissism to describe splits in the person's sense of self or character, where their manifest way

of relating to the world presentation masks a more authentic self. Although these concepts describe longstanding problematic personality traits and ways of relating resulting from failures in the person's parental care, such as a lack of attunement between mother and infant or pressure to comply with parental standards in their early development, it may be that such individuals are less able to perform emotional labour without adverse consequences.

9.4.2 Emotional literacy

Knight's concept of emotional literacy may also add to our interpretation of this study's findings in that it draws attention to the pre-existing capacity for emotional recognition and empathic skills in staff, including researchers, working in in the criminal justice system. Knight also found that the practice of emotional literacy was negatively affected by organisational constraints, with participants feeling that their organisation did not recognise or understand the value or impact of their emotional work and how the increasing bureaucracy and managerialism of the service undermined this. This is germane to the impact of the RCT under investigation in this thesis in which systemic issues, including the turbulence and malfunction of the system and perceived antitherapeutic culture, were one of the main themes identified in the interviews of staff as negatively impacting on their efforts to implement the trial. Knight highlights how emotional literacy was not included in probation training nor was integral to on-going supervision. Many participants in her study felt they gained emotional support from colleagues and debriefing after traumatic incidents, but these experiences were not recognised by the organisation which was more concerned with gaining quantitative information to meet its targets of reducing offending and protecting the public.

Looking at Knight's concept of emotional literacy, although this also does not explicitly include an awareness of unconscious processes, the core elements of emotional literacy – motivation, self-awareness, self-regulation, empathy and social competence – would comprise some of the expected attributes of any competent psychotherapist, and bear a particular similarity to some of the skills required by MBT practitioners, not only in being able to mentalize emotional states in self and other, but also her description of the 'value base of respect, positive regard and a non-judgmental approach towards offenders' (Knight, 2014 p.194) shows correspondence with the 'not knowing stance' of interest and curiosity in the patient without making assumptions or

coming to the premature conclusion that a reflective process about internal mental states can be generated.

9.4.3 Social, moral, and affective climate

The research by Liebling and her colleagues specifically enhances the findings of this thesis in their exploration of the emotional hazards of doing research within the criminal justice system. In contrast to psychoanalytic organisational studies or the literature on mentalizing social systems, Liebling's work focusses specifically on the emotional demands of the labour on researchers rather than on other professionals and occupations employed in criminal justice settings. This is of significant interest to this thesis in reorientating our focus on those employed within this RCT, namely the research assistants and assistant psychologists, who are tasked in carrying out the bulk of the research in the follow up of trial participants, the administration of measures, and the data collection and input. The research assistants and assistant psychologists felt that other members of the MBT team and the trial coordinator did not fully understand the pressures they were under, and if they did, they didn't do enough to address these, for example, having to travel long distances to interview travel participants who often didn't attend their appointments, having no food expenses, and difficultly accessing their emails remotely. They tended to be the youngest members of the team, which they felt disadvantaged them in feeling belittled, or not getting replies to their emails as it was clear from their signatures that they were junior. They felt deskilled and sometimes confronted with situations that were beyond their capabilities, for example having to manage clinical risk. Moreover, they described challenges related to their gender – the female research assistant experienced some participants who were inappropriately flirtatious, whereas the male RA met some offenders who seemed more 'stand-offish' and threatened violence. This finding compliments the literature on gender differences in managing emotions in criminology researchers mentioned above. Interestingly, the difficulties in their relationships with the rest of the team voiced by the assistant psychologists only emerged at the end of their interview after I had pressed them into thinking about more potential obstacles, as if they were reluctant to admit to these pressures for fear of being seen as not coping with the work and taken less seriously by their seniors.

Nevertheless, there are also similarities and overlaps between Liebling and her colleagues' work on social and moral climate and psychoanalytic studies of organisations in relation to research methodology and the mode of data collection.

The autoethnographic research used by Liebling bears resemblance to Bick's psychoanalytic observational research methodology (Bick, 1964) and its adaptations for use in psychoanalytic research into institutional settings (Blacker et al., 2017; Hanley et al., 2017; Hinshelwood and Skogstad, 2000) as described in chapter 3. Ethnography is a form of qualitative research involving the study of social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities by the researcher observing, interviewing, and/or interacting with the study's participants in their real-life environment. It originated in the anthropological studies of remote societies in the early 1900s (Reeves et al., 2008). Autoethnography stems from studies in the 1970s in which researchers, via storytelling and exploring personal narratives, provided insights into their own cultures, and it developed into a formal research methodology in the 1990s. It is aimed at describing and systematically analysing and interpreting the researcher's personal experience in order to understand cultural experience. As such, it embraces and foregrounds the researcher's subjectivity rather than trying to limit it, as in most empirical research. Evocative or emotional ethnography (Ellis, 1999) pays particular attention to the researcher's feelings and bodily responses, as well as thoughts, evoked by their contact with the research participants and their lives.

In her studies on moral climate, Liebling proposed that such research needed a sensitivity to the inner states of others and that emotional responses, including the researcher's physiological responses, to the research participants, should be seen as primary sources of data (Liebling, 1999; 2012), a view echoed by other ethnographic criminological researchers (Jewkes, 2012; Yuen, 2011). Liebling highlights the dynamics at play between researcher and participant in shaping these emotional responses, how the researchers' 'inner lives interplaying with the lives of others' (Liebling, 1999, p. 160) and how awareness of one's own emotional responses may give an insight into the emotional world of the other – 'we may understand affectual worlds more deeply when we have access to or experience of those emotions in ourselves' (Leibling, 2014, p.483). Although she does not use the term, what she is

describing is very close to the psychoanalytic concept of countertransference - the use of one's emotional responses as a tool to access the inner world of the patient – described in chapter 3. What is missing, however, from Liebling's account is the unconscious dimension. She refers to subconscious processes - 'evaluations of one's circumstances are often performed below the level of consciousness—at the level of emotion (Liebling, 2014, p. 483) -, but this seems to not quite reach the idea of a psychoanalytic dynamic unconscious, the bi-directional unconscious communications of fantasies and affects between researcher and participant via projection and projective identification that constitute the psychoanalytic notion of countertransference. Nevertheless, we can see how Liebling's methodology approaches that of Hinshelwood and Skogstad (2001) as described above, in her emphasis of employing subjective experience, relating to the research subjects and setting in 'reserved participation' whilst refraining from action – akin to Hinshelwood and Skogstad's method of observation with evenly hovering attention and without premature judgement, and being able to think and reflect about the experience as a whole. This process is also similar to the psychoanalytic qualitative research method developed by Kvale (1999), Cartwright (2004), and Holmes (2013) in which interviews with research participants and their analysis are psychoanalytically informed by listening for layers of meaning in the participants' free-associative verbal and non-verbal responses, careful attention paid to feeling states in both interviewer and interviewee, keeping extensive notes, and reflecting and interpreting the data with other researchers.

9.5 Conclusion

Attempting to make sense of one of the key results of this thesis – that the emotional impact of implementing the trial was one of the main obstacles in doing so – has exposed the schism between psychological and sociological theoretical paradigms of emotionality within criminal justice systems. On the one hand there is a growing literature on psychoanalytic organisational studies and mentalizing social systems which are relevant to understanding the generation and dynamics of emotions in criminal justice settings, and on the other hand there exists a substantial body of work stemming from sociology in the areas of emotional labour, emotional literacy and moral and affective climate that focus on emotions and their management in criminal justice

staff and offenders, including a specific focus on criminological researchers. What is conspicuous is that, despite distinct areas of theoretical correspondence and interrelation, there has been to date very little cross reference in the literature between these two broad paradigms.

This chapter has explored the findings within these different frameworks, starting with the hypothesis that they could be meaningfully illuminated in differing ways through the respective lenses of psychoanalytic organisational and mentalizing frameworks, but then revealing the limitations of these two models and finding in criminology alternative theoretical frameworks, namely emotional labour, emotional literacy and moral and affective climate, all of which offer distinct, albeit overlapping, degrees of conceptual fit.

The interpretations of the findings of this thesis within each of these models may be used to inform effective interventions to reduce the emotional toll exerted on the workforce by their labours within the criminal justice system. The most cited intervention within all of the theoretical frameworks is the provision of thinking spaces, specifically supervision and reflective practice, for which there is some empirical evidence for their effectiveness. Despite the growing literature on the emotionality of criminological researchers, there are no studies, to my knowledge, on the emotions involved in personnel involved in implementing RCTs within the criminal justice system, nor in any other setting, and as such this doctoral thesis offers a novel contribution to the field.

These findings may be valuable in influencing academics, commissioners, and funders involved in such trials to consider the emotional impacts of their implementation, and to incorporate interventions such as reflective practice for staff within study designs and protocols that may mitigate against the negative emotional effects on researchers and other staff engaged in these trials. Although the trial under investigation in this thesis – the effectiveness of MBT in reducing violence in offenders with a diagnosis of ASPD –was commissioned as part of the OPD pathway, which is based on a model of relational practice in which reflective practice is key to establishing and maintaining helpful interpersonal relationships (Benefield & Haigh, 2020) and which has been shown to improve staff wellbeing and staff sickness absence (Kordowicz, 2019), it did

not specifically offer reflective practice or related activities to the staff involved in the RCT, although some may have had access to these opportunities in other areas of their work within the pathway. This should be a priority for planning future RCTs, not only those conducted within the OPD pathway, but within the criminal justice system as a whole. The next chapter examines in more detail reflective practice and other interventions that may be helpful in alleviating the emotional stressors within staff that impede research in the criminal justice system.

Chapter 10: Addressing the problem and proposed solutions

10.1 Introduction

Although, as noted in the previous chapter, there is very little cross-referencing in the literature between psychoanalytic and sociological theories of emotionality in staff working in the criminal justice system, there is significant overlap in the solutions proposed by researchers in each of the frameworks under review – namely psychoanalytic organisational, mentalizing of social systems, emotional labour, emotional literacy and moral and affective climate - to prevent or mitigate the negative effects of the emotional impact on staff, including researchers, of working in criminal justice settings. This chapter examines in detail the various interventions described in the literatures on these respective frameworks that may avert or alleviate the negative psychological consequences for staff working within criminal justice settings, which may also be of direct relevance to reducing the emotional burden of implementing trials, such as that described in this thesis, in such environments. I will start with examining the role of clinical supervision and review a range of approaches under this broad umbrella, including reflective practice and in particular psychoanalytically informed reflective practice, that are aimed at helping criminal justice staff identify and process their often-disturbing emotional responses generated by their work. I will then describe the development and practice of interventions within the mentalizing model that are aimed at improving mentalizing within social systems, which, although not explicitly focussing on emotionality, nevertheless include affective processing as an integral component of healthy mentalizing. I go on to describe more informal practices such as support groups and 'communities of coping' which utilise peer involvement in reducing the emotional burden of the work. I subsequently summarise the contributions of more structured training and education, and conclude with the brief mention of other interventions, including self-care strategies, informal briefing, and including the emotional consequences of engaging in criminology research in applications for ethical approval, which have been proposed by various researchers in the field. Integral to all these interventions is the relational aspect – the coming together with others in safe spaces in which to talk about, understand and work

through the emotional responses stirred up by the toils of personnel, including researchers, employed within criminal justice settings.

10.2 Clinical supervision

The provision of regular thinking spaces in which staff can come together to safely reflect about their emotional responses to the work is the most cited intervention in all three frameworks thought to be most helpful in equipping them to manage the emotional demands of forensic work. Broadly speaking, these reflective spaces may be one of two types – clinical supervision and reflective practice.

In regulated care settings, supervision should be available to support staff in the delivery of safe practice (Care Quality Commission, 2022). Supervision is also a requirement of professional practice within the criminal justice system (HM Inspectorate of Probation, 2020). Staff supervision is a multifaceted process, involving at least 3 elements: 'Managerial supervision' where the supervisor reviews the performance of the supervisee, sets objectives in line with the organisation's priorities and identifies needs for development and training; 'professional supervision' which refers to the review of professional standards as stipulated in codes of conduct and the boundaries of the profession; and 'clinical supervision' where the supervisor enables the supervisee to review and reflect on their practice, including discussing individual offenders that they are managing, in line with their training needs. In healthcare, managerial, professional, and clinical supervision are often carried out as separate activities; however, within criminal justice settings, such as probation, these aspects are almost always combined within supervision, which has led to confusion and tensions. In probation, supervision has been based on Procter's (1991) theoretical framework of three primary functions involved in the clinical supervision process: 'normative', which refers to the practice of supervision providing a safe environment in which trust can be built and professionalism can be thought about with the supervisor acting like an advisor or coach-mentor; 'formative', which involves learning and development for staff in which professional boundaries and practice with clients are reflected upon; and 'restorative' supervision, which refers to a clinical supervision approach in which the emotional factors within practice can be explored (Coley, 2020). However, the increasing dominance of administrative criminology with its focus on

managerialism, achieving targets, and bureaucracy, as well as a more punitive and defensive risk-averse culture within the criminal justice system which extends beyond the supervision of offenders to surveillance and control of professionals, is partly maintained through the supervision process (Beddoe, 2010). Research findings show that staff prefer supervision which prioritises a more clinical approach, but it frequently becomes dominated by managerial aspects (Coley, 2020).

Several of the criminological papers on emotional labour summarised above (Knight, 2016; Phillips et al., 2016; Waters et al., 2020) recommend that regular clinical supervision should be provided to acknowledge and explore the emotional aspects of the work. A study investigating the emotional labour of probation officers within the NPS found that one of the coping mechanisms for dealing with large caseloads of high-risk offenders was being able to 'offload' anxieties in clinical supervision. This was available within the OPD pathway, but the majority of participants reported finding the supervision they received inadequate as it was too managerial with a focus on the caseload rather than the cases and lacked a reflective clinical component (Phillips et al., 2016).

In their study on the emotional labour of criminological researchers, Waters et al. (2020) recommend clinical supervision, particularly for pieces of research considered to be emotionally high risk due to the research subject, environment, participants, or the needs of the researcher themselves. Knight (2016) also recommends clinical supervision with supportive and understanding line managers, which includes open and frank discussion of emotions without them being labelled as weak to minimise emotional labour and increase the capacity for emotional literacy within probation staff.

These authors do not provide details of the type of clinical supervision or its underlying theoretical framework, although one might expect that the clinical supervision provided within Phillip's study was psychodynamic/attachment-based in line with the theoretical basis to the OPD pathway. Another study of clinical supervision within the OPD pathway was that based explicitly on a psychoanalytic framework (Wood & Brown, 2014). This was an initiative from the Portman Clinic in London which offered psychoanalytically informed individual and group clinical supervision to all frontline probation officers within the OPD pathway. Feedback forms from supervisors during

the first months of this project highlighted the countertransference challenges of probation work, with probation officers commonly reporting anxiety; being the recipient of service users' hostility or animosity; feelings of dislike or retaliation towards the service user; confusion and doubt; splitting between the offender's vulnerability and deprivation, and their potential risk and capacity for violence; discomfort at vulnerable, dependent feelings in the service user; and feelings of hopelessness and impotence in the face of their clients' relentless offending. These emotional responses were also related to anxieties about the lack of containment from the probation service in the context of the organisational changes of TR which were occurring at that time.

Clinical supervision is also integral to mentalizing interventions and was an essential component of the MBT delivered by the MBT team in the treatment arm of the RCT which is the subject of this thesis. The effectiveness of MBT for individual patients relies in part on the therapist being able to maintain a mentalizing stance and to recognise and recover from lapses in mentalizing. This is facilitated by regular clinical supervision with a more experienced MBT practitioner, and a system of supervision is integral to any MBT treatment programme. Supervision is provided not only for the individual clinician, but for the team around the clinician. This may involve group discussion of cases focussing on techniques, practice, and knowledge, often using video recordings of patient sessions. Another type of team supervision is called intervision, which is aimed at improving the mentalizing of individual team members of themselves and others within the team to enhance its cohesion and collective mentalizing levels (Bateman & Fonagy, 2016). This involves discussion of disagreements within the team and their underlying meanings.

10.3 Reflective practice

Reflective practice is today a term encompassing a very broad range of activities employed in many different contexts but originates in the field of education and is essentially a tool that enables professionals to critically think about and appraise their experiences and actions in order to continually learn from them and arrive at new insights (Dewey, 1933). In recent years it has been widely applied in healthcare to assist in clinicians' understanding of their patients, enhance their development as professionals, improve the healthy functioning of their teams and institutions with the

overall aim of improving patient care (Li et al., 2019). There are many different models of reflective practice interventions, which may also be referred to as relational practice, case discussion, staff sensitivity groups, staff support groups, or consultation.

The provision of monthly reflective practice groups to all staff members is one of the key quality standards expected of all low and medium secure forensic mental health services in England and Wales (Quality Network for Forensic Mental Health Services, 2019). Within the criminal justice system, the Ministry of Justice and HMPPS see reflective practice as a key aspect of probation officer skills training and its importance is stressed throughout the current graduate diploma undertaken by PQiP (Professional Qualification in Probation) learners (Ainslie, 2020). It is also part of continuous professional development for qualified probation officers, and it use is encouraged within a framework of reflective line management supervision ultimately to engage service users. A new line management supervision framework is currently being rolled out which includes direct observation of responsible officers doing their job and reflective discussions on this. New guidance on the case supervision of offenders also emphasises the capacity to be reflective as a key quality in probation officers (HM Inspectorate of Probation, 2021), and there is reference to reflection time in the recent HMPPS Workforce Strategy (HMPPS, 2020). Recent guidance has also been published for practitioners working with people showing personality difficulties in the criminal justice system, highlighting the impact of this on the well-being of the workforce and the effectiveness of practice, and emphasising the benefits of being a reflective practitioner so that staff can recognise and reflect on how they respond to their emotional reactions, and how they work together as a team and with their clients (HMPPS/NHSE, 2020).

Reflective practice within the criminal justice system is for the most part based on the Gibbs model (1988), a 6-staged cyclical framework for examining experience: description of the experience, feelings and thoughts about the experience, evaluation of the experience, analysis to make sense of the situation, conclusion about what has been learned and what could have been done differently, and an action plan for how one would deal with similar situations in the future.

Training promotes individual reflection through the use of reflective models, diaries or written narrative methods, but this approach for the most part is not followed by probation officers (Coley, 2016). Reflective practice in pairs is more popular – this can be ad-hoc, discussing cases with colleagues, or part of formal supervision with their line manager. This reflective aspect of supervision should form part of the clinical component as described above. Group reflective practice with peers is found helpful by some but is not widely available outside of the OPD programme, and heavy caseloads deter many staff from prioritising the time to participate (Coley, 2016).

There is variation in the way probation officers make use of reflective practice, and although many regard it as vital in enabling them to practice effectively and use critical reflection in both a professional and personal capacity, they also find it hard to master and can be uncomfortable (Ainslie, 2020). Probation officer training has been criticised in being too prescriptive and focused on learning about tools, processes, and procedures rather than developing interpersonal and relational skills, and the pace and scale of changes within the criminal justice system such as TR has been found to limit the ability to become a skilful and reflective practitioner (Cracknell, 2016). A recent Inspectorate of Probation (2021) showed that interviews with both CRC and NPS staff indicated that they felt that high caseloads were having an impact on the quality of their work, with some seeing their role as becoming ‘a box ticking exercise’, and left staff with little time to reflect on their work. One NPS probation officer summed up this up: ‘The work is not manageable in the sense that you can do the basics but have no time to dig into the detail. No time for reflection or professional curiosity.’ (HM Inspectorate of Probation, 2021, p. 26).

Although reflective practice interventions are recommended to lessen the emotional impact of working within the criminal justice system, there is a lack of empirical evidence base for their efficacy (Freestone et al., 2015). One recent study (Webster et al., 2020) evaluating the impact of staff reflective practice within the OPD pathway indicates that the majority of staff have found it to be a valuable resource, specifically in managing stress and challenges within their role; allowing an opportunity to reflect on client issues, personal emotional responses and team dynamics; providing a safe space to offload and reflect on practice; allowing opportunities to seek advice and support from peers; and allowing opportunities to take time to reflect on their individual

practice and to consider how they will both manage the pressures of their role and the emotional impact of working with offenders with personality difficulties.

Another study (Bruce et al., 2017) evaluated a training and consultation intervention that included reflective practice as one of its components. This was an RCT testing the effectiveness of 'psychologically informed practice' (PIP) over 12 months for staff working within community-based approved premises providing supervised accommodation for offenders, which formed part of the OPD programme. The control group did not receive the intervention. PIP consisted of four components: a 6-day intensive staff training programme, which included a psychological framework for understanding and managing personality disorder; therapeutic alliance training and knowledge consolidation and application; ongoing staff support, which included supervision, case formulation, and reflective practice; and 'rapid response' telephone consultation. The results showed that significant improvements in the knowledge and understanding of personality disorder as well as a greater sense of personal accomplishment only occurred in staff who received the intervention, and significantly lower rates of warnings and recalls to prison were observed only for the intervention group at 6 months following initial staff training. However, there are no details on what the reflective practice component was comprised of, and this formed only one part of the overall intervention, so it is not possible to tease out how much this component contributed to the effectiveness of the intervention.

10.3.1 Psychoanalytically informed reflective practice

Psychoanalytic and psychodynamic models of reflective practice focus on the relational aspects of relationships with colleagues and clients and explore the emotions evoked by the work. Different types of reflective practice have emerged, but a key historical influence is the ideas of the psychoanalyst and physician Michael Balint and his wife Enid (Balint, 1957). They initiated seminars for general practitioners to learn about the doctor patient relationship in the context of everyday consultations, particularly considering the emotional aspects of this relationship. Since then, Balint groups have been widely applied in medical education and in the UK form a compulsory part of the curriculum for psychiatric training.

There is a growing literature within forensic psychotherapy on the application of psychoanalytically informed reflective practice groups for staff in forensic settings (e.g., Adshead, 2012; Blumenthal et al., 2011; Carlyle & Evans, 2005; Scanlon, 2012; Moore & Lord, 2017; Reiss & Kirtchuk, 2009; Ruszczynski, 2012; Winship et al., 2019). Again, the format of the groups and how they are conducted varies, but they have in common the exploration of the countertransference of members of the group, whether or not this is explicitly named, in order to understand the emotional impact of the work, the difficult dynamics that may arise between staff, and how these are linked to, and lead to greater insight into, the mind of the patient or offender.

Staff need to be psychologically secure to manage the anxieties of their work and to be given the space to become aware of their anxieties, which may be unconscious (Adshead, 2012; Yakeley, 2010). If feelings are not acknowledged and examined there is a risk that these will be acted out by staff, often unconsciously, in unhelpful ways, such as overly punitive behaviour or boundary violations, which might be minor infractions, or more extreme, such as sexual relationships, or turning a blind eye to such behaviour (Adshead, 2012). The Department of Health (2010b) has distinguished between three types of security – 'physical security' (the fences, locks and personal alarms), 'procedural security' (the policies and procedures in place to maintain safety), and relational security. Relational security is the knowledge and understanding staff have of the dynamics between patients and their environment, and the translation of that information into appropriate responses, boundaries, and care. Where there have been serious breaches of security, such as patients absconding from forensic hospitals and committing serious violence, subsequent inquiries frequently highlight the 'toxic' relational culture existing within the institution. Reflective practice provides a space for psychological containment and mechanisms to understand the relational links between patients, staff, and patients, within staff teams, and between the teams and the organisation (Aiyegbusi, 2004; McGauley, 2010).

Psychoanalytically informed reflective practice groups usually last one hour, are held weekly, and are centred in the treatment setting, whether this is a hospital ward, prison landing or approved hostel. Ideally, all members of the multidisciplinary team should be involved, not just front-line staff who have the most contact with patients or offenders, i.e., nurses or prison officers, but more senior clinicians and managers as

well, whose presence lends legitimacy to the work and facilitates attendance. Moreover, the different levels and subgroups that exist within forensic systems of care are exposed, which are defined by overt terms of occupation, level of seniority, gender, age, or ethnicity, or by more abstract and unconscious connections such as the shared expression of hatred, grievance, love, and despair (Scanlon, 2012). Membership of these subgroups and their interrelationships are fluid, and reflect, at least in part, the internal conflicts of the patient/offender, and how these are played out in parallel processes, or in the wider conflicts within the institution.

Some reflective practice groups focus their discussion around a particular patient, starting with being reminded of their developmental history, index offence and experiences of health and social care (Ruszczynski, 2012). Each person is invited to discuss their own experiences, thoughts, and feelings about the patient as openly as possible without the group focussing on decision making or action planning. What then emerges is how different members of staff are identified with different aspects of the patient's internal fragmented world, and how his internal object relationships and primitive defences are reflected within the staff group. For example, splitting may occur when some staff experience the client as a victim of their childhood trauma, and others may see the patient as a more aggressive perpetrator of violence. These different presentations of the patient can be seen to represent different aspects of his personality, and gradually a more integrated picture of the patient emerges, who then staff may relate to in a more coherent and whole person way. Although the activity in the reflective practice group centres on individual clients, it also promotes the development at a wider staff and organisational level of a 'culture of enquiry' promoting the capacity of staff to be curious about the minds of their clients rather than being focussed on their offending actions, which in turn strengthens the relational security within the setting.

Other reflective practice models more explicitly include consideration of the staff dynamics between each other in the group rather than just in relation to the patient or offender. Although this can be uncomfortable, especially when conflicts between different staff members are made more apparent, it may highlight more overtly parallel processes, i.e., how the offender's offending behaviours are being repeated within the staff groups and organisation. Winship et al. (2019), describe their development of

reflective practice groups for prison officers, which enable them to learn and apply Klein's (1946) and Bion's (1962) concept of projective identification in their work. In the group, the therapist tries to expose and make sense of the projective processes, feelings and conflicts that are felt by the supervisor and occur between members of the group, to recognise subtle enactments and to try to differentiate between those which belong to the prisoners, and those which are part of the staff dynamics, and the relationship between them. An example might be a situation in which the supervisor may have a sense of feeling intruded upon, that her psychological boundaries have been subtly breached. Putting words to her own experience in the group may allow other group members to voice feelings of irritation with each other, although it is not initially clear what this is about. The discussion then turns to a particular prisoner, who has been described as 'psychopathic' but who also experienced significant abuse in childhood, and who is evoking strong feelings in the staff group by alternating between submissive, and non-compliant and aggressive behaviour. This has resulted in conflicting responses in the prison staff – on the one hand, officers who feel sympathetic, resulting in being overly lenient with him, for example, turning a blind eye to his verbal outbursts towards other prisoners; and on the other hand, officers who feel angry with his behaviour and feel he should not be allowed out of his cell. From a psychoanalytic perspective, the differing emotional responses in the prison officers may be the result of different aspects of the prisoner that he is disowning and projecting into the officers – the hated more vulnerable part of himself, and the more sadistic part of his personality. The prison officers, in turn, each depending on their own personal history and experiences, will then unconsciously identify in a particular way with either of these projections and behave accordingly – too indulgent or too punitive. In the group, the supervisor picks up, names, and helps the group explore the conflicts between them, but also makes sense of her own feelings of being subtly violated as a reflection of the prisoner's and officers' boundary breaches.

Staff within the criminal justice system, particularly if they are not clinicians, may initially feel uncomfortable with an experiential, rather than didactic way of learning. They may also be wary of talking about their feelings or, at the opposite pole, reveal too much personal information about themselves. The group supervisor needs to be careful to keep the discussion on the offender, negotiate personal and professional boundaries and be clear that the discussion about emotions is in relation to the work

setting, to limit too much self-disclosure or drifting into personal therapy (Adshead, 2012).

Some groups are more structured and/or contain educational elements. Team Development Consultancy (Scanlon, 2012) is a psychoanalytically informed version of reflective practice in forensic settings based on Schon's (1987) theory that reflective practice contains two essential elements: reflection-on-action and reflection-in-action. Reflection-on-action is where practitioners learn skills from recalling past actions (such as serious incidents) and preparing for future action and building a team narrative of the work. Reflection-on action involves problem solving and is directly or indirectly dealing with physical and procedural security. Reflection-in-action is a higher form of learning where the discourse on physical and procedural security is integrated into thinking about the relational security of the team as a whole, taking into account social defence mechanisms, team dynamics, and parallel processes, as described above. The Team Development Supervisor needs to be skilled in both types of learning and teaching and have expert knowledge in the management issues of the setting, as well as in the relational dynamics of team functioning.

Another type of reflective practice is interpersonal dynamics and multidisciplinary teamwork, which is a structured and systematic approach to reflective practice, aimed at understanding the transference and countertransference processes that occur within the patient–team interaction, and the repetitive and problematic relational patterns that might be at play in a patient's engagement with care. It provides a model to assist in difficult cases and an accessible psychotherapeutic tool that draws on existing experience.

Interpersonal dynamics and multidisciplinary teamwork was first developed within forensic psychiatry and has subsequently been applied within general mental health services and physical health settings (Kirtchuk et al, 2008; Li et al, 2019; Reiss et al., 2009). The model draws from a number of theories, including object relations theory, attachment theory, the work on interpersonal therapy by the psychoanalyst and psychiatrist Harry Stack Sullivan (1953), the psychologist Timothy Leary's (1957) 'interpersonal circle', the psychologist Lorna Smith Benjamin's (1996) work on personality disorder and the Structural Analysis of Social Behaviour (SASB) model,

and most recently, Operationalized Psychodynamic Diagnosis (OPD) (OPD Task Force, 2001, 2008), a form of multiaxial diagnostic and classification system based on psychodynamic principles, analogous to those based on other principles such as DSM-5 and ICD-10.

Interpersonal dynamics and multidisciplinary teamwork is offered as a training spanning four sessions, each lasting three hours. Like the reflective practice model described by Ruszczynski (2012) above, the sessions focus on one particular patient case and should include as many members of the multidisciplinary team as is practicable, as different members of the team tend to experience the patient in different ways, representing different figures or parts of the self. The team describe the history of the patient, with a particular focus on childhood and significant relationships, and why they have brought this particular case for consultation. The facilitator then takes the team through each of four interpersonal perspectives in turn: Perspective A: how the patient experiences others; Perspective B: how the patient experiences themselves; Perspective C: how the staff experience the patient; and Perspective D: how the staff experience themselves (in relation to the patient). For each perspective, the team are asked to give their thoughts and feelings, where possible with examples of the patient's actions or statements. The team are then helped to synthesise a formulation describing how these perspectives may interrelate in a dysfunctional and repeating cycle into which patients and staff are drawn. This is developed into an extended formulation bringing in what is known about the patient's history and facilitating exploration of how the patterns of relating stem from significant past relationships which are being played out with the team members caring for them in the present. The final part of the meeting is a discussion about the changes of strategy that can be adopted by members of the multidisciplinary team in relation to their own interactions with the patient to improve his or her management and treatment (Li et al, 2019; Reiss et al., 2009).

Despite the development and application of the psychoanalytically informed types of reflective practice and their widespread use in forensic settings, an empirical evidence base for their efficacy and effectiveness is lacking and most have not been systematically evaluated. One study (Blumenthal et al., 2011) evaluated the impact of a psychodynamically informed consultation aimed at helping staff to think about the

patients in their care in a high-security hospital ward of male patients with chronic mental illness, all with a history of serious offending, in comparison with a therapeutic programme explicitly aimed at encouraging contact between staff and patients on a comparison ward. Patients were matched for demographics, offence-related and diagnostic characteristics, and measures included the Ward Atmosphere Scale (WAS) and an index of burnout. Interactions between staff and patients were observed and rated for content and quality. Most scales on two of three dimensions of the WAS (the relationship and personal growth domains) improved on both wards, as did the quality of staff-patient contact, and change at the levels of behaviour and attitudes also occurred in a positive direction. Although there was little evidence here for a distinct advantage of one intervention style, the results were encouraging for the consultation, because ward atmosphere and staff-patient interaction were not a direct target for change.

10.3.2 Interventions aimed at improving mentalizing in social systems

Within the literature on mentalizing, there is a paucity of descriptions of what is overtly referred to as reflective practice. Di Stefano (2017) mentions the importance of having reflective spaces (e.g., meetings, working groups, continuous training groups, supervision) included in the ordinary dimension of their own work, but doesn't offer details as to their model and delivery. Nevertheless, a range of mentalizing interventions have been developed aimed at improving mentalizing in social systems which are akin to reflective practice as described above. This includes adolescent mentalization-based integrative treatment (AMBIT; Bevington et al, 2013), which can be viewed as a training in reflective practice in helping teams to mentalize the different relationships in the system between clients, staff, and organisation to improve understanding and care of clients, and to improve team and interagency dynamics.

AMBIT is a manualised mentalization-based multimodal intervention aimed at helping adolescents with severe, complex, and multiple needs by influencing the wider treatment system. Working with this difficult patient group presents challenges to the cohesiveness and communication within the team due to the emotional demands on staff members often working in anxiety provoking community settings. AMBIT applies mentalizing as an organisational framework. The AMBIT model focuses on three forms

of relationships within the system - client-worker, worker-worker, and worker-agency. Each patient has a keyworker or primary clinician who delivers the treatment. However, the central keyworker-patient mentalizing relationship must be sustained by a responsive and supportive 'team around the worker'. This is actively addressed in peer and team supervision by not only supporting the team worker's capacity to mentalize, but with all aspects of practice - mentalizing the client ('active planning'), mentalizing the worker ('supervisory structure'), mentalizing the wider system ('addressing disintegration') and team learning ('wiki-manualisation') (Bevington et al., 2013; Fuggle et al., 2015).

There is growing evidence that other mentalizing interventions that reach beyond the clinician and the clinical team and focus on the patient's family and social environment to support mentalizing and the generation of epistemic trust may lead to positive clinical outcomes for the individual (Asen et al., 2019; Luyten et al., 2020). Studies evaluating mentalizing treatment approaches that are aimed at family members have shown effectiveness in substance-abusing mothers and their infants (Suchman et al., 2018); fostered and adopted children (Redfern et al. 2018); mothers living in underserved and poor urban communities with children at high risk of maltreatment (Byrne et al. 2019, Slade et al. 2020); and individuals supporting a family member with borderline personality disorder (Bateman & Fonagy 2019).

Mentalizing approaches aimed at changing social systems have also been applied to schools, particularly in relation to children presenting with aggressive behaviour, some of whom, one might imagine, may be predisposed to developing ASPD in adults. Creating A Peaceful School Learning Environment (CAPSLE) (Twemlow, et al. 2005a; Twemlow et al., 2005b) is an attachment-based mentalizing programme designed to combat bullying in schools where a culture of aggression and violence shuts down mentalizing in staff and pupils. CAPSLE is a manualised teacher-implemented programme focused on the whole school community, which seeks to create a mentalizing climate by not just focusing on the bully/victim dynamic, but by addressing the wider bystander culture where others – pupils, parents and staff –implicitly condone interpersonal violence by failing to act against it. The CAPSLE programme was evaluated in a cluster-randomised controlled trial involving 1,345 children across

nine elementary schools in a city in the USA (Fonagy et al., 2009) and was found to significantly reduce aggression and improve classroom behaviour.

Another social systems mentalizing approach applied to addressing problematic pupil behaviour in schools is the Family Classroom model pioneered in mainstream primary and secondary schools in the UK (Asen, et al., 2001; Dawson and McHugh 1994). This programme aims to help children who act out and are failing academically by promoting effective mentalizing in their families and teachers. Multi-family work consists of bringing the pupils' parents together to encourage and practice mentalizing with each other. Being exposed to other families, observing their interactions, seeing their own behaviours mirrored in other families, encouraging them to think about the mental states of other families and being exposed to multiple descriptions of their own mental states by other families, and thinking about how others view them in relation to their own perceptions of themselves produces a virtuous circle of effective mentalizing themselves and others. At the same time, teachers are taught to mentalize their pupils' parents, and parents are encouraged to put themselves in the shoes of the teachers, fostering a mentalizing culture to develop in the whole school system (Asen et al., 2019).

10.4 Support groups and communities of coping

Within the literature on emotional labour in the criminal justice setting, informal support from peers, or 'communities of coping' are mentioned by several authors as being an important resource to mitigate against the emotional pressures of working within these stressful environments. Hochschild (1983) herself noted that workers tended to rely on each other for emotional support. Korczynski (2003), in his sociological work on emotional labour in call centres, formalised Hochschild's description into a what he called 'communities of coping'.

Fohring (2020) describes how coping communities of fellow researchers were invaluable in her work as a criminological researcher into victims of crime to alleviate the effects of vicarious trauma and recommends peer-support groups for researchers and other criminal justice employees. She speaks of the loneliness of working within a competitive academic environment where difficulty in coping may be perceived as weakness, and how finding and bonding with other researchers who were also

experiencing emotional pain from the work was reassuring. Moran & Asquith (2020) also describe the benefits of peer support and the development of working cultures that acknowledge the significance of emotional responses in qualitative and quantitative research as providing protection against vicarious trauma.

In their research on the emotional labour of doctoral criminological researchers Waters et al. (2020) also mention the need, especially for new researchers, for the creation of formal and informal support networks and communities of coping, which they suggest could include mentoring schemes or 'buddy' programmes, social media groups, walking groups and pub nights. Attending and presenting at academic conferences was also identified as a source of support.

However, Phillips et al. (2016), in their research on the emotional labour of probation officers working with high-risk offenders in the aftermath of TR, warn against the risk that colleagues providing inappropriate forms of emotional and practical support could lead to poor decision making.

Within the psychoanalytic literature, Kurtz and Jeffcote (2011), in their qualitative study of experiences of forensic mental health staff in two contrasting services, found that the staff garnered support from small groups of close colleagues. However, these were often isolated from other groups and from the wider institution and the outside world and were limited in the extent to which they supported the work and made it difficult to address areas of professional conflict and further separated staff from others in different professional groups and the wider hospital environment.

10.5 Training

Training and education about the importance of emotionality is another area which is promoted in several of the papers on emotional labour in the criminal justice system. Knight (2012) advocates for probation staff to have pre- and post-qualification training with opportunities to 'rehearse' emotional literacy via drama or role play, as well as more didactic teaching about the emotional component of offending behaviour with reference to attachment theory.

Regarding criminology researchers, Waters et al. (2020) believe that training about emotional labour should be provided at all levels, not just for doctoral students and early career researchers, but also supervisors, so that they are better able to support their PhD students. This would include acknowledging and performing emotional labour, understanding how emotions are used in research, planning emotional wellbeing into research projects, the acknowledgement and mechanisms of self-care, and asking for help and accessing support. In relation to criminology researchers being at risk of vicarious trauma, both Guerzoni (2020) and Moran & Asquith (2020) similarly recommend that undergraduate programmes and research method courses should include dedicated discussions on emotional labour.

Interestingly, the psychoanalytic literature on emotions within organisations do not mention training as a method of reducing the negative emotional impact of working in these settings. Within the mentalizing literature on organisations, Lind et al. (2020) showed that following participation in a mentalizing-based workshop to staff working in government-supported organizations providing help to vulnerable families, participants reported significantly higher empowerment and lower symptoms of depression.

10.6 Other strategies and interventions

Several other coping mechanisms and practices are suggested by researchers on emotional labour in the criminal justice system as being helpful in preventing or alleviating its harmful effects. Waters et al. (2020) and Guerzoni (2020) mention self-care strategies, which might include physical activity, reading and writing, talking, and listening. Waters et al. (2020), in their study of the emotional labour of doctoral criminological researchers in the UK, found that many described ‘shedding rituals’ which involved cleanliness, for example washing and changing clothes in a ritualised way to foster self-care, and creating space to separate from their work to reflect on and process their research experiences, for example during the commute.

Knight (2012) found that probation officers referred to debriefing informally with colleagues as a way or reducing stress, although these were often unplanned and rushed. She also mentions, as does Guerzoni (2020) and Waters et al. (2020), the

provision of counselling, offered regularly and supportively to staff, to legitimise the expression and discussion of emotions. Guerzoni goes further in recommending that universities should offer compulsory PhD candidate appointments with a counsellor, quarterly or annually. The nature of such counselling, however, is not specified.

Knight (2012) also suggests that mentoring can offer support and debriefing that sits somewhere between informal networks of colleagues and more formal counselling or debriefing sessions, although she underscores its resource implications. She advises that if it is 'in-house' experienced staff need to be given workload relief to offer time to colleagues, and that if provided by an external consultant, it needs to be adequately funded.

Waters et al. (2020) recommend that institutional ethical approval forms should have a dedicated section for reflecting on the potential emotional impact of the research on the researcher which should be considered of equal importance to their physical safety and to the physical and psychological safety of their participants. McGowan et al. (2020), Fohring (2020), and Garrihy & Watters (2020) also argue that the ethical approval for studies in the field of criminology should take into account their emotional impact in the lived experience of researchers in these settings.

Finally, several authors mention attempts to change the culture of the system. Laws (2019b) proposes that prisons could do more to encourage therapeutic talk and psychological attunement. Knight (2012) recommends that emotions should be put on the 'agenda' in probation to build emotional resources within the organisation, emphasising the importance of developing positive relationships with offenders and colleagues. Fohring (2020), Moran & Asquith (2020), and Waters et al. (2020) call for overarching 'culture change' around the discussion of emotion and emotional labour in research and how the above interventions might go some way to achieve this.

10.7 Conclusion

This chapter reviews the interventions described in the respective literatures on psychoanalytic, mentalizing and sociological theories of emotionality in staff working in the criminal justice system to reduce the emotional toll exerted on the workforce within the system. The most cited intervention within all three of the theoretical

frameworks is the provision of thinking spaces, specifically supervision and reflective practice, for which there is some empirical evidence for their effectiveness. Although there is a growing literature on the emotionality of criminological researchers, there are no studies, to my knowledge, on the emotions involved in personnel involved in implementing RCTs within the criminal justice system, nor in any other setting, and as such, this doctoral thesis offers a novel contribution to the field.

The predominant theme that emerged from the qualitative analysis of the interviews of the participants involved in the RCT in this study was that a major impediment to its implementation within the criminal justice system was the emotional impact on staff. This finding may be valuable in influencing academics, commissioners, and funders involved in such trials to consider the emotional impacts of their implementation, and to incorporate interventions such as reflective practice for staff within study designs and protocols that may mitigate against the negative emotional effects on researchers and other staff engaged in these trials. Although the trial under investigation in this thesis – the effectiveness of MBT in reducing violence in offenders with a diagnosis of ASPD – was commissioned as part of the OPD pathway, which is based on a model of relational practice in which reflective practice is key to establishing and maintaining helpful interpersonal relationships (Benefield & Haigh, 2020), and which has been shown to improve staff wellbeing and staff sickness absence (Kordowicz, 2019), it did not specifically offer reflective practice or related activities to the staff involved in the study, although some may have had access to these opportunities in other areas of their work within the pathway. This should be a priority for planning future RCTs, not only those conducted within the OPD pathway, but within the criminal justice system as a whole.

Chapter 11: Conclusions

This concluding chapter of the thesis will present the key findings in relation to its research aims and research hypotheses and evaluate and discuss their value and contributions to the field. In doing this, the results from each chapter will be summarised and integrated into the overall findings. This chapter will also review the limitations of the thesis, offer recommendations for conducting trials in criminal justice settings, and suggest directions for future research. It will finish with some personal reflections on the experience of conducting this research.

11.1 Research aims and hypotheses

The aims of this study were twofold: firstly, to identify the barriers to implementing an RCT testing a psychological treatment for violent offenders with a diagnosis of ASPD within the UK criminal justice system; and secondly, to interpret the results within the frameworks of two theoretical paradigms – mentalizing social systems, and psychoanalytic organisational theory respectively – and investigate which framework might provide the best conceptual fit. These aims arose from the hypothesis that systemic factors which created and maintained a hostile environment would be one of the main obstacles to conducting the trial, and that these factors could be conceptualised in differing ways within each of these two theoretical frameworks, which in turn could inform effective interventions to facilitate the implementation of such trials with criminal justice settings.

11.2 Key findings and contributions to the field

This thesis adds to the literature on the challenges in conducting RCTs in the criminal justice system in the UK in the robust methodological design of its component studies and its empirically derived findings.

The key findings, summarised in more detail below, relate to the following studies which constitute this thesis:

- A systematic literature review to identify the number, quality and reported difficulties in implementation of all RCTs conducted in the UK criminal justice system to date (chapter 5),

- Qualitative analysis of interviews with the MBT team, commissioners, and experts by experience to identify the obstacles they encountered in the implementation and delivery of the RCT (Chapters 6, 7 and 8),
- A review of the psychological and sociological literature to identify relevant theoretical paradigms which offer the best conceptualisation and in-depth analysis of the main obstacles identified from the qualitative analysis (chapter 9),
- The identification of facilitators and interventions that may mitigate or prevent these resistances in implementing RCTs in criminal justice settings (chapter 10).

The first four chapters provided the background and context to the thesis. Following the introductory chapter, chapter 2 described the setting of the RCT within the UK criminal justice system. It specifically summarised the history from its origins in the 19th century to the present day of the probation services in England and Wales, and how cultural and political influences contributed to a succession of major structural reorganisations which have caused considerable systemic turbulence and dissatisfaction culminating in the part privatisation, and subsequent renationalisation, of probation services within the past 10 years. The chapter also reviewed ASPD - its clinical presentation, research into its aetiology including the relationship with attachment studies, and available treatments; and then described the specific treatment which was being evaluated in the RCT - MBT - and the theory on which it is based. Chapter 3 reviewed the two theoretical frameworks, namely the psychoanalytic study of organisations and mentalizing social systems, which were to be explored in providing insight into the study's findings regarding the obstacles identified as impeding implementation of the RCT, and chapter 4 described in more detail the setting in which the RCT was embedded, namely the OPD pathway. The findings of the subsequent chapters were discussed in relation to the topics described in these initial three chapters.

The key findings of chapter 5, which described a systematic literature review conducted to identify all RCTs that had been conducted in the UK criminal justice system, their risk of bias and any difficulties reported in their implementation, found that the number of such trials – 50 - was much fewer than the number that have been conducted in other fields of research, such as health. Of these 50 published trials, 32

shared authors with at least one, if not more, of the other trials identified in the review, suggesting that the number of criminological researchers involved in empirically tested interventions is very small. Although there was indication of a positive trend in the quality of trials over time, the majority published in 2015 or earlier were rated as having an overall high risk of bias. For some trials risks of bias were due to methodological weaknesses in design, such as failure to apply correct methods of randomisation sequence and allocation, or failure to use ITT analysis to account for missing data, but for the majority of trials, specific risks of bias, especially lack of blinding and attrition of data, were influenced by challenges within criminal justice settings, including difficulties in recruitment and engagement of trial participants, poor communication and collaboration between different agencies, poor staff morale and motivation, poor treatment fidelity, lack of research knowledge, and ethical concerns regarding randomisation.

This review contributes to the literature in being the first systematic review investigating RCTs within the UK criminal justice system since the two previous reviews of Farrington & Welsh, (2005) and Petrosino (2005) respectively. As well as finding similar challenges reported by the authors of the studies identified in the review in implementing and delivering the trials in criminal justice settings to those previously documented in the literature, this systematic review also found that more recent publications on RCTs in the UK criminal justice system mentioned work stresses such as staff shortages and organizational changes as significant obstacles to trial implementation, which is of particular significance in the context of the MBT RCT taking place during the process of TR.

In the following chapters, the results of the qualitative study interviewing the staff involved in the trial were analysed and discussed at two levels. Firstly, in chapters 6, 7 and 8, the qualitative interviews with the MBT team, commissioners, and experts by experience respectively, were subjected to thematic analysis to address the primary aim of the thesis, i.e., to identify the obstacles which may have interfered with the delivery of the RCT. Secondly, in chapter 9, the main finding resulting from this primary analysis was subjected to further analysis within the relevant theoretical frameworks identified as providing a deeper understanding of the underlying issues and dynamics.

Many of the themes emerging from these interviews were found to be consistent with the obstacles to implementing trials in the criminal justice system that have previously been identified in the existing literature as considered in chapter 5, notably systemic issues, resistance to randomisation, attrition of trial participants, and a general lack of research expertise within the criminal justice system. Analysis of the interviews with the MBT teams and commissioners supported this thesis' hypothesis that systemic issues would be one of the main obstacles to the implementation of the RCT. This was found to be the second most prominent theme identified in the commissioners' interviews, and the third most prominent theme identified in the MBT team interviews, which could be further divided into the sub-themes 'turbulence of system/malfunctioning' and 'antitherapeutic culture/active resistance'. The interviewees in both groups referred to their experience of the current disorganisation and failures in performance of the probation system caused by the restructuring and part-privatisation of the UK probation service with TR, which had just been implemented at the time the RCT started and its duration coincided almost exactly with that of the trial; as well as more longstanding evidence of a punitive culture within probation that opposed rehabilitative work.

However, the key finding of the qualitative analysis of the interviews with the members of the MBT team, in chapter 6, was that the emotional impact on staff was the most prominent factor that impeded implementation of the RCT. This was an unexpected finding that has not been previously described in the literature on conducting controlled experiments within criminal justice settings. This predominant theme was further broken down by the thematic analysis into three sub-themes which shed light on the factors that contributed to the staff's emotional responses generated from participating in the trial: lack of staff and time, lack of support within the RCT, and working with antisocial men. These factors have been discussed in the wider literature on the stresses of working within the criminal justice as a whole, particularly in relation to occupational stress and burnout in probation staff which has been linked to high caseloads, lack of time to do the work, poor support from managers and lack of recognition of good work. Moreover, this finding replicates recent research into the deleterious effects, including work-related dissatisfaction, stress, and poor mental

health, caused by TR (Logan & Ramsden, 2015; Millings et al., 2019; Senior et al., 2016; Walker et al., 2019).

The other significant finding of the interviews with the MBT staff that has not been previous discussed in the literature on the problems of conducting trials in criminal justice settings was that another significant obstacle was the personality traits and resulting behaviours of the trial participants which made it difficult to recruit, randomise, engage, and keep them in the trial. This is a surprising omission given that the participants in most RCTs in prisons or probation settings are offenders, many of whom would fulfil a diagnosis of antisocial personality disorder or have problematic antisocial personality traits given that the prevalence of this mental disorder in prison populations is so high. In the MBT RCT staff identified the participants' paranoia and lack of trust in authority figures, emotional instability, and impulsive and chaotic behaviour, which stemmed from disorders of attachment, as particularly problematic personality traits which interfered with their engagement in the RCT and motivation for treatment in the intervention arm of the trial. This issue is particularly complicated in relation to the question of mandated treatment. In the MBT trial, all participants were subject to mandated conditions in that they were under the supervision of the National Probation Service. This involuntary status was at odds not only with the ethics of research trials where participants' involvement must be voluntary, but also with the ethos of the intervention, MBT, which was less likely to be effective if its recipients felt coerced into treatment. The working solution for this particular trial, which not all staff agreed with, was that entry into the trial was voluntary, but those participants who were randomised to MBT were subject to 'assisted compliance', which was a licence condition in which the probation officer operated a degree of flexibility and leniency in how it was enforced, for example by not immediately recalling participants to custody in response to breaches of their licence conditions by taking into account the personality difficulties of the offenders.

Chapter 7 presented the views of the three commissioners of the clinical services within the OPD pathway that facilitated the MBT RCT. The main obstacles to the trial's implementation that they identified concerned the allocation of resources, systemic issues, the challenges of doing research in the CJS, the emotional impact of the work, and recruitment and retention of participants. These were similar themes to those that emerged from the interviews with the MBT teams, except that the emotional impact

was not the most prominent. In their view what was key to the success of the project was working closely with the research, service development, and clinical teams over its duration to develop a shared sense of ownership. Although generalizability of these results is limited by the small sample size, nevertheless, they offer a contribution to the literature on the implementation of empirical research in the criminal justice system as they demonstrate the essential role that commissioners play in the evaluation of interventions for offenders.

Chapter 8 described the analysis of the interviews with the experts by experience in the trial. Their role was to co-facilitate groups as well as promote engagement of the participants randomised to MBT. Because the experts by experience were only involved in the intervention arm, what became clear in their interviews was that they had less knowledge and understanding of the RCT than anticipated. However, their experience of what they perceived as their roles adds to the nascent literature on the views of forensic peer workers about the nature of their work. As found in other qualitative studies of peer workers in forensic settings (Simes, 2021) they highlighted on the one hand the value of their shared experience with the offenders they were working with in contributing to their therapeutic progress, but on the other hand conflicts between their former identity as criminals and their current identity as workers paid to help others, as well as confusion regarding the boundaries of their role. A novel finding, previously unreported in the literature on peer support as well as in the mentalizing literature, was that their beliefs on how they promoted positive change in the offenders they were working with were consistent with the ideas of how fostering epistemic trust may increase desistance in offenders by the experts by experience putting themselves in the offenders' shoes, offering alternative views, and fostering curiosity.

Chapter 9 focussed on exploring further, through the lens of different theoretical frameworks, the most significant challenge to trial implementation that was identified via the thematic analysis of the interviews with the MBT and research teams, which was the emotional impact of the work. The hypothesis set out at the outset of the PhD that two particular fields of knowledge - psychoanalytic organisational theory and mentalizing social systems respectively - would offer the most relevant frameworks in which to understand in more depth the obstacles identified to trial implementation, was

only partially upheld, because they had been chosen with the assumption that systemic factors would be the most commonly cited obstacle, whereas the emotionality generated in staff by the work was found to be the predominant issue. These two theoretical frameworks were in fact very useful in elucidating the origins and dynamics of these emotional responses: from a psychoanalytic organisational perspective how unconscious primitive affects and defence mechanisms operating in the minds of personality disordered individuals are projected into those that are working with them to generate negative emotional responses at the level of individuals, teams and organisations; and within a mentalizing social systems framework how the non-mentalizing culture of the criminal justice system as a whole reinforced non-mentalizing attitudes in both the offenders and workforce involved in the trial, which included difficulties in being able to reflect and tolerate difficult emotional states without resorting to teleological solutions. However, certain areas, which could further exploration of the issue of emotions, were identified as missing in both models: the legitimacy of emotions within the workplace; the pre-existing emotional capacities of staff within the criminal justice system; the emotions experienced by offenders and how these are affected by the emotional culture of the organisation; and studies on emotionality in criminology researchers. This led to a search for alternative theories which might address these gaps, of which three were found to be of particular interest: emotional labour theory in understanding the stresses on staff in feeling obliged to display socially accepted emotions rather than their true feelings; the concept of emotional literacy in highlighting how the pre-existing capacity for emotional recognition and empathy in individuals working within the criminal justice system may be undermined by organisational changes and constraints; and research on moral and affective climate that shows how the punitive culture of the prison system negatively impacts on prisoners' affective states, which in turn exert a harmful effect on the experiences of researchers within criminology.

Chapter 9 offers another contribution to research by this thesis is its integration of psychoanalytic, mentalizing and sociological concepts pertaining to emotions in criminal justice settings which has not previously been examined in the literature despite areas of considerable overlap. This includes finding similarities between: the psychoanalytic concepts of defence mechanisms and the work of emotional labour in surface and deep acting; the components of emotional literacy and the capacity to

mentalize others and the 'not knowing stance' of MBT therapists; and the methodology and data collection of autoethnographic studies in the research on moral and affective climate and that of psychoanalytic observational research in institutional settings, particularly in relation to the psychoanalytic concept of countertransference.

The hitherto unexplored intersections between these psychological and sociological theories of emotionality in criminology become especially significant in searching for effective interventions that may prevent or reduce the negative emotional impact of working in criminal justice settings, including conducting empirical research. What is particularly interesting is the discovery that all researchers within each of these theoretical frameworks recommend supervision and/or reflective practice as effective interventions. The different types and evidence for these are reviewed in chapter 10, as are other proposed practices, such as peer support groups, teaching and training, and the specific mention in ethics applications of the risks of emotional harm of criminology research. Again, this offers another contribution to the literature as these interventions have not been previously discussed in the literature in relation to reducing the emotional impact of conducting RCTs in criminal justice settings.

11.3 Limitations of the thesis

As discussed in the individual chapters, potential shortcomings can be identified for each of the studies that comprised this thesis. The systematic literature review may have yielded more relevant publications, thus increasing the number of RCTs found, if more electronic databases had been searched. Additionally, there was only one reviewer who was not blinded to the identity of the studies' authors or institutions, which may have increased the risk of subjectivity and errors. Furthermore, although widely used to assess the quality of RCTs, the Cochrane risk of bias tool has been criticised for having low reliability.

Regarding the qualitative thematic analysis of the interviews with the staff involved in the RCT, the person conducting the interviews had also been part of the staff conducting the trial in that she was the lead for the development, delivery and governance of the MBT community services, as well as being involved in the training of staff, and so her analysis of the interviews and choice of themes may have been subjectively influenced by her own experience of the trial, including its emotional

impact. Moreover, there were potential overlaps between the coding of the themes chosen from the analysis of the interviews, notably, the predominant theme 'emotional impact of the work', identified as the main obstacle to the trial's implementation, could be viewed as an overarching theme, under which the other four themes (attrition, organisational issues, methodological difficulties and problems with the treatment intervention) were subordinate, in that each were one of the sources of emotional responses in staff, rather than these themes constituting separate obstacles in their own right with consequences which were not solely connected to emotionality in the workforce.

The results were also limited by being based on interviews with a small number of participants, particularly for the interviews with the commissioners and experts by experience respectively, and so the specific findings may not be generalisable to other trials.

As with the choice of themes distinguished in the final thematic analysis of the interviews, the discovery and selection of theoretical frameworks beyond the two originally identified (psychoanalytic organisational and mentalizing social systems) may have been influenced by the author's own areas of interest, experience, and expertise, and other disciplines and fields of research may also offer illuminating interpretations and insights into the findings of the interviews.

11.4 Recommendations for implementing trials in criminal justice settings

This thesis has identified several challenges to the implementation of RCTs in criminal justice settings, which have led to the following recommendations in conducting such trials. Challenges should be anticipated at the outset and strategies to prevent or minimise these should commence at the planning phase of the trial and be an integral part of the RCT's design and methodology. It may be useful to develop a checklist of anticipated problems which should cover the following interrelated areas: communication, attrition of participants, systemic issues, and the emotional impact of conducting trials.

11.4.1 Communication

Developing and sustaining active and transparent channels of communication with all parties involved in the research is essential. These should include the staff directly involved in the planning and conduction of the trial – the research team, project management team, staff delivering the intervention(s), and staff involved in recruitment – but also those involved more peripherally in the agencies and organisations whose support is necessary to facilitate its implementation – the prison and probation officers on the ground, senior managers and directors, commissioners, policy makers, funding bodies and other academics in the field. Regular meetings to discuss the research with the different parties are essential but other modes of communication such as newsletters, posters in probation offices and leaflets may also be useful. In a multi-site trial, such as the MBT RCT, it is also important to hold regular meetings where all sites come together to evaluate and compare progress and difficulties which may differ between sites due to differing contextual factors, e.g., recruiting within a culturally diverse inner-city population will present different challenges to recruiting within more isolated rural communities. Key issues for communication, clarification and discussion include the rationale and value of the trial; the methodology including randomisation, data collection and follow-up; and clear processes and protocols around engaging participants e.g., reimbursement for participation in the research, the use of licence conditions, and criteria for recall and other sanctions for non-compliance in treatment.

11.4.2 Attrition of participants

At the early trial planning stages calculating the number of participants needed to produce a sufficient sample size for adequate power analysis to detect a significant difference between intervention and control conditions should include a realistic estimate of participant attrition, particularly if the study population, such as offenders with personality disorders, have characteristics which make them difficult to engage, for example distrust in authority figures, paranoia, non-acknowledgment of their mental health difficulties and need for treatment, lack of motivation for change, dismissive attachment styles, or substance misuse. Reference to previous studies of drop out from trials and treatment programmes of similar individuals should be used to estimate attrition rates, which may be as high as 50%.

Attrition may occur at all stages of the trial – recruitment, intervention(s) or control phase and follow-up - and measures should be put in place throughout its duration to

boost engagement and minimise drop-out. This should include informing potential participants about the trial, its implications, potential benefits to themselves and others, what will be expected of them at each stage, how it might impact on them and what their experiences might entail. Information should be delivered in a manner consistent with their level of understanding, and space and time for discussion should be allowed. Those who are randomly allocated to the intervention under evaluation should be given information about the treatment model, which should include expectations regarding attendance and boundaries and the consequences if these are not upheld. For participants allocated to the non-intervention arm, disappointment, anger, or distress may occur, which may result in disengagement from the trial or deterioration in their mental state and/or behaviour. For all participants attendance at appointments may be boosted by supporting them with travel expenses, if possible, as well as proactively contacting them to remind them in advance of appointments or explore with them what difficulties led to missing appointments.

The research team should also liaise closely with the other professionals involved in the trial participant's management, such as their probation officers or the clinicians delivering treatment, to ensure that they support and encourage the person's participation in the trial, and that research-related appointments do not clash with treatment sessions, meetings with their offender managers, or other appointments.

The involvement of peer researchers and experts by experience may significantly enhance recruitment and retention of participants by increasing trust, sharing experiences, providing role models, and instilling hope. Moreover, participants may be more open and likely to tell the truth about their current offending or antisocial behaviour to someone whom they trust, which is particularly important for self-reported outcome measures of violence where the trial participant may fear that such disclosures, even with assurances of the confidentiality of the research interviews, will lead to sanctions.

11.4.3 Systemic issues

Although the research team is unlikely to be able to influence politicians and policy makers regarding major organisational changes in the criminal justice system such as TR, it is crucial that the team have an in-depth understanding of these issues and how

these may impact on all aspects of the implementation and delivery of the trial, including the psychological and emotional stresses on staff. Communication between the research team and local staff, including senior managers, in the setting where the trial is taking place is essential such that they can be kept informed of any structural changes which may evolve during the course of the trial and adaptations to its delivery may be implemented where possible without deviating too much from the study's protocol.

Cultural differences between the different institutions involved in the trial - academic, health and criminal justice - which manifest in differing attitudes and behaviours of their staff, should be acknowledged, explored, and worked with where possible to avoid conflicts which may impede the progress of trial. The primary aims of a criminal justice service of law enforcement, punishing those convicted of crimes and protecting the public from harm, may seem in opposition to the purpose of a health system aimed at improving health for all regardless of their wrongdoings. Criminal justice systems are frequently described and experienced as harsh and punitive, which may reflect the mindsets of individual personnel, but may also be a result of a more hierarchical system where staff have less autonomy and are expected to conform to rules set by more senior management and ultimately politicians influenced by societal attitudes.

For trials evaluating therapeutic interventions these tensions may become manifest in differing views as to whether the primary aim should be reducing the risk of the participant, which in the MBT trial was measured as a reduction in violent behaviour, or whether the primary aim should be improving their mental and/or physical health. However, these aims may not be mutually exclusive – not only that improving health may also support the rehabilitation of the offender, but fair and proportionate punishment may also be in his or her best psychological interest in establishing appropriate boundaries for their behaviour, boundaries which had been absent in their early psychosocial development. Discussions between the different professionals involved in the trial which can explore these issues and identify potential misunderstandings and conflicts may be very helpful in improving communication and relationships between them so that impediments to the trial's implementation may be lessened.

11.4.4 Emotional impact

The emotional risks of doing research trials in criminology, especially with high-risk offenders, should be thought of as important as the physical risks, and acknowledged at the planning stage of trials. Consideration of these risks, as well as measures to be put in place to mitigate them, should be included in applications for ethical approval boards, which may not only offer useful feedback but may also help to raise awareness of the issue within the research community which may be more focussed on potential risks to the trial's participants than to the researchers.

As much as possible, the researchers, and others involved in the trial such as the clinicians delivering the intervention, should be able to access sources of support to process the psychological and emotional effects of the work. At the very least there should be regular supervision, whether in individuals or in groups, with more experienced practitioners who are familiar with working in such settings. Ideally the trial staff should be provided with reflective practice where the focus is on emotionality in the work, and that this is included in the trial protocol. The many different professional groups and personnel involved in the trial implementation – the clinicians delivering the intervention, experts by experience, research assistants, peer researchers, commissioners, steering group, and trial investigators - may benefit from separate supervision and reflective practice according to their roles, pre-existing knowledge, and needs, and at the very least should be aware of the potential emotional impact of participation in the trial at its outset.

Other sources of support may be in the form of peer groups, mentoring, debriefing, or counselling for individuals who feel that the emotional strain is adversely impacting on their lives. Although self-care strategies such as physical activity, reading and writing may also be useful, staff should not be expected to cope with these issues by themselves without professional support from others. More junior, less experienced, researchers may be especially at risk of experiencing distress or emotional burnout, particularly if they have not previously had clinical contact with individuals with disturbing psychopathology.

11.5 Future research

Despite its limitations, the RCT remains the gold standard methodology for studying causal relationships between an intervention and its outcome, and as such is essential in demonstrating that the interventions used within the criminal justice system, many of which have not been subject to empirical evaluation, are effective. It is also essential that obstacles to carrying out these trials be identified and interventions to prevent or ameliorate these are developed.

The literature to date on the implementation of RCTs in criminal justice settings is for the most part limited to descriptive studies of the researchers' individual experiences and observations of the trials they have been directly involved in, rather than empirical studies aimed specifically at investigating these difficulties. To address this gap, future RCTs could include in their methodology qualitative studies to identify obstacles to implementation, not only via interviews with staff as in this thesis, but also via observational methods used in ethnographic research, where the researcher observes others' behaviours but also records their own subjective feelings and thoughts evoked by the trial participants and other aspects of the research.

There is also a lack of empirical studies on the effectiveness of reflective practice in forensic settings in general, and none to my knowledge that have included researchers in criminal justice settings. Future studies in this area could be both qualitative and quantitative; for example, conducting qualitative interviews to ascertain participants' experiences of reflective practice in facilitating their involvement in their research; or using more objective measures, such as the Maslach Burnout Inventory (Maslach & Jackson, 1981) to measure levels of stress and whether these might be reduced following participation in reflective practice, using a pre/post design study.

More ambitiously, the effectiveness of an intervention such as the provision of reflective practice to staff in facilitating the implementation of a trial in the criminal justice system, could be tested using a randomised experimental design. For example, in a large multi-site trial such as the MBT RCT, sites could be used as the unit of randomisation, reflective practice (or other strategies aimed at reducing stress in staff) as the intervention, and outcome measures such as rates of attrition of trial

participants, so that differences between the ease of implementation of the RCT between sites could be evaluated.

More generally, this thesis has exposed the lack of collaboration within criminal justice studies between researchers in the psychological field, and those within academic criminology, who for the most part are working within a sociological model. Research involving emotionality in criminology researchers, as well as in prisoners, and in the system as a whole could be enhanced by the linking of these different disciplines.

11.6 Personal reflections

The evolution of this thesis has inevitably been influenced by my own progressive involvement in the MBT RCT at several levels: the development of the MBT services in probation sites across England and Wales, meeting regularly with the commissioners, training and supervising the clinicians delivering MBT, being part of the MBT team as a therapist in one of the sites, being part of the research team as a principle investigator, working closely with the trial coordinators, and being a member of the Trial Steering Committee. Working closely with and interviewing the professionals for this thesis also gave me the opportunity to get to know some of them at a more personal level, which deepened my immersion in the research enterprise. This involvement inevitably included an emotional element, which became more evident to me as the trial advanced, and undoubtedly influenced, consciously and unconsciously, the trajectory of the thesis which unexpectedly found its way towards emotionality as its nodal finding. My own emotions encompassed a wide range, both positive and negative: pride in being instrumental in initiating the interest in the commissioners in the possibility of conducting an RCT within the OPD pathway; excitement in evaluating a psychological therapy that I believed was effective in helping a neglected population of offenders; frustration on encountering the challenges to the trial's implementation; anxiety that such challenges might interfere with its results in determining whether MBT was an effective intervention; anger at the negative attitudes in some probation officers towards the rehabilitation of offenders; empathy for the staff's day to day experiences of working within a harsh and punitive system; and alternating hope and despair that the culture of this system could ever change.

These emotions were experienced in a relational context – in my interactions with, and attachments to, the different individuals, teams and organisations involved in and affected by the trial. This reflects the ethos of the OPD pathway – that it fosters relational and attachment bonds, and continuity of care for offenders who did not have these experiences with their primary caregivers and who have been left with unmanageable emotional states that can only find relief in violent action.

My mentalizing capacity and skills also increased during the development of the RCT and in the process of completing this thesis – not only through the experience of being trained and training others in adapting MBT to working with individuals with ASPD and in delivering MBT to the offenders randomised to the treatment arm, but also through learning about the experiences of others in different parts of England and Wales with their own differing cultures and contexts of working within the criminal justice system, as well as listening to the lives of the experts by experience and their identities as former and reformed offenders. This expansion in my mentalizing abilities, as well as the acquisition of new research skills (e.g., carrying out the systematic literature review, learning about qualitative research methods) contributed to a shift in my mindset from the concrete to the conceptual; from teleological modes of action to mentalizing social systems; and from identifying the more practical and concrete obstacles in the implementation of the trial to the discovery of new theories and paradigms external to my own discipline.

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