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The trauma, bereavement and loss experiences of women in prison

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Introduction

Offending and sentencing trends

The female prison population has risen over the past few decades (Commission on Women Offenders, 2012; McIvor & Burman, 2011:1376). During 2017/2018 the average number of women in prison stood at 370, with around one-quarter untried or awaiting sentence (Scottish Prison Service, 2018b). These figures are up 79% since 2000/01, when the daily average was 207, and remands have almost doubled in the same period. Although the daily population appears to be declining slightly from a peak of 469 in 2011/12, the very latest statistics reveal that on November 16, 2018, the total number of women in prison was 394.

These numbers do not reflect an increase in offending by women (McIvor & Burman, 2011). Males account for 83% of those people convicted in court and receive 92% of all custodial sentences handed out (Scottish Government, 2018). However, these figures *do* mask the fact that much offending by females is low-level and does not pose a risk to public safety, being predominantly characterised by crimes of dishonesty (Commission on Women Offenders, 2012). McIvor and Burman (2011) report that in 2004/05 the most common offences that women were convicted of were failure to pay a TV licence, shoplifting and breach of the peace, followed by minor assault (including resisting arrest). As a result women who enter custody tend to do so on remand or a short sentence (Commission on Women Offenders, 2012; Earle, 2018; McIvor & Burman, 2011). In Scotland, 80% of females who were handed a custodial sentence in 2016/17 were imprisoned for six months or less, compared to 61% of men (Scottish Government, 2018).

In trying to make sense of the trends in women's imprisonment in this context, women's involvement in offending can be perceived as a double wrong, violating not only the law but also gender norms and expectations in society (Earle, 2018; Heidensohn, 2013). Thus sentencing trends, rather than crime trends may be a factor behind women's imprisonment (Earle, 2018; McIvor & Burman, 2011). The emphasis on remands and short sentences is also problematic, combining all of the disadvantages of longer-term imprisonment (shame; stigma; disruption to employment, housing and education; discrimination), but with none of the (albeit limited) benefits of a longer sentence, such as stability, the ability to engage with therapeutic supports within the prison or eligibility for support upon release in to the community.

The loss, bereavement and trauma experiences of women in prison

The pains of imprisonment are often understood in terms of loss. In his seminal work *The Society of Captives,* Sykes (1958) described the five key pains associated with imprisonment specifically as *deprivations*: of liberty, of goods and services; of heterosexual relationships; of autonomy and of security. These deprivations remain relevant today, and include social, environmental and personal losses such as privacy, material possessions, outside connections, health, social roles and identity, etc. (Aday & Krabill, 2016). While these pains apply to both males and females, there has been a long-standing perception that prison is

not only different for women, but is a more distressing experience for them (Crewe, Hulley, & Wright, 2017; Rowe, 2011)

A perspective of women as predominantly relational beings suggests that the loss of outside roles and relationships (partner, carer, mother) is especially hard to bear (Rowe, 2011). With many women in prison the main caregiver for dependant children (Commission on Women Offenders, 2012), the pain of separation from children is often seen as the most difficult adjustment (Crewe et al., 2017; Ferszt, 2002). Females in prison are more likely to have dependent children than males (Commission on Women Offenders, 2012; Crewe et al., 2017). With women often fulfilling the caregiver role in the community, many women find that there is an absence of a reliable adult to ensure that children (and other family members) are encouraged to keep in touch and are brought to visits. This leaves many women in a very painful 'psychological limbo' (Crewe et al., 2017:1370). Young women serving long sentences also face the loss of their fertility, and their ability to create or extend their families should they wish to do so (Crewe et al., 2017).

There are also specific challenges when it comes to dealing with loss, bereavement and grief in prison. Particularly problematic is the distance (physical and metaphorical) from the outside world, which can heighten the shock of a death, even when it has been anticipated (Ferszt, 2002). This distance also means that people in prison have to undertake the process of grieving in prison without family and social supports (Harner, Hentz, & Evangelista, 2011), without access to traditional bereavement rites and rituals (Ferszt, 2002; Harner et al., 2011; Vaswani, 2014) and without the ability to turn to usual nurturing or creative coping strategies such as art, music, distraction (Ferszt, Hayes, DeFedele, & Horn, 2004; Vaswani, 2014) or even simple gestures such as receiving flowers (Ferszt et al., 2004). Even when people are permitted to partake in death and bereavement rituals, the security restrictions (handcuffs etc) mean that full participation is restricted and the involvement is often experienced as humiliating, degrading and disrespectful (Aday & Krabill, 2016; Ferszt, 2002; Vaswani, 2014). These exclusions and complications meant that grief is typically described as 'delayed (Aday & Krabill, 2016), 'frozen' (Harner et al., 2011), or 'suspended' (Ferszt, 2002) while in prison, and this means that grief becomes disenfranchised (Doka, 1999). For some people in prison there is the added predicament of grieving when one has been responsible for another person's death (typically in a road traffic offence, but also through violent crimes), with shame, stigma, guilt and hostility towards the individual all complicating this process, compounded by the additional loss of imprisonment (Fraser, 1988).

To add to the complexity of female imprisonment, women in prison tend to be some of the most vulnerable members of society. Abuse, neglect, mental illness, poverty, childhood trauma, adult victimisation and substance misuse (Crewe et al., 2017; Ferszt, 2002; Green et al., 2016; Maschi, Viola, & Koskinen, 2015) are common features in their lives, and these women are frequently more vulnerable and victimised than their male counterparts in prison (Messina, Grella, Burdon, & Prendergast, 2007; Scottish Prison Service, 2018a) and their female peers in the community. The negative life experiences of women in prison are often presumed to make the pains of imprisonment more difficult (van Ginneken, 2016), although Crewe et al. (2017:1362) caution that exactly "…how these traumas…interact with the problems and deprivations of prison life remains unclear."

However, it is clear that entering prison can be traumagenic in itself (Liebling & Ludlow, 2016), and is frequently retraumatising (Burrell, 2013; Heney & Kristiansen, 1998). Experiences of abuse, neglect, victimisation and discrimination often leave women in the community feeling powerless and wary of trusting others and these dynamics are replicated in the prison environment (Crewe et al., 2017; Heney & Kristiansen, 1998). Maschi et al. (2015) report that more than half of the women in their US study of older adults in prison had experienced stress or trauma directly associated with their imprisonment, including social trauma, such as separation from children (45%) and interpersonal trauma such as bullying and harassment (31%). Women have been observed to express shame and guilt for their crimes more intensely than males (Crewe et al., 2017; Rowe, 2011), with more presenting symptoms such as nightmares and flashbacks (Crewe et al., 2017) and to experience more stigma for not conforming to traditional stereotypes (Earle, 2018; Heney & Kristiansen, 1998) contributing to a reduced sense of well-being and self-esteem (Rowe, 2011).

Research has also suggested that it is not just women's adverse life experiences that makes adjustment to prison life so difficult but also their achievements and successes in life. As mentioned, females are more likely to have dependent children and to be the primary carer within their families. This role is associated with significant responsibilities and, typically, an independent living environment. Thus the loss of autonomy and the need to conform to other people's rules and boundaries can be a particularly difficult adjustment to make (Aday & Krabill, 2016; Crewe et al., 2017; Rowe, 2011).

The perceptions of women as relational and more emotionally articulate means that women are often assumed to have increased interpersonal and social skills compared to males. Certainly women tend to more quickly make kinship systems and relationships with others in prison (Ferszt, 2002), are more likely to receive emotional support in prison (Crewe et al., 2017), and social coping (attending groups etc.) and social skills have been found to facilitate adjustment and help with depressive symptoms (Maschi et al., 2015). Yet this perception of women may be outdated and contested or may not apply within the prison boundaries. While there is evidence that males find prison life more emotionally repressive, and evidence of more emotionality in women's accounts of serving a life sentence in prison, this is not necessarily experienced or utilised in a positive way: "…the women described an environment whose emotional intensity was suffocating" (Crewe et al., 2017:1374). Laws (2018) found that, although emotional suppression was more obvious in male prisons and clearly linked to traditional notions of masculinity and strength, the females in his study (all of whom were serving very long sentences) reported similar accounts of repressing emotions for mainly pragmatic reasons such as the fear of triggering reports, sanctions or actions. Both males and females reported feeling overwhelmed by these bottled up emotions, although it is not clear whether this would also apply to females serving shorter sentences, who may have less of a need to successfully adapt and assimilate into prison life in the long term.

Crewe et al. (2017) conclude that these gendered experiences, including early life experiences and the intensified deprivations of imprisonment, such as the loss of key relationships or the loss of previously held autonomy "…render their time in prison more acutely painful and problematic than their more numerous male counterparts"

The research study

It is against such a backdrop that this study takes place. HMP & YOI Polmont had recognised the extent of bereavement, and the wider impact of trauma and loss on its population of young men (Vaswani, 2014) and had taken proactive steps to enhance the support provided to them through not only specialist service provision, but through the knowledge, attitudes and culture of the entire establishment. This three-pronged approach aimed to: increase staff awareness of the prevalence and impact of trauma, bereavement and loss through awareness-raising training; better meet the needs of young people through the piloting of a specialist trauma, bereavement and loss service, Here and Now, delivered by Barnardo's Scotland; and create organisational and culture change in part through a sequenced and more joined-up approach to service provision that would help create a more 'trauma-informed' establishment.

These developments for young males within HMP & YOI Polmont were externally evaluated and deemed to have been positive overall (Vaswani et al., 2016). More than 200 members of staff attended the awareness-raising training and demonstrated a significant increase in knowledge, skills and confidence over the course of the two-day training. The specialist service worked with 50 young men during the course of the evaluation and there was a significant decrease in their trauma symptomology by the end of the intervention. Furthermore, although certain values, attitudes and practices were hard to shift, there was evidence of a small step towards organisational culture change. The report concluded that:

> "the strategic vision appeared to be slowly beginning to change the nature of the organisation. No-one seemed to underestimate the distance that still needed to be travelled, or naively thought that everyone was on board with the direction of that travel, but the fact that a journey had been embarked upon was undisputed" (Vaswani, Paul, & Papadodimitraki, 2016:37)

Elsewhere in the prison estate the Commission on Women Offenders concluded that the criminal justice and the prison system was not meeting the needs of women, many who were of lower risk to public safety, had dependent children and complex presentations (Commission on Women Offenders, 2012). The findings of this commission led to the subsequent relocation of many of the women from Scotland's only dedicated female prison, Cornton Vale, to HMP & YOI Polmont (previously a male-only institution for under 21s). In order to ensure equity of provision, Barnardo's received a small amount of funding from the Scottish Government to extend the service to the females in the establishment. This funded one WTE member of staff to deliver the Here and Now service to the female population.

Cognisant that the service needed to be both gender and age-responsive, several adaptations were made to the original service before implementation, informed by several informal service-planning focus groups with women and staff about service preferences and needs. The service was extended to include all females (young and adult women) in the establishment, given the low numbers of young women in custody. The 12-week psychoeducational programme (the main mode of service delivery for the young men) was deprioritised in favour of a focus on a more open-ended psychotherapeutic intervention (of up to 30 weeks where required). Therapeutic goals were agreed with each individual based on the information gathered at an initial assessment meeting about the frequency and impact of symptoms and the woman's wishes and priorities. Progress towards these goals was

reviewed every five weeks, and goals adjusted or added as required. In addition, a short-term 'Here and Now Link' service was designed to support women who were due to be released imminently. The focus of this service was on immediate stress reduction strategies, and linking women into the available supports in their communities. Plans for a Here and Now women's group were not realised during the course of this study.

As a result of these changes, Barnardo's Scotland commissioned CYCJ to undertake a further small-scale evaluation of the extension of the service to females. The aims of the research were to:

- Generate new knowledge and understanding about the trauma, bereavement and loss related needs of women in custody
- Evaluate the experience and effectiveness of trauma, bereavement and loss interventions for women in custody
- Identify any gender-specific needs or responsivity factors for academics and practitioners to consider when working with women in custody in relation to trauma, bereavement and loss.

Methodology

Ethics

The research was given approval by three ethics boards: The University of Strathclyde Ethics Committee; the Barnardo's Research Ethics Committee and the Scottish Prison Service Research Access and Ethics Committee. Participation was voluntary, not linked in any way to decisions or progression through the criminal justice system, and no incentives were offered for participating.

Participants

There were 77 women who were referred to the Here and Now service and who consented to their anonymised data being shared for research purposes. Information gathered from their initial assessment forms and about the length of service provided was shared with the researcher. The mean age of the women at the date of referral was 31.5 years (*SD*=8.3) with the youngest aged 18 and the oldest 63 years old. Women could then opt in or out of a further interview with the researcher after the end of the service. This sample was limited due to the number of women reaching the end of service provision by the study's completion, and doing so in a planned manner without being liberated or transferred unexpectedly. While attempts were made to contact women in the community this was not achieved.. Therefore only four interviews were completed with female service users.

Three focus groups were held with staff who worked directly with the women, drawn from SPS, health and third sector agencies but not involving the Barnardo's Here and Now staff. The first focus group was made up of five residential officers; the second was comprised of eight staff who provide a service to women within the prison but were mainly employed by agencies other than SPS (although the exception was SPS Forensic Psychology); and the third focus group was made up of three SPS operational staff. Six semi-structured face-to-face interviews were also undertaken with key stakeholders, mainly senior managers and

individuals involved in directly implementing, delivering or overseeing the Here and Now Service.

Measures

In order to reduce the burden on the service, the measures used were simply those selected by Here and Now for use in practice, including the referral form, the Adverse Childhood Experiences Questionnaire, an adapted Trauma Symptoms Checklist for Children (TSCC) and The Resilience Research Centre – Adult Resilience Measure (RRC-ARM). The TSCC and RRC-ARM were repeated at the end of service provision to measure change. All data was anonymised and entered on to a research database.

Adverse Childhood Experiences Questionnaire

Adverse Childhood Experiences are adverse events (abuse, neglect and household dysfunction) that occur before the age of 18, and that have been linked to a range of health-harming behaviours and poor health outcomes in later life, such as heart disease, stroke and diabetes (Felitti et al., 1998). Although the original study only considered seven adverse experiences, in later years a 10-item questionnaire (Appendix 1) has commonly been administered to assess the presence of key childhood experiences. The items are: sexual abuse; physical abuse; emotional abuse; physical neglect; emotional neglect; parental separation; mother treated violently; substance abuse in the household; mental illness in the household and imprisonment of a family member. An affirmative response to each item is given a score of 1, and the responses simply summed up to give a total 'score' out of 10. It should be noted that the resultant 'score', although strongly linked to poor health outcomes, is only a proxy measure of adversity and it does not consider the context of these childhood experiences (for example frequency or duration of the experiences; the impact of the experiences on the child, and other experiences not captured by the questionnaire, including, importantly for this study, bereavement).

The Trauma Symptoms Checklist for Children

The Trauma Symptoms Checklist for Children (Briere, 1996) is a 54-item self-report questionnaire for children aged eight to16. The Trauma Symptoms Checklist for Children (TSCC) is designed to assess the level of post-traumatic stress and post-traumatic distress and related psychological symptomatology in male and female children aged eight to 16 years. For the purposes of accessibility, relevance and ease of administration in the Here and Now Females service, this TSCC was adapted by shortening the questionnaire to 35-items, and adding an additional score to the Likert scale so that it ranged from 0 'never' to four 'always' (the original range was from 0 'never' to 3 'almost all of the time'). The subscales were also revised to incorporate these additional items. Furthermore the TSCC is not validated or normed for adult women. These adaptations mean that the results are not comparable with other studies that report the results from the TSCC and also that the clinical cut-offs are also no longer useable.

A further adaptation was made to the TSCC, in that participants were asked not only to rate the frequency of their symptoms, but also to indicate the *impact* that this had on their day-to-day functioning, from 1 (no impact) to 5 (significant impact). This amendment was made to assist the Here and Now service to firstly prioritise women for intervention, and also to guide

the focus of the treatment. Both the frequency 'score' and the combined frequency and impact 'score' are reported in this study.

The Resilience Research Centre – Adult Resilience Measure

The Resilience Research Centre-Adult Resilience measure (RRC-ARM) has been adapted from the Child and Youth Resilience Measure (CYRM) for use with adults aged 23 and over (Ungar & Liebenberg, 2013). The 28-item self-report questionnaire looks at resilience across three major subscales: individual, relational and contextual and is scored by a five-point Likert scale, ranging from 1 (not at all) to 5 (all the time). The RRC-ARM permits the addition of up to 10 site-specific questions, and the Here and Now Service added nine questions, mainly relating to resilience within the prison context. In addition some minor changes to wording were made, to make the tool culturally relevant and accessible to the women completing it. The minimum score was therefore 37, and the maximum score (indicating higher resilience) was 185.

The major subscales are broken down into eight minor subscales, with individual resilience incorporating: personal skills, peer support and social skills. Relational resilience including physical caregiving and psychological caregiving from the primary caregiver; and contextual resilience involving spiritual, educational and cultural items.

Analysis

Quantitative data was analysed using SPSS Statistics 25 (IBM Corp, 2017). Descriptive statistics were used to present the profile of need according to the referral data and

pre-service measures. The Likert scales used in the two measures were treated as ordinal data rather than interval level data and so non-parametric versions of statistical tests were used. Correlations between the three measures were analysed using Spearman's Rho (which measures the strength of association between two variables), and the change over time between pre-and-post data was measured using Wilcoxon Signed Ranks (which measures change across two repeated measures).

Qualitative data was transcribed verbatim and analysed thematically using NVivo (QSR International Pty Ltd, 2012).

Findings

The findings from the consultation with women, HMP & YOI Polmont frontline staff and key stakeholders have been amalgamated with the quantitative data analysis, to triangulate the data gathered. This allows for both the validation of findings, as well as highlighting points of uncertainty or debate where the divergence of data reveals potentially different perspectives.

Profile of Need

The needs of the women were identified from referral forms, information gathered from the measures conducted at the initial assessment and from the feedback provided by the women and the staff who participated in the focus groups.

Reason for referral

Drawing from the referral forms provides an incomplete picture of need, as the forms contain only information that was known by the referring party at the point of referral. A number of the women who self-referred chose not to disclose their experiences and needs at this point, and those referrals from third parties may have been incomplete. However the referrals form provides a good indicator of the information available to Here and Now at the point of referral.

Out of the 77 referrals, the referral reason was documented for 69 women, although 15 women chose not to disclose the reason behind the referral. This meant that information was available for 54 women. Almost all of the women were referred as a result of a current or past bereavement, but this was usually just the most obvious trigger for referral, and for many of the women there were multifarious experiences of abuse, trauma, loss and separation throughout their childhoods and extending into adulthood, with continuing exposure to traumatic experiences and victimisation. Thirty-one women had experienced the bereavement of a close family member such as a parent or a sibling (57%). Eight women had experienced the death of a spouse or long-term partner (15%). Four women had suffered the death of a child (7%). Twenty-four women had been the victim of abuse or assault. Referral forms often acknowledged the loss of contact with a child or children as a significant loss in the women's' lives (mentioned in eight referral forms, 15%), over and above the fact that all women who were mothers were separated from their children by virtue of being imprisoned.

In addition, there were often potentially complicating factors noted in the referral forms, such as eight women who were experiencing offence-related trauma (such as being implicated in the death of a person); witnessing a death, or finding a body (five women); and the prevalence of traumatic deaths such as murder (six women) or suicide (five women) in the sample.

Adverse Childhood Experiences

This measure was only concerned with the ten Adverse Childhood Experiences that are most commonly measured in ACEs research studies. It does not consider the prevalence of other experiences that the women may have experienced in childhood, nor the frequency, severity or impact of such experiences.

Exposure to Adverse Childhood Experiences was high, with the mean exposure to adverse events 6.07 (*SD*=2.7) as outlined in Table 1. Almost all women had been exposed to four or more of the measured experiences (*n*=24, 85.7%). Around two-thirds (*n*=18, 64.3%) had been exposed to six or more ACEs, and two-in-five (*n*=11, 39.3%) eight or more ACEs (Figure 1).

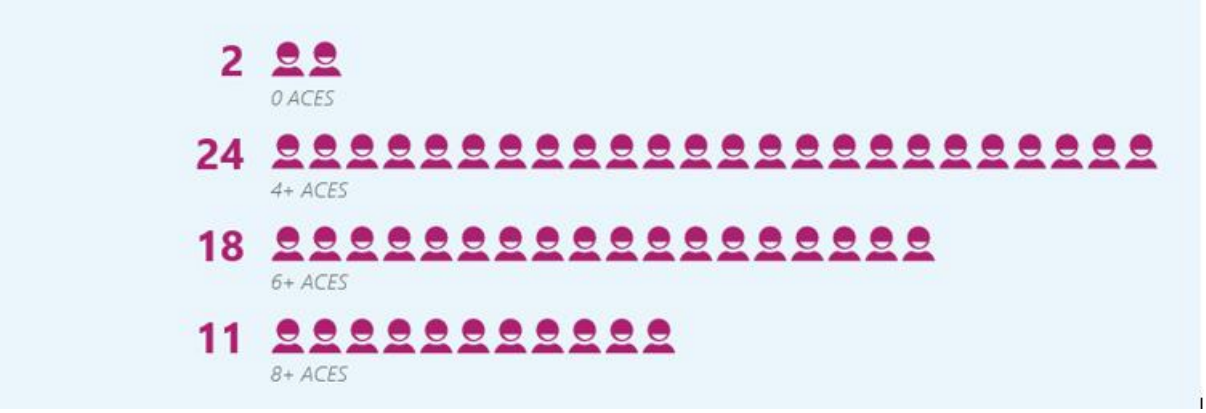

Figure 1: Total Exposure to Adverse Childhood Experiences (*n*=28)

The women in the study had greater exposure to all Adverse Childhood Experiences (with the exception of physical neglect) than their male counterparts, and also in comparison to the wider population of women across the SPS estate. This is likely to reflect greater exposure to traumatic events among women seeking help from the Here and Now service, but may also reflect an increased propensity to disclose in an environment in which help may be received, rather than in an impersonal survey. However, from the application of the ACEs framework it is clear that loss and separation is a widespread feature in the lives of women in prison.

The most frequently occurring Adverse Childhood Experience was that of parental separation or divorce (*n*=24, 85.7%), as outlined in Table 1. Furthermore, emotional neglect and household dysfunction (including substance misuse, incarceration and mental illness) were common. Depending on the circumstances, these events may be experienced as an ambiguous loss (Boss, 2006), which typically denotes a complex and confusing situation where the family member is *physically* present but *psychologically* absent or vice versa.

Trauma Symptoms

Trauma symptoms were assessed by an adapted Trauma Symptoms Checklist (Briere, 1996) which looked not only at the presence and frequency of symptoms, but also the impact that these symptoms had on the women's day-to-day functioning.

The most frequently occurring symptoms were related to anxiety, intrusive thoughts dissociation and sadness: 'worrying about things'; 'remembering things you don't want to'; 'go away in your mind, try not to think' and 'feel sad or unhappy' (Table 2). These items had the highest mean score in terms of frequency, with participants indicating that they experienced these symptoms somewhere between 'a lot' (a score of 2) and 'almost all of the time' (a score of 3). However, these were not necessarily the items that had the biggest impact on the women's day-to-day functioning. Impact was also assessed on a 0 (no impact) to 4 (intense negative impact) scale, and the highest scoring impact items were: 'worrying

about things'; 'remembering things you don't want to', mirroring the frequency of these symptoms (Table 2). Yet the next items assessed as having the biggest impact on day-to-day functioning were: 'can't stop thinking about something bad that happened to you' and 'remember scary things', indicating that intrusive thoughts were having the biggest impact on women, and perhaps leading to the frequency of symptoms relating to dissociation and sadness. As each subscale of the adapted Briere contains a different number of items (ranging from three to 12) the mean score for each subscale is presented in Table 2 as a percentage of the maximum possible total for that subscale (i.e. experiencing symptoms all of the time, with significant negative impact on all items in that scale). Certainly when the mean scores for each scale are expressed in this way, then intrusive thoughts are the most debilitating group of symptoms.

The analysis of subscales indicates that women may have developed a level of coping skills to manage their experiences, as this subscale has the lowest combined impact and frequency score. Items in this subscale relate to dissociation, angry outbursts, or feeling the need to harm themselves or others. However, there may also be an element of reluctance to disclose the presence of these symptoms for fear of repercussions or interventions. The lowest scoring item across the whole measure was 'want to hurt myself', with almost two-thirds of females responding 'never' yet the consultation with professionals acknowledged a high level of self-harm among the female population in custody.

Resilience

Data from the Resilience Research Centre Adult Resilience Measure (RRC-ARM) (Liebenberg & Moore, 2018) suggests that the women had a reduced pool of resilience from which to draw in order to cope with everyday life. The RRC-ARM allows the addition of up to 10 site-specific questions, and in this study nine questions were added (mainly about resilience within the context of prison), bringing the total number of questions to 37, with a maximum possible score of 185. The mean 'score' on this adapted RRC-ARM was 120.2 (*SD*=30.53). The mean score on the standard 28-item questionnaire (excluding site-specific questions) was 90.12 (SD=24.5) and, while adult (or Scottish/UK) norms are not yet available for the measure, the comparable mean score on the 28-item youth version (from which the RRC-ARM was developed) was 114.1 for all 2,199 female young people in the study and 110.4 for females with complex needs (Resilience Research Centre, 2016).

Table 1: Prevalence of Adverse Childhood Experiences (*n*=28)

	Individual ACEs										Overall ACE Exposure	
	Abuse			**Neglect**		**Household Dysfunction**						
	Sexual	Physical	Emotional	Physical	Emotional	Domestic Violence	Parental Separation	Incarcer-ation	Mental Illness	Substance Abuse	M	*SD*
Prevalence %	42.9	64.3	67.9	21.4	67.9	64.3	85.7	53.6	41.6	75.0	6.1	*2.7*
Other Populations[a]												
SPS adult males	21.0[b]	44.0	55.0	28.0	-	44.0	48.0	23.0	32.0	36.0[c]	-	-
SPS female population	44.0[b]	53.0	64.0	33.0	-	56.0	58.0	35.0	42.0	47.0 [c]		

[a] From the SPS Prisoner Survey (2017)

b The SPS Prisoner Survey distinguished between experiences of sexual touching and intercourse by an adult at least five years older. This is the % of participants responding affirmatively to the question about touching, rather than intercourse. This figure is therefore an underestimate of the extent of sexual abuse and sexual assault among people in prison

c The SPS Prisoner Survey distinguished between problematic alcohol use and problematic drug use within the household. This is the % of participants responding affirmatively to the question about alcohol, rather than drugs. This figure is therefore an underestimate of the extent of problematic substance use within the household.

Table 2: Frequency and Impact of Trauma Symptoms from the adapted Trauma Symptoms Checklist (*n*=31)

	Top 4 most frequent symptoms				**Top 4 symptoms with biggest impact**			
	Worry about things	Remember things you don't want to	Go away in your mind	Feel sad or unhappy	Worry about things	Remember things you don't want to	Can't stop thinking about something bad	Remember scary things
Mean score (0-4)	2.52	2.42	2.16	2.03	2.74	2.61	2.48	2.45

	Overall combined frequency and impact score (subscales)				
	Intrusive thoughts	Emotions	Prescriptive effects	Behaviours	Coping Skills
% of the maximum score	48.5%	42.1%	38.2%	35.4%	32.7%

Further analysis of the major and minor subscales (Table 3) suggests that women possessed higher levels of internal resilience (their own skills, characteristics and motivations), and their resilience may have been reduced by a lack of familial, peer, community or spiritual supports available to them, suggesting a group of women that are excluded or disengaged from society. On the three major subscales, individual resources were highest, despite low levels of peer support which is included within this subscale. Relational resources were lower than internal resources, but bolstered by high scores on the physical caregiving minor subscale i.e. the ability to provide food for oneself. Contextual resilience was lowest, especially on the minor subscale of 'Spirituality', perhaps reflecting cultural and religious differences between Scotland and North America (where the RRC-ARM was developed and normed). On the minor subscales, resilience was also lower on peer support (supported and accepted by friends); and psychological caregiving (feeling close, secure and supported by family), and highest on social skills (knowing how to behave, where to get help, manage behaviours etc), personal skills (cooperation, problem-solving, express emotions etc) and education.

Relationships between the different measures

The total 'score' on each of the measures was significantly correlated with each of the other measures, as indicated by the results from the Spearman's Rho analysis (Table 4). The relationship tended to be strongest with the measures that had been through the least adaptations (for example the total frequency score on the Trauma Symptoms Checklist, rather than the combined frequency and impact score which had been added by the Here and Now service). This suggests that the measures are appropriate and measuring the intended constructs accurately, but also that adaptations may not be necessary and should be used cautiously.

There was a strong positive correlation between the Adverse Childhood Experiences 'score' and the total symptomology on the adapted Trauma Symptoms Checklist, and a moderate and negative correlation with the resilience score on 28-item RRC_ARM (and a strong correlation with the site-specific RRC-ARM). This indicates that increasing exposure to adversity is associated with increased frequency of trauma symptoms and reduced resilience. There was a much smaller, although still significant, relationship between the Adverse Childhood Experiences score and the *impact* of those trauma symptoms, suggesting the association is stronger for the *frequency* of symptoms, rather than how the individual is *affected* by those symptoms. There was also a strong negative correlation between the total symptomology on the Trauma Symptoms checklist and the resilience score on both the 28-item RRC-ARM and the 37-item site-specific RRC-ARM, suggesting that increased frequency of trauma symptoms is associated with reduced resilience.

Table 3: The Resilience Research Centre: Adult Resilience Measure (*n*=24)

	4 highest scoring items (high resilience)				**4 lowest scoring items (low resilience)**			
	I am able to manage routine	If I am hungry I can get food to eat	Getting/improving qualifications or skills is important to me	I know how to get support in prison	I participate in organised religious activities	I talk to my family about my feelings / experiences in prison	I enjoy my community's culture and traditions	I feel supported by my friends
Mean score (1-5)	4.28	4.24	3.92	3.80	2.12	2.60	2.68	2.72
	Resilience subscales							
Major subscale	Individual			Relational		Contextual		
% of the maximum score	67.2%			64.2%		61.7%		
Minor subscale	Social Skills	Personal Skills	Peer Support	Physical Caregiving	Psychological Caregiving	Education	Cultural	Spiritual
% of the maximum score	70.6%	67.6%	58.1%	69.1%	61.7%	67.6%	64.8%	52.5%

Table 4: Spearman's Rho Correlations between Adverse Childhood Experiences, trauma symptomology and resilience[ab]

Measure	ACES score	TSCC (frequency of symptoms)	TSCC (impact of symptoms)	TSCC (combined frequency and impact)	RRC-ARM (28-item)	RRC-ARM (37-item site-specific)
ACEs score	-					
TSCC (frequency of symptoms)	.653***	-				
TSCC (impact of symptoms)	.437*	.724***	-			
TSCC (combined frequency and impact)	0.617**	.942***	.891***	-		
RRC-ARM (28-item)	-.484*	-.708***	-.630**	-.705***	-	
RRC-ARM (37-item site-specific)	-.522**	-.676***	-.617**	-.680***	.986***	-

[a]n varies between 24 and 28 [b] According to Cohen (1988) the strength of the relationship is small if r_s is .1 to .29; moderate .3 to .49 and strong .5 to 1.0.

***p<0.001 (2-tailed); **p<0.01 (2-tailed); *p<0.05 (2-tailed).

Participant perspectives

Participants from all professional backgrounds and the women participants unanimously agreed that the women's trauma, bereavement and loss experiences were significant both in terms of magnitude and in terms of nature. Complicating, but related factors, such as comorbidity with mental health issues and addiction were noted. There was agreement that this was on a scale that differed noticeably from their male counterparts in Polmont, although potentially by virtue of age and stage rather than solely gender.

> "There's a huge diagnosis of personality disorder, and whether we think they exist or they don't exist, certainly there are clusters of extreme difficulty that these women experience, and how they express that difficulty. I think there's something about imbalances of power, that they experience, however... huge amount of medication from the NHS, which, regardless of what I think about diagnoses, indicates that there's massive symptomatology…There are significant levels of self-harm…I would say that there are relational difficulties. Not just in their relationships, but how they manage to relate. Things like eating disorders... and also some psychosis, and maybe this is an ACE related thing as well, but there's certainly descriptions of psychosis, with aural/visual hallucinations" (Key Stakeholder)

There was also agreement that these experiences underpinned much of female offending and were a contributor to their arrival in custody.

> "It is a good thing that it's offered to people in prison, cos grieving, I would say, is like a big factor in a lot of people's kind of, ah, offending, or reoffending, cos if you can't deal with it you abuse alcohol or drugs to kind of numb how they're feeling, so if you get the... the help that you need, then I think people would be less likely to go out and do it" (Woman)

> "I think an incredibly high proportion of them have suffered some, various trauma, whether it be one significant trauma or a kind of series of small traumas that have carried through to even their adulthood, and obviously when they go into the offending lifestyle, they increase the risk of exposing themselves to further trauma, so it's a kind of vicious circle" (Focus Group)

The challenges that this multitude of experiences presented to both the women, and the staff tasked with their care, often proved to be overwhelming, and staff described feeling ill-equipped.

> "Sometimes you lose track of what it is you're trying to deal with them, because they've had that much happen, and their issues are so complex, that it's beyond our capabilities" (Focus Group)

> "But what [training] you did as a residential officer certainly didn't prepare you for some girl randomly screaming at you, and you've no idea why, and it turns out it's because her mum's just died, but it turns out that she was abused when she was younger, and you've happened to say a word that triggers her, you're not taught any way of how to deal with that, you're literally, that's what we mean when you learn on the job, you deal with that situation and you think 'oh my god, what the hell was that'..." (Focus Group)

These observations highlight the importance of the organisation being trauma-informed as well as having trauma-specific services to directly address issues relating to trauma, bereavement and loss:

> "And you know, when you're talking erm, especially about the female population, because you do have the alcohol, you do have the illicit substance issues, you do have the domestic violence, and you do have the mental health issues that are in there as well, and I think for... for any of the agencies working in there at least at informed knowledge of this, we're not looking for trauma focus, we are looking for trauma-informed work for everybody to be aware of that, as well" (Focus Group)

Implementation of Here and Now

Despite a clear level of need and despite considerable experience and familiarity gained through previously establishing and delivering a trauma, bereavement and loss service to the young men in HMP & YOI Polmont, the extension of the service to the women proved far from straightforward. Barnardo's Scotland underwent significant restructuring during the implementation phase and as a result the service experienced several changes in line management which undoubtedly was unsettling and delayed implementation:

> "Barnardo's, organisationally there may have been some barriers at that time to prevent it maybe being implemented as quickly and as efficiently as it could have been" (Key Stakeholder)

However, there were numerous other challenges encountered in implementation and this section of the paper documents these, grouped into eight broad themes: sentencing practice; throughput and demand; waitlists and capacity; staff knowledge and awareness; staff roles, skills and confidence; organisational practice and priorities; organisational culture and the physical environment.

Sentencing practice

Sentencing was seen as contributing to difficulties in providing services, especially those interventions that dealt with sensitive issues and relied upon trust and relationships to be established first, as well as requiring an enduring therapeutic relationship. Women were perceived to be predominantly serving shorter sentences or very long sentences, both of which could affect motivation and practical considerations when intervening:

> "And I have found myself referring less to Here and Now for the females, than I did for the boys. And, I don't know if that's because I'm aware erm, of the wider programmes, for the females, such as the survive and thrive and I think that that really encompasses an awful lot of what [the Here and Now] service can do but in you know, for a 12-week kinda programme. So, I find myself referring less, and I think as well, erm, we've got to look at the sentence structure, as well, for females" (Focus Group)

> "You know, you get some of the girls that are coming in they've maybe been in for short term sentences but they've done thirteen of them you know" (Focus Group)

The biggest single group of women were on remand (23, or 30%), which is frequently

short-term and unpredictable. Figure 2 highlights the sentence length for the 51 women[1] who had been convicted and sentenced.

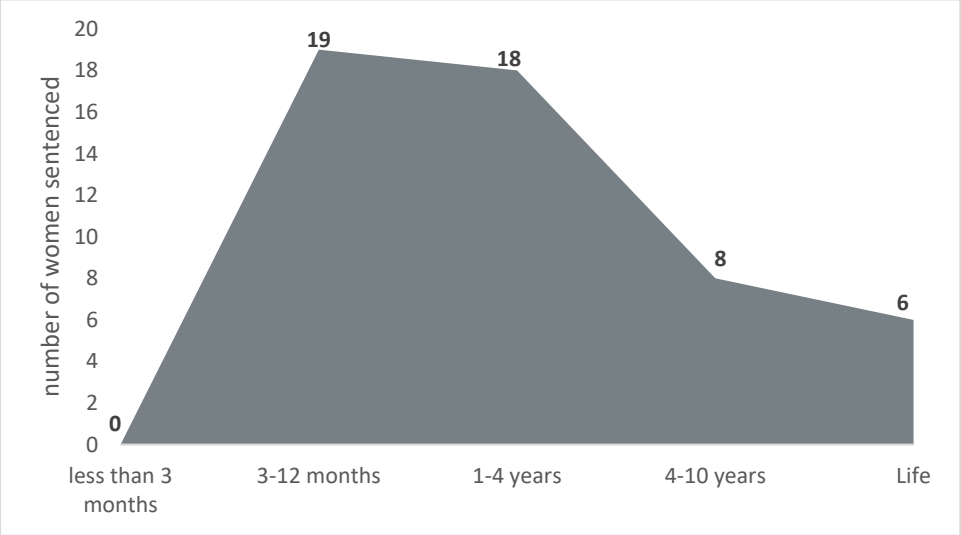

Figure 2: Sentence length of women who had been convicted and referred to Here and Now (*n*=51)

While the referral data shows that the majority of women referred to Here and Now were serving short-term sentences (of less than four years), most were serving sentences that should not necessarily preclude some form of intervention or support while in prison, and none of the women were serving less than three months. In this regard, the sentencing pattern does not appear to reflect wider sentencing of female prisoners in Scotland. The most recent statistics (Scottish Government, 2018) suggest that only 1% of females in prison are serving four or more years (including life); 91% are serving less than 12 months, and 43% less than three months. In the Here and Now sample, 27% of those sentenced were sentenced to four years or more, and only 37% less than one year, which may perhaps reflect the huge losses incurred by receiving a long prison sentence. However, there also appeared to be more unpredictability in women's custodial experiences, with women sometimes moved at short notice, for sanctions, for prison management or for other reasons. What was not always clear was whether this was a result of differential treatment for women, or simply a factor of the availability of other prison establishments for the adult women (which does not exist for young men).

> **"**Polmont's unique in that it can't put any population anywhere unless they turn 21. Because it's a national facility. Whereas the females there I've got Edinburgh Grampian and Cornton Vale that I can vent, if I need. And likewise they can do to us" (Key Stakeholder)

[1] For three women their sentence length had not been recorded

> "Participant: And also, as well, people get transferred and we don't really get to know about that. So they could be working, doing some really valuable work with whatever agency and suddenly you've got 'oh they're getting transferred', we'll just hear, you know and folk, you just hear they're getting transferred in two days' time.
>
> Participant: Yeah, if they don't turn up for an appointment and you check it and they've gone" (Focus Group)

In addition, the Here and Now service at times felt that they were sometimes forced to deprioritise women serving long sentences in order to juggle meeting overall therapeutic need as well as immediate need due to imminent release. The implementation of the Here and Now Link arm of the service was designed to provide a short-term input for those women due to be released and although successful for some women, the overall level of demand and unplanned transfers made balancing these priorities a challenge.

Throughput and demand

Early service-planning focus groups had indicated a high level of need and a desire for such a service, from both the women and the staff group working with them (Thomson, 2018), yet the perception from the Here and Now service was that referrals to the service had remained slow for several months after it had launched. Uniformed prison staff also felt that the capacity of the Here and Now service did not meet the demand in the establishment, and meant that the service was not visible or regular enough to become familiar with or for the women:

> "I think there's a problem with the regularity that he's coming in is not, you know, it isn't sustainable for the needs for the... for what the women are looking for" (Focus Group)
>
> "I don't think the service is big enough to meet the need. I really think, especially with the women because of the complexity of their needs, we have two members of staff across all populations, so the service they get isn't going to be what they need unfortunately" (Key Stakeholder)

However, analysis of the data suggests that referrals were at their peak in the first two months of the service (September and October 2017), although almost entirely fuelled by self-referrals from the women. In these initial months 76% of referrals came directly from women, and comprised a third of all referrals during the period of research (Figure 3). This indicates either a low level of awareness, or reduced use of the service from staff in the initial stages of implementation. Although the rate of referral from staff and other agencies has increased since then, and the rate of self-referrals has declined, self-referrals comprised almost half (49%) of all referrals to the service.

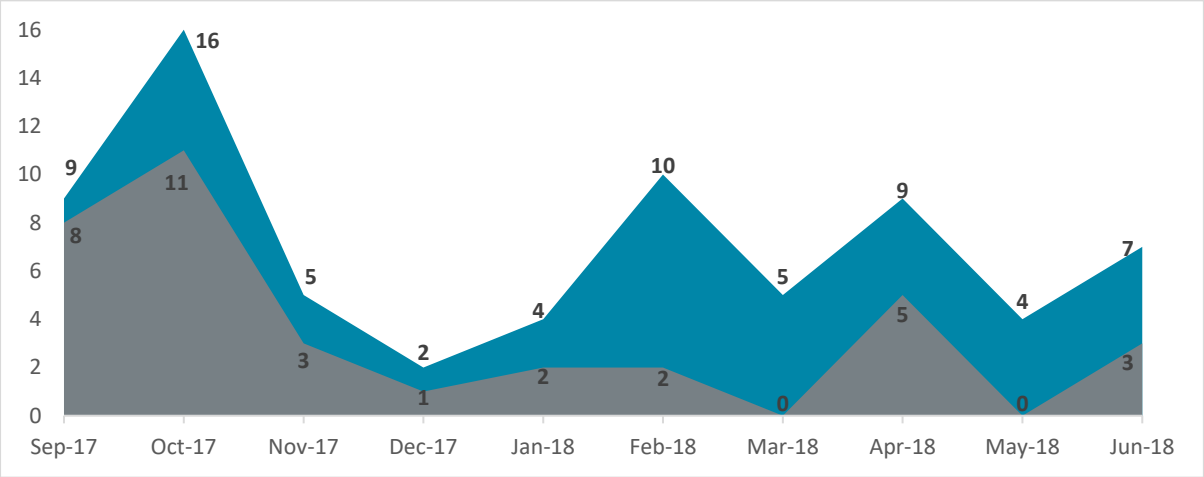

Figure 3: Referrals to the Here and Now service[2]

> "I think because the women were getting quite a lot from it, they were going back to the halls and they were sharing, you know, with the other women, so I think some of it's came through word of mouth from the women themselves" (Focus Group)

Waitlists and capacity of the service

This level of self-referral was not without its challenges and affected the speed at which the service could respond to referrals.

> "…we had anticipated and we hoped, because we'd sent all the information out to various other agencies, NHS didn't send any referrals through, or very few up until recently, hall staff were anticipated because they knew the women, and would send them in. They didn't, we did a mailshot for the women and we got a swathe of self-referrals, but what that means is that every time you send out a series of referrals you're going to get peaks and troughs in referral, rather than a steady stream of thought about referrals, and I think that seriously impacted on how we were able to start" (Key Stakeholder)

Analysis of referral data (excluding the early referrals made several months in advance of the service commencing) did indicate challenges in processing referrals. The mean time from referral to receiving a service was 28 days (four weeks), although this ranged between one day and 86 days. The time from the first assessment meeting to the first official Here and Now session[3] was much quicker at six days on average (ranging from zero days to 22 days). This meant that the mean time from referral to the first session was 44 days (just over six weeks), ranging from one day to 86 days (roughly 12 weeks). This waiting time affected either staff's willingness to refer people to the service, or the service that was able to be provided.

[2] Five referrals made prior to the service commencing have not been included in this figure
[3] Sometimes the assessment meeting was counted as the first official one-to-one session

> **“**At the moment, we've got... I think... 12 on the waiting list, with the women, which is... um... just manageable. But what will happen is that, a series of those people will be on remand and will be on short sentences, or people get referred near the end of the sentence, which means that they will only get a link service - a shorter piece of work” (Key Stakeholder)
>
> “Unless that's something that they're getting up twice, two or three times a week, they're not going to engage in that, they're no wanting to engage one week and then not go see anybody for two, three weeks” (Focus Group)
>
> “The only issue was putting the referral in and then the length of time until someone got back to them.” (Focus Group)

Staff knowledge and awareness

Slow take-up of the service was in part felt to be due to a lack of awareness among uniformed staff in the female unit about the service. Uniformed prison staff felt that the Here and Now service had not been well promoted by Barnardo’s or HMP & YOI Polmont, and that they tended to turn more to well-known services, typically those that had transferred across with the women from Cornton Vale. This view was echoed by the women.

> “So if we know what 'here and now' actually does we can say to the girls by the way this is 'here and now', this is what they do and if you want us to refer you to them we can and they would be the best people to speak to about that particular issue” (Focus Group)
>
> “I think for me, you want to know that you’re referring people to the right place. If you don’t have a lot of information on a service, you’d be less likely to refer someone. You'd rather refer someone to a service you know a lot more about because then you can back up why you’re referring them. But for me I don’t know enough about 'here and now' to feel that comfortable in referring someone personally” (Focus Group)
>
> “I don't know really, I think it could be promoted better, the whole like, posters up or something. Um, cos usually when you come into prison there, you're not really told very much, you kind of need to try and find a lot of it out yourself” (Woman)

The original males’ service had been accompanied by a two-day trauma, bereavement and loss awareness-raising course. A focus on professionalisation of the workforce meant that some training had to be deprioritised, and natural staff turnover coupled with the transfer of new staff from Cornton Vale meant that knowledge about the prevalence and impact of trauma, bereavement and loss within the prison system had become diluted across the organisation over time. This also had a direct impact on knowledge about the Here and Now service and referrals to the service.

> "I think if, say for example ahh, one of the, the population here has an episode where they behave in a way that's totally out of character and.... and that's explored and it was found that it's an anniversary of something that's happened to them, I think would be maybe quite clear, you know, that that was potentially a trauma, bereavement and loss issues, erm, but if somebody was struggling being here in terms of their loss of freedom, for example, then, if you're not doing that continual professional development, then expecting staff to either know or remember, that might be a trauma, bereavement and loss issue, I think is maybe a challenge for Here and Now" (Key Stakeholder)

The Here and Now service, however, felt that there had been logistical challenges in implementing the training and awareness-raising strands of the work which meant that, even with their flexible and persistent approach, this had not been achieved as desired with staff working with the female population.

> "so we tried to focus on offering the training package for the staff, we did that, we had several meetings, they had a change in management structure down there [in the female hall], and that kind of got lost for a while, we attempted that again, and we came up with a modular idea, where we would offer an hour a week. It transpired that still the numbers would only be three people per training session, which probably isn't the best way forward for training, because not everybody would receive every module, so the notion now is that it'll be a training that is consultative. So I'll be offering a monthly consultancy, to a smaller cohort of people, who've volunteered, who want to do or learn some more…" (Key Stakeholder)

Staff roles, skills and confidence

The lack of additional training also meant that uniformed prison staff did not always feel able to support the women in relation to their trauma, bereavement and loss experiences. There was a perception that this was not their role, or if it was they were not skilled or confident enough to do so, or the situation did not permit such conversations to be had. Even staff with different professional roles, such as the third sector or the NHS felt wary about the skillset required to support work in relation to trauma, bereavement and loss.

> "I don't mean it in a negative way, but if we start opening up…with the women, we then don't have the time to continue that and isolate that case and be there, continue it, cos you could be in there for half an hour, forty minutes, and then it suddenly becomes that, you know, you're starting talking about stuff that's a way out of your comfort zone as an officer, and also where your skillset kind of ends, in terms of how you deal with that and acknowledge it" (Focus Group)

> "And I think, also not to work above and beyond your capability as well, because there is a huge temptation isn't there erm, you know, that we all do take on you know, this kinda care approach in our work, and there is a huge temptation to say, you know I can fix that, I can manage all that, it's not perhaps within your role, within your remit and I think that there's, there's a danger for us to over, to kinda, to put ourselves in that position as well and know who to refer and what's appropriate to refer" (Focus Group)

Staff also appeared to feel constrained by the complexity of the interaction between background experiences of trauma, the prison environment, the inherent tensions between care and control, and the influence of their role within that:

> "Even sometimes how you interact with them, and you don't realise that sometimes the way you're interacting can be a trigger for them. And it's not that anybody means anything disrespectful, and we're not disregarding their emotions, but we're human as well, and there are times when we get frustrated, and particularly if you've got an individual who is quite challenging who won't follow the regime, in particular, you may become quite curt, quite short, you may avoid them, and then that can trigger them, because of abandonment issues or, kind of, attachment issues or stuff, and they we are obviously perpetuating that circle, but at the same time, we can't always be conscious of how our behaviours trigger everybody or everything else, because we'r not always aware of their trauma, either, so we're doing it blind"

Organisational practice and priorities

Another factor that potentially affected the take-up of trauma, bereavement and loss provision was the priority that was given to the different types of provision offer within the prison establishment. There was a sense from third sector agencies that more traditional SPS activities, such as offence-focused programmes, were prioritised over other provision. How a woman's activities were prioritised and booked was also felt to be ad hoc, or at times even shrouded in mystery.

> "Participant 1: Cause there is a hierarchy and…..
>
> All Participants: Mmmm , yeah
>
> Participant 2: there is a hierarchy of what we can see in clients as well…
>
> Participant 1: Which I imagine for Here and Now, you know, we've got them booked for you know a one-to-one appointment and if they're down for the laundry, you know, that gets, yeah, laundry would get the…that's what I mean, laundry would get the priority, and life skills or…
>
> Participant 2: Anything SPS related…
>
> Participant 3: You know, you can be sitting waiting and, yeah, it's not until you go and check up to see where they are, and then you, you catch up with them and they say, well, actually I had to, I was told I had to go there I knew I had your appointment but…." (Focus Group)

Senior managers were optimistic that this emphasis was beginning to shift, with greater understanding about the importance of addressing trauma, mental health and substance issues in order to improve both wellbeing and engagement with other activities such as work or education.

> "The regime needs to reflect the trauma and abuse. Right now, we haven't got that right. And that's not about us as a team, it's just, historically, prisoners go to work. If you're a convicted prisoner, you will go to work, end of. You will create a wage. Well, why can't we not just go away from the work activity, for the female population, and their work is in recovery… For us, the knowledge that what they've got wrong with them, and be able to work towards hopefully fixing that... I know it's a long, long road, but you've got to ask yourself about the distance travelled" (Key Stakeholder)

Yet the theme of a problematic booking system was strong and compelling and had been a feature in previous research in the establishment (Vaswani et al., 2016). Conversely, there was also some feedback from uniformed staff that the booking system was not properly utilised and that communication, or a lack of it, made their jobs more difficult.

> "We don't know if someone's been referred or they've got the referral until they literally turn up to the pod and say I'm from 'here and now' I'm here to see so and so. We don't even get an email to say just to let you know I've got this person's name, this is when I'm planning on seeing them. We don't get any follow up to that. That's where I think it's got to be a stronger link between that service and the hall" (Focus Group)

> "Because very often when a girl asks you to refer her somewhere, she'll ask you every day, have you heard from them until they get the answer" (Focus Group)

However, the reality for Here and Now, and for many other organisations, was that there was disproportionate power over how women were booked, transported or interacted with before, during and after appointments.

> "There's a power thing. When you're working in this environment there's always power and control issues going on and again who ends up being the people who get most affected by it is the women" (Key Stakeholder)

> "How is that working for kinda building relationships as well, you say 'I'll see you weekly, no I can't see you weekly because your hall is not allowing me to come back" (Focus Group)

> "Well [worker] usually comes out and says to the officers look she's had a really tough day today it would help if you could try and get her back soon and they normally do do that. But then sometimes you are left when you've not had as tough a day but it's still tough enough and you're sitting there for 20 minutes, half an hour, sometimes even 40 minutes and wee guys are there and it's just not good when you're in that frame of mind" (Woman)

These misunderstandings or misperceptions between different agencies within Polmont may have been symptomatic of factors relating to communications across the establishment. The importance that organisations placed on confidentiality at times meant that services were not always best coordinated, or important changes were not able to be taken into account during service provision:

> "It worries me hugely. I don't want somebody being involved or meeting three people that day and … what we're doing is, we are basically bombarding these people you know…And then it doesn't help, like what we were saying earlier about the confidentiality within different services so it doesn't help that those three people that might be working with that person cannae then sit down and come up with a plan and that would be beneficial for that person" (Focus Group)

> "When people come in, there seems to be often a lag in the timeline between them being attended to, to receive their medications….so there's a lag there, and how they manage in that time…is impacted by that lack of medication. If medications are changed, there isn't a conduit between the NHS and SPS services, because of confidentiality clauses, that allows you as a therapist, or a third sector organisation, to know that medication's been changed, so people will self-report, or you'll just notice that people are different, whether that's because they're more anxious, or because they're more zoned out. So there's an impact on how people access services, I think" (Key Stakeholder)

The organisational culture

A small minority of staff directly voiced attitudes towards punishment and rehabilitation that were not aligned to the espoused vision and values of the SPS, although they were referring to their experiences across the whole prison, not specifically about working with females. These staff acknowledged that their opinions did not fit, and would not be easy to hear, but they also felt that they needed to share their views with candour.

> "There's only one thing that really annoys me about all this stuff, is people seem to forget that they are in jail and it's a punishment. I dunno what their victims get? What do they get? Do they get all this counselling and one-to-one interviews? Do they get all that stuff? Because they just seem to forget that they're in jail, and they're here for a punishment" (Focus Group)

> "There's so much emphasis put on changing their lives, but...barely any emphasis on punishment. If you are good behaved your full life sentence you'll not get a bad thing done tae ya, zero punishment other than you get locked up at night" (Focus Group)

Their testimonies are an acknowledgement of the fact that working with people who have committed serious violent crimes is complex and can provoke strong emotions. Those who openly expressed such views felt that they were probably not that different from many other officers in the establishment. There was evidence from some of the language used, and the views expressed in the wider establishment that, despite policies and directives from senior management, more time was still needed to effect organisational culture change and a more trauma-informed environment. Even when the intentions were clearly benign, the language suggested underlying attitudes towards female prisoners that might take more time to shift.

> "Yeah, I think it's a cultural change that's required, like with SPS it is seeing, I know the strapline now is 'transforming lives' nope, I forget the other bit, but I'm actually not too sure how that's translating into this kinda SPS sub culture that we have within the prison... It always will be I think the kinda culture of the hall will always be a bit penology, or punitive, or about the punishment erm, side to that" (Focus Group)

> "Participant 1: …how we sort of deal with it as well is, like sometimes it is, kind of like, sometimes with personal issues that we can somehow we chat with them about stuff like how we would deal with, kind of like something like how we'd, is it empathy or something?
>
> Participant 2: Don't start with empathy, do not start with empathy.
>
> Participant 1: Well that's what they said.
>
> Participant 3: I know." (Focus Group)

It was also clear that even small actions or processes could have a big impact on the wellbeing of the women in prison.

> "Hmm, of course depending on... on each individual session, sometimes it was nae an issue at all, but I think there could maybe be better communication with the hall staff, I think maybe hall staff should have a wee bit of training, there was one particular incident, I'd had a... a hard session, I'd been crying, and I went back to the hall and one of the officers was just over the top, I'd only been in the hall about 60 seconds and she was raising her voice at me, and, it was all just too much, and because I was upset, I got locked in my room" (Woman)
>
> "yeah, just a basic understanding, cos I think, I know they've got a lot on their plate, the hall staff, um, a very wide variety of issues to deal with, and jobs to get done, but I really don't think they understand the impact they can have on individuals. Like silly, silly wee comments, and... cos everything means so much to you in here, cos, a lot is so limited, so... silly wee things like a passing comment can stick in your head and you can build it up to much more than it was intended to be" (Woman)

The physical environment

The physical built environment and the regime itself were also not conducive to supporting a safe therapeutic environment within which the women could explore difficult issues such as trauma, bereavement and loss. Whether it was simply the lack of privacy and space, or sessions being unexpectedly interrupted for route movements, or conflicts and arguments going on outside the interview room, there were many challenges for the women and for the provision of services.

> "Maybe... and this is quite particular to this particular jail... I probably would have liked to have known that I was going to be in a room with a window when there's people constantly walking past, and a lot of noise from downstairs, it's the performing arts area, so music instruments being played, and, erm, a lot of people walking past all the time, and, you just kinda cannae help but look in when you're walking past, erm, which can be quite unsettling when you're trying to open up about something, erm, it can make you quite anxious" (Woman)

> "The only one thing I didn't like was having to go up to that centre. After coming out from your session you're sometimes waiting for half an hour in the open bit to get even back here and sometimes you just want to get right into your room and shut the door over and have a fag or whatever. That's the only bit of it I didn't like and that's nothing to do with [worker] or the work itself, it's actually to do with the prison service" (Woman)

> "And, like I said, there's forty of them, we don't have the time to individually go round everybody 'are you alright?' before we lock the doors, cos, we've got a regime to run" (Focus Group)

> "If it's the first time that they disclose, the first time they've wanted to discuss erm, whether it's trauma, bereavement and loss, mental health erm, housing issues, whatever it is, you know we, and now we're sending them back to a cell. Locked up for 14 hours, 12 hours" (Focus Group)

Impact and Outcomes

Engagement and Disclosure

The level of self-referrals are an indication of the women's willingness to engage with the service. It was apparent that, despite some initial apprehension and uncertainty, women did not engage superficially with Here and Now, but poured their heart, soul and traumatic experiences into sessions, demonstrating an unprecedented willingness to disclose. This may have been in part due to the breadth and scope of the service (rather than a focus on a narrow aspect of experience) meeting a hitherto unmet need and allowing women to feel that the service was for them.

> "I was putting my name forward for... it's gonna sound horrible... but... to tick all the boxes they want ticked…And I felt differently about this [service]... because I thought, it's, it's for me, it's not for their tick-a-box" (Woman)

However, there was also something about the demeanour and approach of the Here and Now worker that meant that the women felt able to share their experiences.

> "I had, erm, one lady that I worked with last week tell me that she has had four sessions now with [worker] and she has disclosed more to him in four sessions, than she has over her 46 years of life time, so that was really quite profound for me. And this woman, is quite resistive to agencies erm, she's had quite a lot of interventions throughout her life, most of them being negative in her opinion and yeah, that was, that's her reply to me" (Focus Group)

> "But the support it's offered me has been tremendous, because I'm quite a sort of... closed person... and, to be able to trust somebody, that was the big thing" (Woman)

For many of the women, the Here and Now worker had the ability to provide a safe space in chaotic environment, and some even found that being imprisoned provided an element of stability from which to approach therapeutic provision.

> "I think part of it maybe is about asking the right questions, but, it is therapeutic support, I think and it's that environment that he's creating. So that safe space, you know, it is different, even different, from what I do, you know 'cause yeah, I have to create that safe space, but actually there's a functionality to it. I'm not creating it for a therapeutic process so there is a difference, you know…" (Focus Group)

> "I don't understand it, it's so strange. And do you know something 90% of the lassies say that and it must just be the way that he is or maybe it's just the full service, I don't know. I don't know if it's the service or the way he is because I've not worked with anyone else. I think he just makes you feel dead calm and like you can talk about stuff." (Woman)

> "being in a secure environment, a reasonably safe environment, and having a clear head and not being clouded by drugs and just the drama of the outside world, erm, it can be beneficial, although sometimes it's difficult to see it that way..." (Woman).

Impact on the self

The women interviewed found the service immensely beneficial, whether helping them gain insight and understanding into themselves, their experiences and their behaviour, or in fostering increased understanding and tolerance of others, especially within the prison setting.

> "It's been really really helpful. Everything that he's done has been helpful. I think it's changed my full attitude; my attitude is a lot more positive for some reason. I always thought dead negative and I thought things that had happened to me was my own fault in some way or another do you know what I mean. Whereas he's changed that as well, well we've changed that opinion totally, it's turned round and I know it wasn't all my fault. I think that in itself is something massive." (Woman)

> "Even to get an insight into that, that was massive as well and that was through this work. I always just thought I'm just always going to take drugs I must like them and that's what it is. I didn't like them, I hate the life, I hate the drugs what they do to people and I actually hate them so how could I like them. I thought I liked the buzz but not the lifestyle but no it's not the case at all and it's took me till now to realise that." (Woman)

> "I suppose it kind of makes you think more about other people how if someone's acting different or odd or whatever you might think to yourself why is it that they're acting like that rather than just being odd back to them…insight and maybe even a wee bit of empathy without even knowing anything if that makes sense." (Woman)

> "I found a massive, massive impact with 'here and now' I don't know if it was [worker] himself because I've never worked with any other 'here and now' but [worker] himself for me personally was brilliant, brilliant. (Woman)

Impact on measured symptoms

There was limited data in terms of matching pre-and-post data to objectively measure outcomes. A number of the women had yet to complete the service, and others had been released or transferred after only a session or two, or had not completed the post service measures. Although statistical analysis has been carried out, caution should be taken due to the very small sample size. Feedback from Here and Now also was that one or two of the women may have underreported in the initial assessment and opened up more about their experiences once trust had been established. The women corroborated this perspective:

> "And there was one point in, when I was seeing him, that I... I'd had a sort of difficult time... and he'd had a similar difficult time, very very similar, and from then, that was about four or five weeks into it, and things just sort of 'chhh'... like... he had opened up to me, so I felt as if I was able to open up a wee bit more to him" (Woman)

Seven women had completed the Trauma Symptoms Checklist for Children (TSCC) pre-and-post service. There was a reduction in the median scores on each of the TSCC outputs (total frequency, total impact, combined frequency and impact), with a reduction indicating reduced trauma symptoms. The biggest reductions were seen in levels of anxiety (worry about things) and intrusive thoughts (remember things you don't want to). However, the Wilcoxon Signed Ranks Test was used to explore this reduction, which was only statistically significant for the impact measure (Table 5). This suggests that the service was beginning to make an impact on how women felt about their symptoms, or how they coped with those symptoms on a day-to-day basis, even if it was less able to change the frequency of those symptoms. For some women though, the difference was tangible.

> "I'm more in control of it - when they come into my head and when they don't. That's been massive because I used to think about stuff quite a lot. Sometimes five times a day something would pop into my head and now it's whenever I want. The last time I had an intrusive thought was…two weeks before" (Woman)

Only four women had a pre-and-post Resilience Research Centre Adult Resilience Measure (RRC-ARM). Again there was an increase in overall median resilience scores pre-and-post service, suggesting an increase in resilience, but a Wilcoxon Signed Ranks found this to be non-significant (Table 5). While this is clearly limited by sample size, it may also reflect the fact that the women possessed higher levels of internal resilience to begin with, and are possibly unable to affect change in the social, peer or community resilience domains while imprisoned.

Table 5: Pre and post measures (Wilcoxon Signed Ranks Statistics)

	Median Score PRE	Median Score POST	Z	p
TSCC (frequency)	56	34	-.508	.611
TSCC (impact)	64	38	-2.023	.043**
TSCC (combined frequency and impact)	118	70	-1.352	1.352
RRC-ARM	117	144	-1.069	0.285

** p<0.05 (2-tailed)

It should be noted that the potential for achieving change is limited by the length of time available for intervention, and it is unlikely that any service dealing with a lifetime of trauma, bereavement and loss could effect substantial change in such a short time frame. The average length of service was approximately seven weeks, but comprised on average only two one-to-one sessions within that time. The number of sessions ranged between one and 15 sessions.

> "It hasn't always proved to be possible in as much as sentencing and remands, at times, are quite different. With more remands, I think, for women, and shorter sentences, which mean that work isn't always possible, or only shorter pieces" (Key Stakeholder)

> "That made me think of a case I'm dealing with right now where a lady has been in for, you know, five months, it's now six weeks 'til her liberation date, I've only just found out about her, I've got six weeks to try and put safety planning in place, try and get a secure accommodation, which isn't really my role, but because of significant risks to her, you know…maybe what you were saying earlier about how some sort of, you know, screening for trauma, at the start, so that we can kind of capture people at the starts of their sentences, especially for [Here and Now] as well" (Focus Group)

Community Provision

The lack of community provision, either prior to entering prison, or upon return to the community was felt to be hindering the achievement of longer-term positive outcomes. Women were entering the prison system with long-standing and untreated trauma experiences and had adopted many potentially harmful coping strategies that made intervention more complex:

> "It's self medication, the addiction in the first place is self medication to deal with the trauma" (Focus Group)

The release into the community was a time of hope for many, but also a time of great anxiety when continued supports may have been beneficial. When the Here and Now Link service worked it was perceived to be highly positive, but it very much relied on the availability of services in the community.

> "With the women what I had experienced is, as well, they also work with Tomorrow's Women [community-based service in Glasgow] which is fantastic because they fall out to the community. The other really good thing that I've noticed from working with Here and Now is, the community sign posting so that's always been quite strong…I know that with Here and Now it might not be able to start any kind of work with them due to time constraints but they will try and find community based support, or get somebody in from the community. ….the relief and the hope that that woman then feels, it's not this, you know, pitch up at this building and there'll be a person there. They've met that person, they know that that person's there for them. I think that that's really great" (Focus Group)

> "I think the other end of that is that often people are coming in here out of chaotic community experiences, where maybe they haven't engaged terribly well with services. And at the end of their sentence, they're going out to the same chaos, and there doesn't really appear to be much in the way of a follow through to local services... if they exist, because it really is a postcode lottery" (Focus Group)

Even where service provision existed, many workers found that they were not willing or able to meet the needs of the most vulnerable women:

> "What we find, again, when they go out to the community, is we would be relying on women's aid… we're looking for secure accommodation, a hostel, a BnB is not appropriate for a woman fleeing domestic violence, especially if they then have addiction problems, as well. When we then contact organisations like Women's Aid, they're banned from Women's Aid, because of their addiction problems, or because they've been violent towards members of staff, so that's a huge barrier for us, because we can't seem to try and break that cycle, and the traumas are becoming compounded, yet again" (Focus Group)

Gender Differences

This section reflects on the previous evaluation of the males' service (Vaswani et al., 2016) to highlight a few potential differences between males and females that emerged through the research, in relation to the different presenting symptoms, the gender of staff and attitude towards women in prison and how they are treated. However, caution should be taken as the two groups also differed in terms of age, with the mean age of the females being 31.5 years, compared to 19.5 among the young men.

Presenting symptoms

Both males and females completed the TSCC at the start of the Here and Now service, although only the females were asked to score both frequency and impact of these symptoms. Males were only asked to score the frequency of symptoms. Figure 4 shows the proportion of respondents stating that they experience symptoms 'a lot', almost all of the time' or 'always'. The two most frequent symptoms were the same for both males and females: 'worrying about things' and 'going away in my mind trying not to think', although they differed in order. However, from there on there were notable differences. The males scored highly on 'having trouble concentrating' (70%) and 'feeling angry' (65%) whereas only around half of the women reported experiencing these symptoms regularly. Other symptoms relating to anger and aggression were more prevalent for males, for example 42% of males scored highly on 'wanting to break things' compared to just 16% of females. Women scored more highly on symptoms such as 'feeling sad or unhappy' (65% of females, 46% of males) and crying (29% of females, 10% of males).

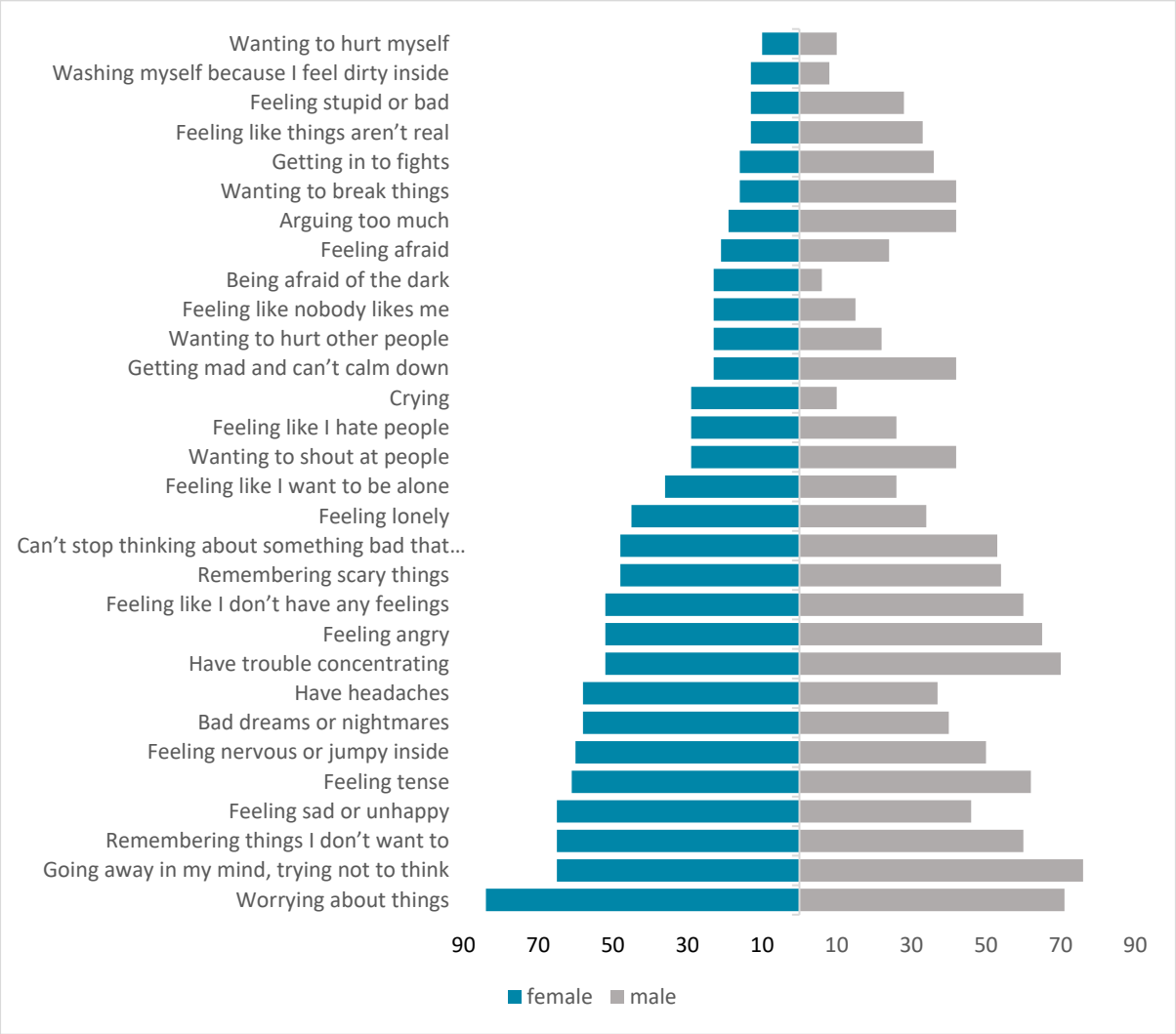

Figure 4: % of females / males experiencing each symptom at least 'a lot' of the time

Both males and females reported having to keep emotions under wraps in the prison estate, although for males this appeared to be a pattern of expression learned across the lifecourse, whereas for females it was more of a response to the current environment they found themselves in.

> "I felt that it was a really good opportunity to get things off your chest, particularly in this environment, it's not an environment that you can be very emotional and open in, erm, so it was very helpful to be able to come once a week to have an intellectual conversation, erm, and to have somebody that was just there to listen to you and talk about you, and what you wanted to talk about" (Woman)

> "Aye, it's probably not quite as bad for women, cos women are more likely to open up to one another and talk about emotions and, and that kind of stuff, but probably very similar to the guys there's always gonna be a feeling of... if you do allow yourself to become emotional, it can be mistaken as vulnerability... well, no, it is vulnerability, so you're kind of putting yourself out on a limb, cos it's not always the most friendly environment" (Women)

Gender of staff

There was a widespread assumption that females would prefer to work with female staff, especially because of past experiences of abuse and victimisation that were often perpetrated by males. While this was true to some extent, in that most of the females were initially anxious about meeting a male therapist, it was clear that what was more important was the type of person that they were and their approach towards the women.

> "It's also maybe the fact that [he's] a man. As [participant] said earlier, they don't always particularly like opening up to a male. If they know that the representative for 'here and now' is a male for some of them it would put them off" (Focus group)

> "…because it's always been women psychologists that I work with on whatever so it's always women it's never really guys. So I was quite like, when I first seen it was him I was a bit taken aback but I think the minute you start speaking to him you just get this... I don't know, a comfortable feeling, like he makes you feel comfortable do you know what I mean like you can talk to him…" (Woman)

> "I was only apprehensive maybe for that first initial meeting, and at the end of that first one on one session, I had no doubt that I was happy to work with [worker], my initial impression was just that he was a... a really lovely guy, pleasant to be around, even just the way he speaks is... is very calming, very non-judgmental. I just... yeah, overall impression is just he's a really nice guy" (Woman)

Perceptions and attitudes towards women

Some women also observed differences between the staff group who were originally employed at HMP & YOI Polmont and the group of staff that had transferred with the women from Cornton Vale. There was a sense of a different way of working between 'Polmont' and 'Cornton Vale' staff and it was not clear if this was simply a result of differences in custom and practice or as a result of the two different populations. This disparity may also potentially be linked to the previous roll out of trauma, bereavement and loss training to the HMP & YOI Polmont staff cohort in 2015 and 2016, meaning the level of awareness and understanding may not have been as present in the staff working with the female population.

> "Err... I'm not saying that the Polmont sort of like experience is kind of particularly different, but it's very kind of entrenched, for want of a better word, paternalistic type attitudes in relation to working with the women, er, and the transfer of that to here [from Cornton Vale] has not been hugely helpful, in all honesty" (Key Stakeholder)

> "I think... in prison I feel that compassion and understanding for prisoners is... is integral, it's... and there's a big difference here at Polmont with staff and the way they are with prisoners, …um... I just think Polmont are streets ahead" (Woman)

> "It seems fairly paternalistic how they're treated, I think, and it seems more punitive. The punishments seems harsher…for lads, when they seem to have fights, yes they get punishments, things are removed... I don't know if it's cultural, or what the impetus is for it, but I think women seem to be punished more severely for fighting. For transgressions. And... there probably seems to be more suspicion, I think, from the staff towards the women, particularly round there's a presumption that people are all using drugs illegally. I don't quite get that sense from … staff who are working in the male population. Yeah, I do think there are differences" (Key Stakeholder)

Few prison staff were openly hostile towards prisoners, and the majority of staff were keen to support the women as best as they could in quite challenging circumstances. However, there was evidence that there was still work to be done in terms of changing the underlying organisational culture and attitudes. This appeared to be especially strong in the female prison, where language hinted that some prison staff at times viewed the women as needy and manipulative, and there was a sense of hopelessness that was not as obviously present in the male establishment.

> "Another massive thing you have to watch and it's not a negative point but it can come across as a negative point is that - the women will use this service whenever it suits them and they'll use it to their advantage of you know their maybe not getting enough attention in the hall therefore they're not using it for the correct purpose" (Focus Group)

> "I think probably morning is probably better [for therapy] as well because I think in the afternoon they're lazier" (Focus Group)

> "… the sense of hope. Erm, where, with a young offender, there's a sense in which, OK, you've made a mistake, and you can move on from this, not many of them are looking at careers in the prison system, whereas, you're working with another population who have a career in the prison system, you know, and that is something you know, so yeah" (Focus Group).

Conclusions and Implications for Practice

The Here and Now Service for females is showing early promise and is clearly beneficial to the women who received a therapeutic input, but the service was beset by a number of challenges in implementation and delivery. The following recommendations reflect the findings of this research study, and should help to embed the service more fully in to HMP & YOI Polmont.

Most pressing is the need for **organisational culture change**, and a greater **organisational awareness and discourse** about the purpose of prisons in punishment and rehabilitation, the pains of imprisonment, the dilemma of care versus control, and about the impact of trauma, bereavement and loss on people in prison. Such change can be complex and certainly will not be quickly and easily achieved, but the immense influence that prison staff can have on individuals in prison, for good or ill, means that this issue cannot be ignored. While Scottish Prison Service policy is certainly admirable, the realities of custom and practice mean that this is often not translated into the right environment for rehabilitation, or therapeutic interventions. Time and effort needs to be spent on developing a shared understanding of the vision and values of the organisation alongside tangible changes to practice that can be made by individuals.

While the nature of prison, and the emphasis placed on security and regime, means that it can never be a truly trauma-informed environment, HMP & YOI Polmont should consider how it can make its spaces more welcoming and therapeutic. Small **physical changes to the built environment** that can afford women some privacy, calm and quiet during therapy sessions are essential. The provision of refreshments may also help women through what can be quite difficult and draining sessions. Small changes to **practice and process** such as in how women are booked and transported, as well as cared for after sessions, can make a big difference to how women experience and engage with the interventions on offer.

SPS prison staff often portrayed very challenging working environments and frequently described feeling overwhelmed and ill-equipped to support the vulnerable and traumatised women in their care. **Staff training**, and the wider **professionalisation agenda**, may assist with increasing awareness, knowledge and skills about how to support women affected by trauma, bereavement and loss. This may support more dialogue in the halls with the women, increase appropriate referrals to Here and Now, and provide a gentler environment for the women to return to after therapy. As there seemed to be evidence of women forming friendships, or encouraging others to attend Here and Now, some form of trauma, bereavement and loss training for women may also help them to informally support and care for each other. **Joint training** with staff may also be an option to help break down barriers between women and staff.

There also appeared to be complications with **communication** and potentially some evidence of professional misperceptions and mistrust, which affected information sharing, service planning and service prioritisation for the women. **Cross-disciplinary and multi-agency training** may increase professional understanding and respect.

The women seemed to be willing and able to engage with the service, and undoubtedly benefited when they did so. However, the service is hugely under-resourced with long waiting lists and a lack of capacity to meet demand. Both **Barnardo's** and **HMP & YOI**

Polmont should consider **increasing the resource** associated with the Here and Now service. There is also clearly a lack of suitable **community provision** for women in the community, both prior to women entering prison, and upon their release.

There is also a need for research and/or practice to consider the **wider supports and networks** that exist in the community for women, and in particular vulnerable women. This research suggested that women possess remarkable levels of internal resilience; however, their resilience was lower in relation to external factors such as peer, familial or community supports. It will be important to be able to find ways to **foster this external resilience** for women in the community.

The evidence on impact and outcomes suggests that in the short timeframe available the service was not able to make a significant change in the frequency of the women's symptoms, but did manage to change the impact that these symptoms had on the women's daily functioning. Importantly, the women described the service as very beneficial, and so it suggests that interventions focused on what Maschi et al. (2011) describe as **'emotion-focused coping'** (aimed at how a person feels about or manages their situation) rather than 'problem-solving coping' (i.e. aimed at changing the situation) may have merit with this population. That's not to say that women should not be supported to change their situation (and in situations where they are at risk they must be supported to do so), but when it is not possible to change the situation i.e. in relation to historical abuse or current imprisonment then emotion-focused interventions may be beneficial in those circumstances. However, the sample of women who had finished the service with completed post measures was very small and **further research** is needed to understand the impact of the service better. **Barnardo's** should continue to administer and monitor pre and post service measures to support this evidence gathering.

References

Aday, R. H., & Krabill, J. J. (2016). The Silenced Emotion: Older Women and Grief in Prison *Handbook of Social Justice in Loss and Grief* (pp. 158-173): Routledge.

Boss, P. (2006). *Loss, Trauma and Resilience: Therapeutic Work with Ambiguous Loss*. New York: W.W. Norton and Co.

Briere, J. (1996). Trauma symptom checklist for children. *Odessa, FL: Psychological Assessment Resources*, 00253-00258.

Burrell, S. (2013). *Trauma and the environment of care in juvenile institutions*. Retrieved from

Commission on Women Offenders. (2012). Final report. Edinburgh: Scottish Government.

Crewe, B., Hulley, S., & Wright, S. (2017). The gendered pains of life imprisonment. *British Journal of Criminology, 57*(6), 1359-1378.

Doka, K. J. (1999). Disenfranchised grief. *Bereavement Care, 18*(3), 37-39.

Earle, J. (2018). Why Focus on Reducing Women's Imprisonment? In E. Milne, K. Brennan, N. South, & J. Turton (Eds.), *Women and the Criminal Justice System: Failing Victims and Offenders?* (pp. 187-219). Cham: Springer International Publishing.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*, 245-258. doi:10.1016/S0749-3797(98)00017-8

Ferszt, G. G. (2002). Grief experiences of women in prison following the death of a loved one. *Illness, Crisis & Loss, 10*(3), 242-254.

Ferszt, G. G., Hayes, P. M., DeFedele, S., & Horn, L. (2004). Art therapy with incarcerated women who have experienced the death of a loved one. *Art Therapy, 21*(4), 191-199.

Fraser, K. A. (1988). Bereavement in Those Who Have Killed. *Medicine, Science and the Law, 28*(2), 127-130. doi:10.1177/002580248802800209

Green, B. L., Dass-Brailsford, P., Hurtado de Mendoza, A., Mete, M., Lynch, S. M., DeHart, D. D., & Belknap, J. (2016). Trauma experiences and mental health among incarcerated women. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(4), 455.

Harner, H. M., Hentz, P. M., & Evangelista, M. C. (2011). Grief interrupted: the experience of loss among incarcerated women. *Qualitative Health Research, 21*, 454-464. doi:10.1177/1049732310373257

Heidensohn, F. (2013). *Gender and justice*: Routledge.

Heney, J., & Kristiansen, C. M. (1998). An Analysis of the Impact of Prison on Women Survivors of Childhood Sexual Abuse. *Women & Therapy, 20*(4), 29-44. doi:10.1300/J015v20n04_03

IBM Corp. (2017). IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp.

Laws, B. (2018). The return of the suppressed: Exploring how emotional suppression reappears as violence and pain among male and female prisoners. *Punishment & Society, 0*(0), 1462474518805071. doi:10.1177/1462474518805071

Liebenberg, L., & Moore, J. C. (2018). A Social Ecological Measure of Resilience for Adults: The RRC-ARM. *Social Indicators Research, 136*(1), 1-19. doi:10.1007/s11205-016-1523-y

Liebling, A., & Ludlow, A. (2016). Suicide, distress and the quality of prison life. *Handbook on prisons, 224*.

Maschi, T., Gibson, S., Zgoba, K. M., & Morgen, K. (2011). Trauma and life event stressors among young and older adult prisoners. *Journal of correctional health care : the*

official journal of the National Commission on Correctional Health Care, 17, 160-172. doi:10.1177/1078345810396682

Maschi, T., Viola, D., & Koskinen, L. (2015). Trauma, stress, and coping among older adults in prison: Towards a human rights and intergenerational family justice action agenda. *Traumatology, 21*(3), 188.

McIvor, G., & Burman, M. (2011). Understanding the drivers of female imprisonment in Scotland.

Messina, N., Grella, C., Burdon, W., & Prendergast, M. (2007). Childhood Adverse Events and Current Traumatic Distress:A Comparison of Men and Women Drug-Dependent Prisoners. *Criminal Justice and Behavior, 34*(11), 1385-1401. doi:10.1177/0093854807305150

QSR International Pty Ltd. (2012). NVivo Qualitative Data Analysis Software (Version Version 10).

Resilience Research Centre. (2016). *The Child and Youth Resilience Measure (CYRM) Manual. Appendix: Norming Data*. Retrieved from http://cyrm.resilienceresearch.org/

Rowe, A. (2011). Narratives of self and identity in women's prisons: Stigma and the struggle for self-definition in penal regimes. *Punishment & Society, 13*(5), 571-591. doi:10.1177/1462474511422151

Scottish Government. (2018). *Criminal proceedings in Scotland 2016-17*. Edinburgh: Scottish Government Retrieved from https://www.gov.scot/publications/criminal-proceedings-scotland-2016-17/.

Scottish Prison Service. (2018a). *16th Prisoner Survey 2017*. Edinburgh: Scottish Prison Service Retrieved from http://www.sps.gov.uk/Corporate/Publications/Publication-6101.aspx.

Scottish Prison Service. (2018b). SPS Prison Population. Retrieved from http://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx

Sykes, G. M. (1958). *The Society of Captives: A Study of a Maximum Security Prison* (Vol. 227): Princeton University Press.

Thomson, L. (2018). *Trauma is everyone's business*. Edinburgh: Barnardo's Retrieved from https://cycj.org.uk/wp-content/uploads/2018/08/Trauma-is-everyones-business-Barnardos-and-CYCJ-Paper.pdf.

Ungar, M., & Liebenberg, L. (2013). The Resilience Research Centre Adult Resilience Measure (RRC-ARM). *User's manual: Research*.

van Ginneken, E. F. J. C. (2016). Making Sense of Imprisonment:Narratives of Posttraumatic Growth Among Female Prisoners. *International Journal of Offender Therapy and Comparative Criminology, 60*(2), 208-227. doi:10.1177/0306624x14548531

Vaswani, N. (2014). The Ripples of Death: Exploring the Bereavement Experiences and Mental Health of Young Men in Custody. *The Howard Journal of Criminal Justice, 53*(4), 341-359. doi:10.1111/hojo.12064

Vaswani, N., Paul, S., & Papadodimitraki, Y. (2016). *Our Lives With Others: An Evaluation of Trauma, Bereavement and Loss Developments at HMYOI Polmont*. Retrieved from Glasgow: