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Trauma-Informed Practice Member Guidance

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Document History

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Contents

Executive Summary Trauma-Informed Practice Guidance

The full guidance can be accessed here.

Definitions (section 2):

'Trauma' is defined by the UK Trauma Council as *"the way that some distressing events are so extreme or intense that they overwhelm a person's ability to cope, resulting in lasting negative impact."*

The focus of the guidance relates to psychological trauma, and not trauma more generally considered as physical harm or injury.

The subjectivity of the term 'trauma', as well as the uniqueness of the way each individual experiences the world around them and construes their experiences within it, makes it important not to make assumptions about whether an individual has found an experience traumatic, or if so, how this has affected them.

A diagnosis of Post-Traumatic Stress Disorder (**PTSD**) is a proxy measure of whether somebody has experienced significant psychological trauma in their lives that impacts their functioning.

Complex PTSD (**CPTSD**) is a recognised diagnosis for individuals who have had multiple or prolonged traumatic experiences, and for whom the resulting clinical symptoms are more severe and pervasive.

Impact of trauma (section 3):

There are many ways in which traumatic experiences have been found to impact on individuals, clinically, psychologically and behaviourally, in the short, medium and long-term.

Trauma can increase the likelihood of developing harmful coping strategies such as substance misuse or self-harm.

Many variables can affect the way trauma influences the behaviour and psychological and physical health of individuals, including gender, age at onset of trauma, and other co-occurring stressors.

Potential impacts of trauma and trauma-related symptoms:

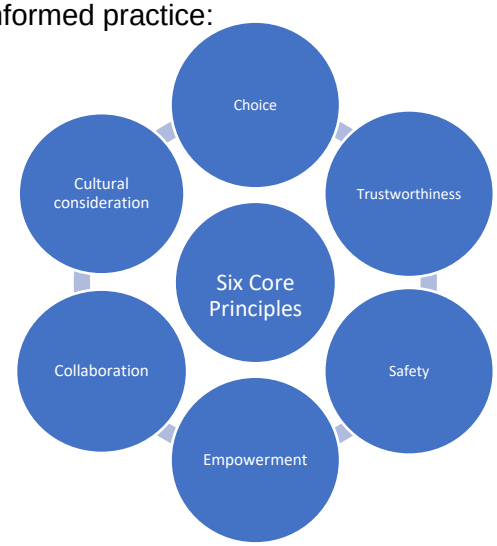
- Enduring heightened levels of anxiety and using extreme strategies to avoid perceived threats
- Impulsive or aggressive behaviour
- Health-related risk-taking behaviours
- Self-harming, harming others, physical health issues and retreating (isolating or disassociating themselves)
- Presenting as unemotional or uncaring as part of a defence mechanism
- High levels of co-occurring mental health or chronic health problems

Being trauma-informed and trauma-responsive (section 4):

Being 'trauma-informed' refers to understanding trauma and its impacts.

Being 'trauma-responsive' refers to organisations and services creating a positive environment with policies and practices that minimise the chance of re-traumatisation.

There are six principles of trauma-informed practice:



Trauma and prisoners

There is a high prevalence of traumatic adverse experiences in the lives of prisoners, and it is accepted that prison can be re/traumatising. Understanding the impact of trauma and '**triggers'** is particularly important in the justice system when prisoner's freedom is at stake.

A prisoner's history of trauma may result in:

- **Retreating**: isolating and disassociating themselves from others; this may lead to mental health problems, such as depression and anxiety.
- **Self-harming**: substance misuse, eating disorders and physical self-harm.
- **Harming others**: aggression, violence, rage or making threats.
- **Physical health issues**: diseases, autoimmune disorders, or the inability to maintain a healthy weight.

The goal of taking a trauma-informed approach is to undertake parole reviews where prisoners are not re-traumatised by the experience of engaging in the parole process.

This can be achieved by requiring only small changes to practice on the part of panels. This could have a significantly positive impact for the prisoner's experience of their parole review, ability to provide their best evidence at an oral hearing, and for procedural fairness of the review.

Advice for panels (sections 5):

This guidance informs panels about the rationale for adopting a ***trauma-informed and trauma-responsive approach*** and translates the six core principles of trauma-informed practice into advice for preparing for, and conducting, parole reviews.

There is also advice on preparing decisions which may be helpful at the MCA stage.

Key messages

- Whilst taking a trauma-informed approach, panels should not be deflected from securing the information needed in order to make a robust and fair assessment of risk.
- Panels will need to ask difficult and searching questions which may make the prisoner feel uncomfortable.
- How questions are phrased and presented may reduce the likelihood of triggering any trauma response.

Children in prison (section 6):

Children and young people in the Justice System have a disproportionate amount of trauma in their backgrounds and are more likely to have suffered adverse impacts from trauma or display problematic behaviour that is linked to their experiences of trauma.

Panels reviewing child cases must have completed the mandatory QVP training.

Women in prison (section 7):

Evidence suggests that half of the women in custody have experienced violence at home, with one in three women in custody having been sexually abused. PTSD is highly prevalent amongst women in custody, and they are more vulnerable to the impact of trauma.

Victims (section 8):

Whilst panels do not engage with victims in many cases, there are some where contact may take place; taking a trauma-informed approach may be beneficial. This section suggests advice for minimising re-traumatisation of these individuals.

Section 9 provides supplementary information which may be helpful background reading.

Members are reminded that they can access PAM assist should they need support after reading traumatic content.

1 Introduction

1.1 This guidance provides information about trauma-informed practice and offers advice to Parole Board panels on the benefits of conducting parole reviews in trauma-informed and responsive ways. The guidance also provides practical advice about how this can be achieved when conducting parole hearings.

1.2 Specifically, the guidance will:

- Provide a definition of relevant concepts and terminology.
- Assist panels in understanding the nature and prevalence of trauma and its impact on the lives of individuals who have experienced trauma.
- Present the rationale for being trauma-informed and taking a trauma-informed approach.
- Translate the principles of being trauma-informed and responsive into practical advice about how to conduct parole hearings with prisoners in trauma-informed and responsive ways.
- Offer information on women and children in prison.
- Offer information on supporting victims who have experienced trauma.

1.3 There is an additional section which provides supplementary information for panels to gain a wider appreciation of the impact of the custodial setting on prisoners.

2 Definition of trauma

2.1 The term 'trauma' as explained by the UK Trauma Council[1] is:

"Trauma refers to the way that some distressing events are so extreme or intense that they overwhelm a person's ability to cope, resulting in lasting negative impact."

2.2 The focus of this guidance relates to psychological trauma, and not trauma more generally considered as physical harm or injury.

2.3 The concepts implicit within a definition of trauma are subjective, which has contributed to there not being a universally accepted and agreed definition. What is experienced and interpreted as having been a significantly distressing event for one individual may be deemed less significant by someone else.

2.4 Additionally, the level and degree of psychological harm caused by seemingly similar traumatic experiences may differ depending on a range of factors, such as the individual's previous experiences of traumatic or adverse experiences, their gender, or their resilience and personal coping

[1] *The UK Trauma Council*

strategies. There is also a growing body of research on racism and trauma.

2.5 These factors are explored in more detail in published research.[2]

2.6 **The subjectivity of the term 'trauma', as well as the uniqueness of the way each individual experiences the world around them and construes their experiences within it, makes it important not to make assumptions about whether an individual has found an experience traumatic, or if so, how this has affected them.**

2.7 The subjectivity of the term trauma, as well as the sensitivity of it, can also make it difficult to accurately capture the prevalence of traumatic experiences by simply directly asking individuals whether they have experienced certain traumatic events in their lives.

2.8 Individuals may be unwilling or unable to disclose or may not have the language to describe their experiences. Some individuals may not have full awareness or clear memories of what happened to them, especially if it was in their early childhood or they have unconsciously repressed what has happened to them. The way traumatic events are processed in the brain means that they are often not stored as a cohesive, coherent memory, so individuals may not be able to recall the full detail.

2.9 Some individuals may not categorise what has happened to them as trauma or may feel the term is unhelpful. There can be stigma attached to trauma, therefore some individuals do not wish to define their experiences in this way. Labels can be unhelpful for some individuals.

2.10 It is also possible that asking somebody to disclose potentially sensitive or intimate experiences, that they are uncomfortable or ashamed about, may be upsetting or could have a negative impact, especially if there are no trauma services available to refer them on to following their disclosure.

2.11 Discussing such experiences can be triggering, which is where something causes an extreme reaction that relates to a traumatic experience. Triggers can be caused by:

- Visual images, noise, smells, colours, food, or weather associated with the trauma;
- Events similar to the trauma;
- Overwhelming emotions, such as feeling misunderstood, invalidated, helpless, confused, guilty or ashamed;

[2] *Published research:*
Adverse experiences: Kessler, et al (2017) Trauma and PTSD in the WHO Mental Health Surveys. European Journal of Psychotraumatology, 2017, Vol 8, 1353383.
Gender: Blanco, et al (2018) Towards understanding sex difference in the prevalence of Posttraumatic Stress Disorder: Results from the national epidemiological survey on alcohol and related conditions. Journal of Clinical Psychiatry, 79:2, March/April 2018.
Resilience: Nugent, et al (2014) Resilience after trauma: from surviving to thriving. European Journal of Psychotraumatology, 5:1, 25339.
Racism: UK Trauma Council - Racism, Mental Health and Trauma round-up

- Lack of boundaries, such as being touched without permission;
- Overstimulation, such as loud noises or lots of people;
- Dates or anniversaries of the trauma;
- Feeling unsafe or having no clear direction;
- Feeling vulnerable.

2.12 Unless an individual can be offered a support service or therapeutic intervention to help them address their trauma symptoms, asking them to disclose these experiences is likely to cause more damage.

2.13 The diagnosis of Post-Traumatic Stress Disorder (PTSD) is given when somebody has experienced significant psychological trauma that impacts their day-to-day functioning. Vicarious trauma, also known as secondary traumatic stress, occurs when a person is indirectly exposed to the trauma of another through hearing or seeing a first-hand account of it. This may happen when reviewing the cases of individuals who have committed very serious sexual, violent or terrorism-related crimes. **Members should be mindful of the potential impacts of coming into contact with this type of information.** Members can access the Parole Board's Employee Assistance Programme, who provide occupational health and wellbeing services, including various wellness informative sessions.[3]

2.14 An additional diagnosis of Complex PTSD (CPTSD) has recently been added to the European disease classification system.[4] CPTSD is diagnosed separately to PTSD in individuals who have had recurring or prolonged traumatic experiences. CPTSD may be caused by experiences such as:

- Childhood abuse or neglect;
- Domestic abuse;
- Sexual abuse;
- Torture;
- Sex trafficking;
- Slavery;
- War.

2.15 An individual is more likely to develop CPTSD if they experienced the trauma at a young age, were harmed by someone close to them or who they trusted, or where they were unable to escape the trauma. The symptoms of CPTSD are more severe and occur more pervasively.[5]

2.16 CPTSD and PTSD share the below clusters of symptoms:

- Re-experiencing the traumatic memory (flashbacks);
- Avoidance of things reminiscent of the traumatic event;
- Trouble remembering key factors of the trauma;

[3] *Wellbeing, Member Support: PAM Assist SharePoint Information*
[4] *Known as the eleventh version of the International Classification of Diseases – ICD-11, published by the World Health Organisation (2021).*
[5] *NHS Symptoms of complex PTSD*

- Negative mood, such as feeling guilt, anger, fear or shame, losing interest in activities, feeling socially isolated, blaming themselves or others, or having difficulty feeling positive emotions;
- Having a heightened state of alertness and increased sensitivity to perceived threats (hypervigilance), and having difficulty concentrating or sleeping.

2.17 CPTSD has additional clusters of symptoms, which can include:

- Emotional dysregulation;
- Relationship difficulties;
- Dissociation or depersonalisation;
- Suicidality.

2.18 Individuals with CPTSD are also more likely to experience 'emotional flashbacks' (different to flashbacks), where they feel the intense feelings that were originally felt during the trauma, such as fear, shame, sadness or despair. They may then react to events in the present as if they are causing these feelings, without realising that they are caused by a flashback. **Panels should be mindful that intense reactions such as this may be a trauma response to a trigger, and the prisoner may need a break from proceedings to collect themselves.**

2.19 CPTSD is often misdiagnosed as borderline personality disorder (BPD) or emotionally unstable personality disorder (EUPD), particularly in women, as not all professionals are aware of CPTSD. BPD and EUPD occur due to a combination of genetics and trauma, whereas CPTSD does not have a genetic element.

3 Impact of trauma

3.1 There are many ways in which traumatic experiences have been found to impact on individuals, clinically, psychologically and behaviourally, in the short, medium and long-term. There is also a substantial body of evidence that experiencing a traumatic incident is a strong predictor of a range of longer-term psychiatric difficulties.

3.2 Exposure to trauma can have a long-standing neurobiological impact, with individuals often becoming stuck in a fight, flight, fawn or freeze mode as a means of self-preservation.[6] They may see potential danger everywhere, including engaging with professionals.

3.3 Increased likelihood of chronic health problems such as heart disease and diabetes are common in those who experience trauma, as well physical symptoms such as stomach issues, dizziness, headaches and pain.[7]

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[6] Benedict, A. (2014) Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities. Retrieved from: https://www.bja.gov/Publications/NRCJIW-UsingTraumaInformedPractices.pdf

[7] Weissbecker, et al (2007) The impact of violence and abuse on women's physical health: Can trauma-informed treatment make a difference? Journal of Community Psychology, Vol. 35, No. 7, 909-923.

3.4 **Trauma can increase the likelihood of developing harmful coping strategies such as substance misuse[8] or self-harm.[9]**

3.5 Many variables can affect the way trauma influences the behaviour and psychological and physical health of individuals, including gender, age at onset of trauma, and other co-occurring stressors.

3.6 Additionally, different degrees of impact depend on the psychological resources, or protective factors available to the individual, including their self-esteem and the extent to which they hold positive attitudes and beliefs, and take positive actions; their spirituality; their resilience,[10,11] their past experiences, and support networks. Again, this is subjective and personal to the individual and it cannot be automatically assumed that a person will not be traumatised if they have protective factors in place.

4 Being trauma-informed and trauma-responsive

4.1 As with 'trauma', there is no single agreed definition of what a trauma-informed approach is, or what the terminology should be.

4.2 Dr Stephanie Covington,[12] an internationally recognised clinician specialising in trauma, distinguishes between services which are:

- Trauma specific (interventions designed to address trauma and the related symptoms);
- Trauma-informed (where staff are trained to understand about trauma and its impacts); and
- Trauma-responsive (where organisations and services have created a positive environment and have amended or implemented policies and practices to minimise the chance of re-traumatising service users).

Trauma-informed practice principles

4.3 There are six principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, empowerment, and cultural consideration. These are explained below, with some added context in relation to parole.

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[8] Felitti, et al (1998) Relationships 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 (4), 245-258.
[9] Milligan, et al (2005) Suicidal and self-harming behaviour in offender women: The role of shame, anger and childhood abuse. Legal and Criminological Psychology, 10, 13-25.
[10] Nugent, et al (2014) Resilience after trauma: from surviving to thriving. European Journal of Psychotraumatology, 5:1, 25339.
[11] Iacoviello, et al (2014) Psychosocial facets of resilience: implications for preventing posttrauma psychopathology, treating trauma survivors and enhancing community resilience. European Journal of Psychotraumatology, 5:1, 23970, DOI: 10.3402/ejpt.v5.23970
[12] Covington, S. (2018) Becoming Trauma-Informed. A Training Programme for Criminal Justice Professionals. Facilitator's Guide. UK Women's Edition. One Small Thing: London.

Safety

4.4 Creating an environment where individuals feel physically, psychologically, and emotionally secure. This includes measures to prevent re-traumatisation and the implementation of policies and practices that prioritise the well-being of both prisoners and staff.

4.5 Prisoners with histories of serious trauma can frequently feel physically and psychologically unsafe in situations that might *not* feel unsafe to people who have not experienced traumatic events. When a prisoner fears for their safety, they may have difficulties focusing on other things and might instead be preoccupied with seeking ways to feel safer and less fearful or anxious. They may associate feelings of anxiety or trepidation with feeling seriously unsafe (due to the way their brains have been changed as a result of their prior trauma), rather than nerves or worry that many would consider proportionate to the significance of their situation (for example, their parole hearing).

4.6 Responses to their anxiety or fear might therefore appear disproportionate to an observer and might involve having difficulty or refusing to enter the environment which they perceive as fear-inducing, as they perceive that their safety could be threatened if they do so.

4.7 If they begin to feel fearful when already in a room, environment or situation, they may make every effort to remove themselves or could attempt to enhance their sense of their own safety or protect themselves by making threats towards others to keep others away.

4.8 For prisoners, the parole process (and parole hearings specifically) can be anxiety inducing events. To maximise the extent to which prisoners can engage fully and positively in the parole process there may be a number of opportunities at different stages for alternative courses of action to be considered (see section five), to minimise the possibility that they might feel unsafe during the parole hearing, or in the build up to it.

Trustworthiness

4.9 Clear communication about actions and intentions, following through on commitments, and managing expectations realistically is critical. For example, it is paramount that prisoners are given clear and transparent reasons for any decisions that are made about the parole hearing.

4.10 Prisoners who have experienced trauma (especially those who were abused by care givers, loved ones, or others in positions of power or trust) may have come to expect relationships with others to be shrouded in secrecy and a sense of betrayal. Open and transparent communication is crucial to the development of trust, as is the manner in which communication occurs. Presenting with the right balance of professionalism, confidence, humanity, and humility can be reassuring to the prisoner, creating a sense of calmness and authority which can help

for them to feel psychologically contained, in what could otherwise be a stressful experience.

4.11 Prisoners may find it easier to build trust with others who can make them feel safe, reassured and with clear boundaries; providing structure, consistency and predictability when communicating can help to facilitate this. Prisoners can be very suspicious of 'the system', or aspects of it which they feel are either unclear, unfair, or both. Some prisoners may have prior experiences of the parole process and may feel 'let down' by it. Building trust with those who are already mistrustful of aspects of the prison system generally, or the Parole Board specifically, will undoubtedly be more difficult. However, it is important that such efforts are made by all those working with the prisoner in order that they can have the best chance of engaging effectively with their parole hearing.

Choice

4.12 Choice empowers individuals to make decisions about their own care and rehabilitation journey. Trauma-informed practice supports shared decision-making, ensuring that individuals have a voice in determining their goals and plans for recovery.

4.13 Prisoners who have been abused or have suffered other traumatic experiences may have felt that they were not in control of what happened to them, and that they had their choices taken away.

4.14 Additionally, imprisonment removes autonomy and further reduces the choices that individuals have over their day-to-day lives. Finding ways to enable them to feel as though they have some control and can make their own choices is often a powerful way for them to feel a sense of agency in situations which might otherwise be overwhelming or anxiety-provoking. Whilst there are many aspects of the parole process which they cannot control, identifying opportunities for individuals to choose how things will proceed can have a significant impact on their stress levels as their degree of control increases. Some examples are suggested in section five: arranging the hearing.

Collaboration

4.15 Trauma can involve abuses of power, and prison can also be experienced as disempowering. Creating opportunities for those in prison to collaborate in decisions made about them can enable them to feel that they have some power within the process, rather than feeling that it is 'being done to' them. This can be especially important if there are other consideration related to how a parole hearing will proceed for example, taking account of language barriers or other communication needs, style of questioning, etc.

4.16 Prisoners are more likely to contribute during a parole hearing, which increases the chance that it will be an effective means of panels directly engaging with them, if their communication needs are met.

Empowerment

4.17 This involves validating the prisoner and staff's feelings and concerns, supporting their autonomy, and fostering a sense of agency. Trauma-informed care aims to counteract feelings of powerlessness often experienced by individuals who have undergone trauma by empowering them to take control of their own lives.

4.18 Enabling prisoners to feel as though they have a voice and are being listened to and heard can be empowering for them. Also, recognising and acknowledging skills and strengths that they may have can reinforce their rehabilitative successes and can contribute to them feeling more positive about their future.

Cultural consideration

4.19 Cultural consideration recognises and respects the diversity of experiences and backgrounds among prisoners. It involves moving past cultural stereotypes and biases and offering services and systems that the prisoner engages with that are responsive to individual needs.

Trauma and prisoners

4.20 There is a high prevalence of trauma in the lives of prisoners, and HMPPS professionals are developing a clearer understanding about the ways in which coming into custody and living in prison can also be traumatic. It can be particularly triggering and retraumatising for those prisoners whom imprisonment has specific similarities with, or reminders of, their prior traumatic experiences.

4.21 Understanding the impact of trauma and its triggers is particularly important in the justice system when prisoner's freedom is at stake. The following behaviours may be exhibited by a prisoner who has experienced trauma:

- **Retreating**: isolating and disassociating themselves from others; this may lead to mental health problems, such as depression and anxiety.
- **Self-harming**: substance misuse, eating disorders and physical self-harm.
- **Harming others**: aggression, violence, rage or making threats.
- **Physical health issues**: diseases, autoimmune disorders, or the inability to maintain a healthy weight.

4.22 These may be familiar behaviours to panels, and it is accepted that prisons can be (re)traumatising. Indeed, parole hearings themselves can be traumatising for some prisoners.

4.23 **The goal is to undertake parole reviews where prisoners are not re-traumatised by the experience of engaging in the parole process.**

4.24 Given that panels may not know whether a prisoner has experienced trauma or not, it has been suggested that **the starting point is to treat *all* prisoners as though they have potentially been traumatised (a universal approach),**[13] implementing systems and procedures which are designed not to re-traumatise them. Applying trauma-responsive principles to prisoners with no history of trauma would not be detrimental as they are underpinned by compassionate and collaborative ways of working, whereas the absence of trauma-responsive principles for those with histories of trauma (whether known about or not) can be harmful.

4.25 **Taking a trauma-informed approach with prisoners during their parole review is not the same as absolving them of their responsibilities as perpetrators of crimes (which is not within the role and function of the panel).** Taking a trauma-informed approach with prisoners involves understanding the ways in which past traumatic experiences may have contributed to shaping the person they are today, including their offending behaviour and their custodial behaviour.

4.26 There may be specific examples or suggestions in the dossier (for example in a psychology report or other assessment) about ways in which panels might take a trauma-responsive approach, in ways which are directly relevant to the prisoner's specific circumstances (for example, avoiding triggering topics). However, taking a **universal approach** would mean that all prisoners, irrespective of their prior trauma, would be supported to feel safe, to build trust, and to exercise choice and collaborate in the process, as well as being supported to feel empowered.

4.27 Being trauma-informed and responsive will maximise the chance that the prisoner will be able to engage with the hearing in a meaningful way. This should assist strengthening the confidence of panels in their decision making, as all reasonable steps will have been taken to support the prisoner to participate constructively and fairly throughout.

4.28 **The impact of the panel taking a trauma-informed approach is that ultimately it increases the fairness of the process and of the hearing for the prisoner. It does this by aiming to:**

- Minimise a prisoner's negative reactions during a parole hearing caused by the stress of the situation;
- Improve the extent to which a prisoner is able to give their best possible account of themselves at parole hearings; and
- Reduce the likelihood that a prisoner with a history of trauma is re-traumatised further by their experience of their parole review.

4.29 **This can be achieved by requiring only small changes to practice on the part of panels. This could have a significantly positive impact for the prisoner's experience of their parole review, ability to provide their best evidence at an oral hearing, and for procedural fairness of the review.**

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[13] Elliott, et al (2005) Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology, Vol 33, No. 4, 461-477.

5 Advice for panels

5.1 This section of the guidance offers practical advice about a range of ways in which parole reviews could be planned and organised, convened and heard, and then concluded and decisions communicated to prisoners in ways which apply the principles of trauma-informed and responsive practice.

5.2 **Depending on the specifics of the case, some of the following examples may only be appropriate, or possible for certain cases.** Some of them are already used by panels as good practice. This guidance does not claim to provide an exhaustive checklist of actions for every situation, rather it aims to provide helpful tips that panels might be able to incorporate into their practice, at the different stages of the parole process (before, during and after the hearing), which could be beneficial, in what is often a highly stressful situation.

Before the hearing

The Dossier prior to referral

5.3 Whilst the dossier is the responsibility of the Public Protection Casework Section (PPCS) and not the Parole Board, it will be helpful for panels to have an awareness of the following points.

5.4 Panels should not underestimate the impact on prisoners of receiving their parole dossier (or indeed, struggling to gain access to their dossier). The dossier contains a collection of potentially shame-inducing information about them, describing the worst aspects of their behaviour and their life experiences laid out in full in one place.

5.5 A recent study[14] suggested some negative impact of the dossier on a prisoner. The findings from this study suggest that allowing the prisoner an opportunity to offer their own narrative of themselves could lead to better engagement in their parole review. It may also help panels understand the prisoner's level of self-awareness, or their ability to reflect upon what has been written about them.

5.6 It is hoped that a member of prison staff who knows the prisoner will introduce the dossier and its contents in a way that will support the prisoner to read the contents and explain the different reports and sections. It is also hoped they are offered a follow up check-in appointment a few days after the dossier disclosure. **Prisoners with trauma histories will benefit significantly from having professional legal representation who will be able to explain clearly and carefully the content of the dossier and the parole process. Panels may wish to encourage the prison to assist an unrepresented prisoner with securing a legal representative.**

[14] *Read, B (2024) The parole dossier and its negative impacts on prisoner identity doi: 10.1177/17488958231222875*

5.7 There may also be additional anxieties where new and additional documents, reports, or information is received late and following the disclosure of the dossier. For example, it can leave prisoners wondering what else is coming or any other surprises.

Dealing with delays (deferrals and adjournments)

5.8 Whilst it is accepted that delays may be unavoidable, panels are reminded that delays to the parole process can have a detrimental effect on the prisoner's perceptions about, and engagement with, the parole process. The ideal approach is to avoid delays as much as possible.

5.9 **Providing a clear explanation and reasons for why there is a delay will help the prisoner understand and may assist them to better manage their feelings and reactions.** These strong emotional reactions may make them less willing to engage in the future as a means of self-preservation.

5.10 Delivering the message in an empathetic way may also help, for example, using phrases such as:

*"We appreciate that you have probably been counting down to today, and we have no alternative but to adjourn because…" (*explain as clearly as possible the reasons).

"*We appreciate that this is far from ideal, but you will have a fairer experience if we reconvene when…*" (insert clarification about circumstances will be different and better for them next time)."

5.11 Prisoners who struggle with paranoia or hypervigilance, whether fleeting or more entrenched, may interpret a delay as indicative of 'something else' or 'the system' being at play. Clear and timely communication, directly with the prisoner if possible (where the hearing is adjourned on the day) about the reasons for any delays might reduce the likelihood of this. This could also serve to reduce general anxiety for future hearings.

Arranging the hearing

5.12 Consider the location arranged for the hearing. It may be possible for the prison to identify a room which is more familiar to the prisoner, and in which they may feel safer and more relaxed during the process.

5.13 Some rooms may be triggering, for example if the room is also used to hold adjudications, which may be associated with punishment.

5.14 Whilst largely out of the control of panels, the room should be large enough that all attendees are able to sit comfortably and not encroach on others' personal space.

5.15 The panel chair, or the prisoner's representative, could suggest to the prison that the prisoner be allowed to view the room prior to the hearing to see how it is set up, or to familiarise themselves with the room layout

and doors. This could reduce anxieties and enable them to feel more in control of their emotions on the day of the hearing.

5.16 Whilst it may be obvious, seeking confirmation from the prison that basic logistics for the room such as good lighting, privacy, heating (hot/cold) and drinking water, as well as the arrangements to ensure the prisoner has any required medicine (it may be to assist with anxiety) and access to lunch should be made to avoid unnecessary anxiety. This is more pertinent now that the majority of hearings are remote, and these may not always be fully considered.

During the hearing

5.17 Panels could consider encouraging the prisoner and their representative (if they have one) to briefly enter the room to meet the panel members, prior to the formal beginning of the hearing. This may reduce any heightened anxiety about the process, enabling the hearing itself to run more smoothly. This can be achieved with both face to face and remote hearings.

5.18 Consider the set-up of the room so that the prisoner has easy access to one or more of the entrance doors. They may feel more aware of 'access points' if they are hypersensitive to their safety or perceived lack of safety, or if they have experienced trauma during which they were trapped and unable to escape (for example, some prisoners may be anxious if witnesses are sat behind them). Unfortunately, the set-up will be restricted by the practicalities of the room itself and the requirements of the prison staff to ensure security and safety matters are addressed.

5.19 Panels have much less influence or awareness on the way the prisoner is prepared and settled into the practicalities for a remote hearing on the day. Prisoners attending remote hearings may feel unsafe with the process due to their unfamiliarity with it (especially if it is their first parole hearing), or if the location of the room they are using is unfamiliar.

5.20 They may be on their own or may not have access to professionals who can provide responsive support, and it may be much harder for staff to identify the need for the prisoner to be supported or assisted.

5.21 At the outset, think about what could be done to help with settling the prisoner into the hearing, in order that they can relax and give a good account of themselves. Anxiety may present as 'jitteriness', hyperactivity, or outward hostility, rather than as timidity or nervousness, so be aware of the potential to misread body language or non-verbal cues. Some prisoners may feel more at ease by using stress objects, fidget toys etc as long as they are not overly distracting.

5.22 It may be helpful for a trusted member of staff (who is not a witness) to be in the room with the prisoner to provide support, though this will be reliant on prison availability and is not guaranteed.

5.23 Where a case has previously been adjourned, panels may need to bear in mind that the prisoner may already be feeling mistrustful which may result in additional anxiety.

5.24 Use of clear statements about the process can provide reassurance to prisoners who are feeling high levels of stress during an oral hearing. Such statements can help to reduce anxiety, for example:

"I am now going to explain how the hearing will happen, to give you a sense of the structure and the process that we will follow…."

5.25 Find ways to enable the prisoner to contribute to aspects of the process where possible, by giving them choices, for example:

- Checking that they feel comfortable with the room arrangements, where there is time and potential options.
- Checking that they are content with the proposed order of evidence taking and questioning.
- Set out the plans for taking breaks and ask them if they have any other needs that they may wish to build into the proceedings and try to accommodate their requests if possible; again, giving them a choice between a range of acceptable options will help to present boundaries for them which may help make their requests easier, as long as they are feasible and practical.

5.26 Ensuring the prisoner has an understanding of the process, by setting clear boundaries and providing clarity about the structure/format of the hearing, can enable them to feel more psychologically safe and relaxed.

5.27 In remote hearings, panels may find it difficult to pick up cues about how the prisoner is coping and whether a break should be offered. This makes it more important to explicitly offer breaks, for example panels could ask:

"Do you think you might benefit from a short break to take stock and process things, before we carry on?".

5.28 A helpful one-page remote hearing quick reference guide has been produced which may assist panels to check on how the prisoner is coping with the remote proceedings. The guide can be read here: *Remote Hearing Quick Reference Guide*

Questioning technique

5.29 The panel may need to draw on the Questioning Vulnerable Prisoners (QVP) mandatory training and use the skills acquired to ensure the best approach is taken when questioning prisoners with histories of trauma.

5.30 The approach advocated in the QVP training supports trauma-informed practice and should assist with providing the prisoner with the opportunity to give their best evidence in a safe and supportive environment.

5.31 The hearing may take longer, particularly if the best practice advice on questioning vulnerable prisoners is followed.

5.32 Adopting the twenty principles of questioning vulnerable people and children will greatly assist the preparation for the oral hearing. More information about each of the twenty principles can be read here:

The 20 Principles of Questioning A Guide to the Cross-Examination of Vulnerable People and Children

Shame and guilt

5.33 Some prisoners may have feelings of shame and guilt towards their offending. Shame can be separated from feelings of guilt; with shame focusing on the negative global view of the self, whereas guilt focuses on the behaviour. Shame and guilt linked to offending is discussed in more detail in the *Maintaining Innocence Guidance*.

5.34 Those experiencing guilt are more likely to seek to make amends, whereas those experiencing shame can withdraw socially, evade responsibility, and mismanage emotions such as anger and responsibility.[15]

5.35 Panels should be aware that the presence of shame relating to offending may trigger feelings of shame relating to previous traumas. Difficulty in expressing remorse or empathy may be a sign of shame. However, it is important to note that some people cognitively struggle to recognise, describe, or express emotions. This is particularly prevalent amongst neurodivergent individuals. For more information on prisoners who are neurodivergent, please see the *Neurodiversity Guidance*.

5.36 **Adopting trauma-responsive practices as standard may enable hearings to be more productive.**

5.37 Some prisoners may have undergone trauma therapy or counselling in which they have discussed past traumas. In these circumstances, panels should be mindful that these sessions remain confidential, and questioning should not probe areas discussed in these sessions. However, it may be appropriate for prisoners to be asked about their reflections on the therapy and how it has helped them.

5.38 **Panels should *not* avoid asking questions about key areas of risk they feel are essential in making a robust and fair decision. Any adaptations in approach need to be in relation to *how* the questions are asked.**

[15] *Tangney, J. P., Stuewig, J., Mashek, D., & Hastings, M. (2011). Assessing Jail Inmates' Proneness To Shame and Guilt: Feeling Bad About the Behavior or the Self? Criminal Justice and Behavior, 38(7), 710–734.*

After the Hearing

5.39 At the end of the hearing the panel should thank the prisoner for their contributions, acknowledging how anxiety provoking the experience will likely have been. This may reinforce the value of their involvement.

5.40 When drafting the decision, it may be helpful to avoid labels and terminology such as "offender"; "personality disordered"; "violent offender". Instead, refer to the prisoner as an individual or a person who has "engaged in X behaviour", or "committed Y crime". **This language is less punitive and pejorative, and more reflective of the belief that people are not defined by their crimes, and that they can change. However, this must be finely balanced to ensure the gravity of particular offending is not lost.**

5.41 In order to maximise the possibility of the decision being received positively, including encouraging statements about what has been achieved and what to focus on in the future might be helpful.

5.42 The decision represents the last contact between the panel and prisoner during their parole review. Using the decision as a means to communicate with the prisoner in a positive way can be an effective way to conclude the process.

5.43 Whilst bearing the above in mind, it will be important that the decision follows the *Decision-Making Framework* and takes account of the *Reasons Writing Guidance*.

6 Children in prison

6.1 There is evidence[16] that exposure to Adverse Childhood Experiences (ACEs) is associated with increased risk taking and harmful behaviour. This is thought to be because the effects of trauma can blunt children's development and lead them to develop unhelpful coping mechanisms, for example, responding to what is experienced as a threat by fighting.[17]

6.2 The prevalence of ACEs, PTSD and CPTSD among the male prisoner population has been found to be higher than among the general population with strong correlations identified between high ACEs and youth, prolific, and violent offending.[18] Studies specifically on young people in the justice system have found they have a disproportionate amount of trauma in their backgrounds, are more likely to have suffered adverse impacts from trauma and display problematic behaviour that is

[16] *Beyond Youth Custody: "Young offenders and trauma: experience and impact: a practitioner's guide".*
[17] *Archer, et al (2015). Healing the Hidden Hurts: Transforming Attachment and Trauma Theory into Effective Practice with Families, Children and Adults. In Google Books. Jessica Kingsley publishers.*
[18] *Ford et al., 2019; Facer-Irwin et al., 2021).*

linked to their experiences of trauma.[19] Consequently, it is all the more important for panels to adopt trauma-informed approaches for children.

6.3 Experience of trauma can also inhibit children from engaging with youth justice services. Children who have experienced trauma tend to distrust strangers[20] and may lack the self-efficacy and regulation needed to engage with interventions aimed at promoting desistance and dealing with the consequences of their behaviour.[21]

6.4 Further, there is evidence that involvement with the criminal justice system can also in itself be re/traumatising.[22]

6.5 The development of trauma-informed practice among youth justice services sits alongside a number of other approaches, particularly taking a Child First[23] ABCD approach:

A*s children****:*** Prioritise the best interests of children and recognising their particular needs, capacities, rights and potential. All work is child-focused, developmentally informed, acknowledges structural barriers and meets responsibilities towards children.

B*uilding pro-social identity:* Promote children's individual strengths and capacities to develop their pro-social identity for sustainable desistance, leading to safer communities and fewer victims. All work is constructive and future-focused, built on supportive relationships that empower children to fulfil their potential and make positive contributions to society.

C*ollaborating with children:* Encourage children's active participation, engagement, and wider social inclusion. All work is a meaningful collaboration with children and their carers.

D*iverting from stigma:* Promote a childhood removed from the justice system, using pre-emptive prevention, diversion and minimal intervention. All work minimises criminogenic stigma from contact with the system.

6.6 A small number of youth Justice Services adopt an Adaptive Mentalization Based Integrative Treatment (AMBIT), a multi-modal approach to working with young people who experience complex needs across a range of areas.[24]

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[19] Liddle, et al (2016).
[20] Welfare, et al (2012) Involvement in extreme violence and violence-related trauma: A review with relevance to young people in custody, Legal and Criminological Psychology,
[21] Walter, et al (2010). The Role of Protective Self-cognitions in the Relationship Between Childhood Trauma and Later Resource Loss.
[22] Sweeney, et al (2018). A paradigm shift: relationships in trauma-informed mental health services. BJPsych Advances, 24(5), 319–333; McElvaney, et al (2016). A traumatised and traumatising system: Professionals' experiences in meeting the mental health needs of young people in the care and youth justice systems in Ireland. Children and Youth Services Review, 65, 62–69; Pemberton et al (2019): Trauma, Harm and Offending Behaviour: What works to address social injury and criminogenic need with criminal justice involved women?
[23] Youth Justice Resource Hub (2022) A guide to Child First.
[24] Hanson, R. F., et al. (2018) The APSAC Handbook on Child Maltreatment.

6.7 **Panels reviewing child cases should have completed the QVP training and should already be applying the 20 principles and thinking in terms of avoiding retraumatising the child.**

6.8 Panels are reminded that the prisoner before them may no longer be a child but may have been sentenced as a child and carrying the associated childhood trauma with them.

6.9 More information about children and parole can be read in the *Children Guidance*.

7 Women in prison

7.1 Women in custody constitute 4% of the total daily prison population for England and Wales, with 3570 individuals held in custody cross the 12 women's prisons in England as of 30 September 2023.[25] In 2007, Baroness Corston reported that half of the women in custody indicated that they had experienced violence at home, and one in three women in custody stated that they had been sexually abused.[26]

7.2 Gender differences have consistently been found in the nature and degree of psychological impact of trauma experiences, with women being more vulnerable to the negative impact of trauma than men.[27] Women's trauma is found to be more cumulative because it is a different, gendered trauma, and this is often overlooked. Examples of this are domestic abuse, sexual abuse, and ACEs experienced by women. Due to the gendered nature of trauma, it is important to empathise with, but avoid pathologising, women as vulnerable.

7.3 **PTSD is known to be prevalent amongst women in custody internationally[28] and in the UK.[29] There is a large body of evidence that women are more likely to meet criteria for PTSD following a trauma, and experience PTSD symptoms more severely than men, even when both genders were exposed to similar traumatic events.**[30]

7.4 A 2017 study[31] explored perceptions of men and women serving life sentences in prisons in England and Wales about their long sentences and the impacts of these. Women reported experiencing more severe emotional and psychological effects of long-term imprisonment than men. Women also reported feeling a lack of control over aspects of their daily lives and experienced a relative lack of power and autonomy within prison

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[25] Prison Reform Trust: Bromley Briefing February 2024
[26] The Corston Report: a review of women with particular vulnerabilities in the criminal justice system
[27] Blanco et al (2018).
[28] Baranyi et al., 2018; Goff et al., (2007).
[29] Bebbington et al (2017); Karatzias et al., (2018).
[30] Breslau, (2002); Brewin et al., (2000); Tolin & Foa, (2006).
[31] Crewe, et al (2017) The Gendered Pains of Life Imprisonment.

compared to that which existed in their lives before coming into custody. It was also found that feelings of powerlessness were associated with mental health difficulties and psychological distress amongst the female participants.

7.5 Given the evidence of traumatic experiences and the negative mental health and behaviours exhibited in this population, it is recognised that a systems-wide trauma-informed approach to care of women in prison is needed. HMPPS implemented '*Becoming Trauma-informed: Women in the Criminal Justice System*' staff training via *One Small Thing*. The training aims to equip staff with the knowledge and skills to work in more trauma-informed ways with the people in their care.

7.6 A recent study[32] on women in prison found that irrespective of their prior experiences of trauma, most participants in the study emphasised prison as stressful, intense and challenging, and described their imprisonment and experiences in custody as traumatising. These beliefs and experiences were expressed within four sub-themes:

- The stressful prison environment;
- The persistent sense of threat which imprisonment created;
- Punitive and unfair practices and procedures; and
- Uncertainty about how they were managed within the system.

7.7 The Female Offender Strategy for England and Wales[33] published in 2018 set out that:

"…training will be aimed at assessing and managing women with a range of complex needs, which will equip staff to work effectively with women in a trauma-informed way thereby maximising their compliance with their Community Orders and licences and reducing the risk of reoffending."

and

"…work collaboratively and capitalise on existing Government initiatives, such as the set of Principles on gender and trauma-informed care for mental health services for women currently being developed by the Department of Health and Social Care (DHSC) led Women's Mental Health Taskforce."

7.8 In its 2022-2025 delivery plan,[34] HMPPS reinforced the commitment to support a trauma-informed approach by building on initiatives of staff training, prisoner education and ensuring that services are trauma-responsive. Whilst these were developed for women in prison they are now being cascaded into the male estate.

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[32] *Kelman, et al (2024): How Does a History of Trauma Affect the Experience of Imprisonment for Individuals in Women's Prisons: A Qualitative Exploration.*
[33] https://www.gov.uk/government/publications/female-offender-strategy
[34] *Female Offender Strategy:* Delivery Plan 2022 to 2025

7.9 Separate guidance is currently being developed on women to provide more advice for members dealing with these cases.

8 Victims

8.1 Many victims feel excluded, marginalised and unimportant during the parole process which can be retraumatising. Panels may be able to limit this impact by ensuring that the Victim Liaison Officer (VLO) is notified of any delays and the reasons; taking the time to thank the victim for reading the VPS and acknowledging, if appropriate, that this is likely to have been a difficult experience for them; and taking full account of requested licence conditions.

8.2 It should be remembered that prisoners themselves may also be victims, particularly women, children and other vulnerable cohorts. Looking at the prisoner from both the perspective of offending and being a victim will help avoid any re-traumatisation.

8.3 Victims may present with any/all of the following:

- Their sense of safety, their feelings of control over their own body, and their self-esteem has been taken away through victimisation.
- They often blame themselves and perceive themselves as damaged or "bad".
- They feel helpless and out of control.
- They may see others as threats and shut down connection with others.
- They have difficulty regulating their emotional states and have physical symptoms as a result.

8.4 Victims who have been traumatised through offending may not react in the way that panels may expect. For example, some may have been repressing their experiences or dissociating from them to cope, and they may continue this coping behaviour. Some victims may be misunderstood as not experiencing trauma where they are not showing any signs.

8.5 Whilst panels do not engage closely with victims in many cases, there are situations where victims will come before the panel and care will be needed with regards to:

- Victims reading out their Victim Personal Statement to the panel;
- Victims attending as an observer; and
- Victims attending a public parole hearing.

8.6 In the above scenarios panels will have some level of engagement with victims and will need to take an approach that minimises additional trauma, retraumatising the victim or prompting the re-emergence or exacerbation of trauma symptoms.

8.7 It may be helpful for panels to ascertain what arrangements are being put in place by the VLO/HMPPS Victim Representative and seek assurances that these have been considered using a trauma-informed approach.

8.8 **However, it is important to recognise that not all victims accessing support from probation will have disclosed their experiences of trauma and victimisation prior to engaging with the service.**

8.9 Panels writing decision summaries should protect against providing statements that may be triggering or unhelpful. The advice set out in paragraphs 5.40 – 5.43 may be helpful with the emphasis shifted onto how the victim may interpret statements.

9 Supplementary information

9.1 It may be helpful for panels to have a wider understanding of trauma-informed practice, and this section sets out some additional information.

9.2 Panels should be mindful that much of this information is more relevant for practitioners working closely with prisoners and is therefore focused on the prisoner's wellbeing.

9.3 **Whilst this information is helpful, panels should not be deflected from securing the information needed in order to make a robust and fair assessment of risk. Panels will need to ask difficult and searching questions which may make the prisoner feel uncomfortable. How questions are phrased and presented may reduce the likelihood of triggering any trauma response.**

Trauma in a custodial setting

9.4 Although widely reported as being high, there is limited robust research evidence of the prevalence of prior exposure to traumatic events amongst prisoners. A systematic review was published[35] in 2018 which included 36 studies published between 1980 and 2017 reporting PTSD prevalence rates amongst prisoners.

9.5 The review found significant gender differences in the prevalence of PTSD amongst men and women in prison, as well as significantly higher rates amongst those in high income countries as compared to lower income countries. The lifetime prevalence of PTSD was significantly higher amongst women in custody. The estimates of lifetime prevalence of PTSD in prison populations from seven countries including the UK were 17.8% for men and 40.4% for women.

9.6 It should be noted that whilst a useful indicator, PTSD rates are likely to provide a substantial underestimate of the prevalence of traumatic experiences. This is because whilst some form of direct or indirect trauma exposure is necessary for a PTSD diagnosis, it is possible that some individuals who experience traumatic events do not go on to develop PTSD. Additionally, PTSD might be undiagnosed in some individuals as

[35] *Baranyi, et al (2018) Prevalence of Posttraumatic Stress Disorder in Prisoners. Epidemiological Reviews, 40: 134-145.*

there is significant symptom cross over with a number of other clinical conditions such as anxiety, depression, neurodevelopmental difficulties and personality disorder.

9.7 The use of the term trauma-informed care, and an appreciation of the need to train staff to understand about trauma and its impacts on service users gained traction in the criminal justice system from about 2014. A programme of training for staff working in women's prisons in England and Wales was implemented in HMPPS in 2015 which included HMPPS commissioning *The One Small Thing*[36] *"Becoming Trauma-Informed Initiative"* in both women's prisons and high security prisons.

9.8 Since then, services within and connected to the criminal justice system including prisons, probation, youth justice, mental health, and drug treatment services have sought to implement trauma-informed care due to the prevalence of traumatic experiences in the lives of both prisoners and those on licence. Whilst there is no formal HMPPS guidance for either prisons or probation, there is evidence of developing practice.

9.9 It has long been recognised that there are many ways in which the experiences of imprisonment, the prison environment, and prison regimes are all potentially damaging for anyone who is incarcerated.

9.10 The prison environment and staff responses can play a role in re-triggering prisoners who have experienced trauma, therefore exacerbating the trauma.

9.11 Additionally, prison settings can act as sites of new traumatic exposure, due to routine prison practices (such as pat-downs and room searches) which can increase trauma-related symptoms. Some of these symptoms may be impulsive or aggressive and be challenging to manage within a prison environment.

9.12 Trauma can be imported into prison through the diverse lived experiences of those entering custody. The diversity of imported trauma within the histories of prisoners is wide ranging.

9.13 Whilst some prisoners will be acutely aware of their lived experiences, and the way in which trauma impacts their lives, relationships and behaviour, there are many prisoners who are unable to articulate their experience(s) or recognise the subsequent impact. Additionally, there are prisoners who have experienced compounding and repeated trauma(s) throughout their lives, which may have resulted in tragic acceptance or complete disassociation.

9.14 In a recent study, trauma disclosed by women in prison was considered intense, distressing, and consistent as '*almost without exception, the women's life stories read as catalogues of suffering and abuse, including*

[36] *"One Small Thing" is a women's organisation set up by Lady Edwina Grosvenor, with a mission to redesign the justice system for women and their children:* https://onesmallthing.org.uk/

physical and sexual violence, intimate bereavement and drug and alcohol addiction'.[37]

9.15 This is also seen in many of the men's life histories. However, experiences of sexual violence, poly-victimisation and domestic violence were far less common in the lives of men, although this could also be down to the issue of men being less likely to disclose such issues. Alternatively, it has been acknowledged that men in prison "*have often experienced high levels of physical, sexual, emotional and structural victimisation, before, during and after their incarceration*".[38]

9.16 Some prisoners may have reached out for help before and been met with a retraumatising response, such as not being believed or being ridiculed or blamed for their experience. As a result, they may refuse to share their stories again and the consequence is unreported, unrecorded, unrecognised, and unsupported trauma importations within prisons.

9.17 Recent evidence[39] has found that individuals in prison with imported trauma are re-traumatised by the deprivations of imprisonment. This supports the position that the experience of being in prison and associated trauma can be overwhelming for prisoners navigating their way through their sentence.

9.18 It can also be the case that throughout their time in custody, prisoners are repeatedly asked to recall their history or undergo ongoing assessment which results in an emotional stunting so as not to be overwhelmed or repeatedly retraumatised. This can come across as the prisoner being unemotional or being perceived as uncaring when the response is a defence mechanism from the trauma.

9.19 In evidence given to the Justice Select Committee in 2022,[40] it was stated that the indefinite nature of the Imprisonment for Public Protection (IPP) and Detention for Public Protection (DPP) sentence has resulted in "*individuals who are severely traumatised and are mentally ill*".

9.20 When reviewing an IPP or DPP case, panels are advised to bear this in mind. Panels may wish to consider if/how that may have shaped the behaviour and outlook of the prisoner both in the custodial setting and whilst in the community on licence. To access more information on key concerns to consider when undertaking a parole review for IPP or DPP sentence prisoner please see the *Imprisonment for Public Protection (IPP/DPP) Sentences* SharePoint page.

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[37] Crewe, et al (2017) 'The Gendered Pains of Life Imprisonment', British Journal of Criminology, 57, pp. 1359-1378.
[38] Sloan Rainbow, J.A. (2018) 'Male Prisoners' vulnerabilities and the ideal victim concept', in Duggan, M. (ed) Revisiting the 'Ideal Victim': Developments in Critical Victimology, pp.263-279, Bristol: Policy Press.
[39] Kelman, et al (2024) How Does a History of Trauma Affect the Experience of Imprisonment for Individuals in Women's Prisons: A Qualitative Exploration. Women & Criminal Justice, Vol 34, No. 3, 171-191. DOI: 10.1080/08974454.2022.2071376
[40] Evidence given by Dr Dinesh Maganty, Consultant Forensic Psychiatrist to the JSC IPP

9.21 Where it may not be possible or practical to carry out trauma screening with each prisoner when arriving at prison, it is advocated that professionals take universal precautions. This means working from the starting point that every prisoner *might* have a history of one or more adverse traumatic experiences, which requires staff to consistently adopt trauma-informed practice principles with all prisoners. The assumption is that generally such approaches would substantially reduce the likelihood that a prisoner with a history of trauma could be triggered or re-traumatised. Moreover, prisoners who have not had adverse traumatic experiences in their lives will not be disadvantaged, rather they are likely to perceive such an approach as a broadly positive experience.

9.22 When HMPPS staff members understand the connections between past adverse trauma and current behaviour, it will likely help custodial settings become safer, staff jobs become easier and less challenging, and rehabilitative pathway planning being more effective.

9.23 There are several publications that may provide additional reading in how trauma-informed practice is developing within HMPPS:

- Prison Service Journal: *Special edition: trauma and psychotherapy in prisons* (July 2021 No 255)
- HM Inspectorate of Probation: *Working with trauma in adult probation* (Research and Analysis Bulletin 2022/02) Dr Madeline Petrillo and Dr Alexandria Bradley
- HM Inspectorate of Probation: *Issues, Challenges and Opportunities for Trauma-Informed Practice* (Academic Insights 2023/10) Dr Sarah Senker, Dr Anne Eason, Dr Chris Pawson and Professor Kieran McCartan