Barriers to accessing psychological treatment for medium to high risk male young offenders

Katherine McGrath

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DClinPsy, Royal Holloway, University of London

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Acknowledgements

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List of Tables

List of Figures

Table of Contents

I. Executive Summary

Introduction

This thesis as a whole is exploring the barriers to accessing psychological treatment in prison. This first section will act as a comprehensive summary of the research and will briefly describe the content of the three main components of the thesis.

The UK prison population currently stands at around 84,255, of which 95% are male offenders (Ministry of Justice, 2018). Men who have been imprisoned have considerably higher rates of mental health problems, personality disorder and substance misuse than men who are not imprisoned. Services within prisons are commissioned to offer psychological treatments but these seem to be widely underutilized. Male prisoners appear reluctant to seek help or engage in psychological treatment whilst in prison.

Systematic Review

The second section of this thesis was a systematic review of the literature on the barriers to accessing psychological treatment in prison for male adult offenders, this is a relatively sparse area of research and this systematic review was the first to explore barriers for male adult offenders. The systematic review specified that all participants in included papers should be male adult offenders over the age of 18 with no upper age limit. All participants were currently detained in a prison, no research carried out within the community, parole, probation or secure mental health services was included as this review focused on prisons only. Due to the lack of research in the UK prison system, studies from other English speaking countries were

included. Only studies focusing on mental health or psychological treatment in prison were included. Studies that did not meet all of the inclusion criteria were excluded. Due to the lack of research in this field, both quantitative, qualitative and mixed methods papers were included and there was no limit on publication date.

Electronic searches identified 616 citations, which, once duplicates were removed, left 451 unique citations to be screened for inclusion. Their titles and abstracts were assessed for their relevance to the review, resulting in 26 potential citations being retained. The full-texts of these papers were obtained. After applying the inclusion and exclusion criteria to the remaining 26 full-text papers, 21 citations were excluded and 5 papers were included in the final narrative systematic review. There was a high level of heterogeneity in the included studies in terms of design and outcome measures, this meant a meta-analysis was not appropriate.

No research was found which had focused on the young offender population, the average age of the participants in the included studies was 35.15 years. The Mixed Methods Appraisal Tool (MMAT) was used to quality assess the five included studies. The quality of these five included studies ranged from ‘average’ to ‘very good’. After combining the findings, a preliminary model was created to illustrate the barriers to accessing psychological treatment in prison for male adult offenders. This model highlighted four common barriers, these were: Stigma (concerns about what others might think, fears of appearing weak), Distrust (commonly directed towards ‘the system’, concerns about confidentiality), Personal Factors

(preference for self-reliance, preference for alternative sources of help) and Environmental Factors (unsure what treatments are on offer, having to wait a long time to receive help).

Empirical Study

The third section is an empirical study into the barriers to accessing psychological treatment in prison for medium to high risk male young offenders (aged 18-21). This study was aiming to address the vast gaps in the forensic literature highlighted in the systematic review. Previous research has largely focused on adult offenders, been carried out in America and adopted a qualitative methodology with small sample sizes. The present study adopted a quantitative methodology, recruited a larger sample size, recruited from a UK prison, focused on high risk young offenders and explored the impact of treatment stigma and psychological distress as well as pathological personality traits.

Young offenders are an under-researched population. They have higher rates of personality disorder, mood disorder and suicide compared to adult offenders, they are also more violent, more impulsive and more likely to re-offend than adult offenders. This population are at high risk of harm towards themselves and others and it is important to understand what barriers may be preventing access to evidence based psychological treatment and rehabilitation. Due to the vast differences between young offenders and adult offenders it is not possible to generalise previous results or assume the barriers that young offenders face will be the same.

The following hypotheses were investigated in this study:

1. BME young offenders not engaged in treatment will report significantly more barriers to accessing treatment than BME young offenders who are engaged in treatment.

2. BME young offenders will report significantly more barriers to accessing treatment than White young offenders.

3. BME young offenders will report significantly more treatment stigma related barriers than White young offenders.

4. Ethnicity, level of psychological distress, number of treatment barriers, number of stigma related barriers and pathological personality traits will act as significant predictors to engagement in treatment.

This study was a quantitative cross-sectional design, following a power calculation and a service user consultation on recruitment strategy, 128 participants were recruited from a young offenders prison. The majority, 70%, were high risk and 50% had committed violent offences. Equal numbers of BME and White and treatment and no treatment participants were recruited: 32 BME in treatment, 32 BME not in treatment, 32 White in treatment and 32 White not in treatment.

This study found that both BME young offenders not engaged in treatment and BME young offenders who are engaged in treatment reported equal levels of psychological distress, however the BME young offenders not engaged in treatment reported significantly more barriers, including more stigma related barriers, to accessing treatment, than the BME treatment

group. Amongst the White young offenders no differences were found between the treatment and no treatment groups. There were no significant differences between BME and White young offenders in the number of barriers reported, including stigma barriers. Higher scores on an antisocial personality screen meant there was a greater likelihood of an offender being in treatment and a higher number of self-reported barriers to accessing treatment meant they were less likely to be engaged in treatment. Ethnicity, psychological distress and stigma related barriers did not independently predict engagement in psychological treatment.

In this study internal beliefs and negative attitudes towards treatment seemed to be more problematic barriers than perceived stigma. Out of the top ten barriers reported none were stigma related, the average number of stigma barriers reported per participant was only three, out of ten possible stigma barriers. This contrasts with the findings from the systematic review which looked at adult offenders and suggested that stigma was a significant barrier to accessing treatment in adult prisons. However the top three barriers reported in the empirical study did clearly correspond with the other three components of the model developed following the systematic review, these were Distrust (lack of trust in the prison system which these services are based in), Personal Factors (wanting to solve the problem on my own) and Environmental Factors (having asked for help but having to wait a long time to receive it). Future research is needed to explore the subgroup of BME young offenders who seem to face additional barriers and also explore other predictors to engaging in treatment whilst in prison.

This study is the first to empirically investigate barriers to accessing psychological treatment in prison for male young offenders. Whilst all research needs to be considered within its limitations, it is hoped that these novel findings, in addition to the recommended future research, will increase understanding of the barriers to accessing psychological treatment for young offenders in prison and lead the way for the development of interventions to facilitate access for this marginalised population

Integration, Impact and Dissemination

The fourth and final section is a reflective and critical appraisal of the research process. It considered how to integrate the findings from the systematic review and the empirical study and developed a new model illustrating the barriers to accessing treatment for male young offenders. Descriptions of the real world clinical impact of the research are given including on-going projects and interventions that have been developed based on the results of the empirical study. Some dissemination activities have already been carried out including service level presentations, presentations to service users and a national conference presentation. The systematic review and empirical study can stand alone as two separate journal articles which increases the impact of the research. These papers will be submitted to relevant journals in the field, aiming for an international high impact journal in the first instance, 'Criminal Justice and Behaviour'. Finally there is a reflective discussion regarding involvement of service users in the research process and also consideration of the ethical issues in conducting prison based research.

II. Systematic Review

What are the barriers to accessing psychological treatment for imprisoned male adult offenders?

Abstract

The male prison population is characterised by high rates of personality disorders, mood disorders, self-harm and suicide. Despite these high levels of need services offering psychological treatments in prison are widely underutilized. It is important to understand what barriers may be preventing access to evidence based treatments for this high risk population. This review aimed to gather data from a variety of empirical studies as to what barriers can prevent male prisoners from accessing psychological treatment whist in prison.

Three electronic databases were searched and the reference lists of papers included at stage two screening were also checked. To assess the quality of included studies the Mixed Methods Appraisal Tool was used.

This review identified five studies which met the inclusion criteria, the quality ranged from average to very high. The studies varied in terms of methodology, location and participant characteristics. Despite this heterogeneity four barriers to accessing psychological treatment in prison consistently arose, these were: distrust, stigma, personal factors and environmental factors.

The main findings of the included studies, the strengths and limitations of the published research and this review, future research directions and clinical implications were discussed. Based on the results of this review a preliminary model was created to illustrate the barriers to accessing psychological treatment for imprisoned male adult offenders**.**

Introduction

Within the UK the majority of the prison population consists of male offenders, the prison population as a whole is currently around 84,255 and 95% of these are male (Ministry of Justice, 2018). Men who have been imprisoned have considerably higher rates of mental health problems, personality disorder and substance misuse than men who are not imprisoned (Deane, Skogstad & Williams, 1999; Nesset-Berg et al. 2011). A large scale study carried out by the Office for National Statistics showed that over 90% of prisoners in England and Wales meet diagnostic criteria for one or more psychiatric disorders (Singleton et al. 1998). Self-harm and suicide rates are also significantly higher than the general population (Fazel et al. 2011). Since 2017, a quarter of the deaths in UK male prisons were classified as self-inflicted (Inquest, 2018).

The National Health Service (NHS) took over responsibility for mental health care in prisons in England and Wales in 2006 with the intention to provide prisoners with access to the same quality of service as community mental health teams (Cobb & Farrants, 2014). Mental Health In-reach Teams (MHIRT) provide prisoners with mental health problems access to psychologists, counsellors, nurses and psychiatrists, although provision and quality of care varies from prison to prison (Steel et al. 2007). These formal services are said to be valued amongst prisoners according to a report exploring mental health services in prison (Her Majesties Inspectorate of Prisons, 2007). However UK research has shown that services are widely underutilized. Male prisoners are reluctant to seek psychological help for

mental health problems, naming distrust and fear of a diagnosis as factors contributing to their reluctance. (Howerton et al. 2007). There seems to be a discrepancy between these high levels of need and actual service use. The mental health services offered are unlikely to be effective unless male prisoners seek out the help or accept it when offered.

This reluctance to use psychological services is reflected in other prisons around the world. Studies in New Zealand have reported that male prisoners are often averse to seeking any form of help for a mental health problem and that they are more reluctant to seek help for ‘’suicidal thoughts’’ than a ‘’personal-emotional problem’’ (Deane, Skogstad & Williams, 1999). New Zealand male prisoners identified fear of negative reactions and a lack of trust in prison psychologists as barriers to seeking help for suicidal thoughts (Skogstad, Deane & Spicer, 2005). Similar findings have been published in America where lack of trust in staff, stigma concerns, doubts about treatment efficacy and procedural concerns regarding referrals have been identified as barriers to accessing mental health treatment in prison (Morgan, Rozycki & Wilson, 2004; Morgan et al. 2007). One American study found that male offenders were more likely to remain untreated than female offenders despite presenting with equal levels of mental health need in terms of symptoms and equal scores on psychometrics measuring mood (Reinsmith-Meyer et al. 2014).

In Denmark, prisoners who report higher levels of psychological distress were more likely to seek help but their fear of treatment was also higher (Bulten, Nijman & van der Staak, 2009). This study supports Kushner

and Sher's (1989) approach-avoidance theory. This theory describes the decision to seek mental health treatment as a conflict between approach tendencies and avoidance tendencies. For example approach factors such as high levels of psychological distress and a desire to reduce this would increase the likelihood of help seeking. However at the same time avoidance factors, such as stigma and concerns about being seen as 'crazy' would discourage help-seeking. Kushner and Sher (1989) have found that levels of treatment fearfulness increases alongside psychological distress. This theory demonstrates how avoidance factors, or barriers, can impede access to psychological treatment even for people with high levels of distress (Vogel, Wester & Larson, 2007). It is possible that male prisoners face a dilemma in which, despite experiencing high levels of psychological distress, the thought of seeking treatment carries too many negative connotations in the prison environment.

Several models have been applied to help-seeking for mental health problems within community and clinical health samples. Ajzen's Theory of Planned Behaviour (1991) describes how intention to perform a behaviour is influenced by attitudes towards the behaviour, subjective norms and perceived behavioural control. This model has been used to show that attitudes can mediate intentions to seek psychological help amongst young adult men (Smith, Tran and Thompson 2008).

Within a prison population attitudes towards help-seeking are generally negative and it may be that these negative attitudes contribute to the low levels of help-seeking in prison populations. Skogstad, Deane and Spicer

(2006) examined whether adult prisoners intentions to seek help for a personal emotional problem can be predicted using variables from the Theory of Planned Behaviour (Azjen, 1991). They found that general attitudes to seeking professional psychological help did influence intentions to seek help. In addition, interpersonal factors such as social pressures and a lack of control over accessing help also affected prisoner's intentions to seek psychological help.

Another help-seeking model, The Health Belief Model, (Hochbaum et al. 1952) suggests that the decision to perform a behaviour is influenced by the perceived threat of the 'illness', it's severity and the perceived barriers and benefits of the behaviour itself (Gulliver, 2012). This model has been used to understand help-seeking behaviour for mental health problems in the community population (Henshaw & Freedman-Doan, 2009) but has not been applied to the prison population. There is a gap in the literature with regards to understanding help-seeking behaviour for mental health problems in prison.

The Theory of Reasoned Action predicts that behavioural intent is caused by our attitudes and our subjective norms (Fishbein & Azjen, 1977) and Anderson's Behavioural Model (1995) incorporates predisposing factors, enabling factors and level of need to explain health care service use. Both of these theories have also been applied to help seeking for mental health problems in the community (Goodwin & Anderson, 2002; Vorhees et al. 2006) but again have not been applied to the prison population. No single theory has been widely accepted within the literature. It is not possible to automatically assume that these existing models will apply to help-seeking within the prison

population where there are unique social and cultural variables which will influence psychological help-seeking and perceived barriers to accessing treatment.

The prison environment in and of itself is a challenging place to live, let alone seek help for a mental health problem or access psychological treatment. Overcrowding, lack of autonomy and the consistent threat of violence are all likely to exacerbate psychological distress amongst prisoners (Cobb & Farrants, 2014). These variables are not present to the same extent amongst the community samples used to develop the existing models and theories previously described. There is likely to be a conflict in male prisoners between seeking help for this distress and their need to conform to the social norms of the prison environment where masculinity, aggression and limited emotional expression are highly valued (Kupers, 2005). A fear of being seen as ‘’weak’’ is consistently described in the literature as a concern amongst male prisoners (Howeton et al. 2007; Morgan et al. 2007; Wainwright et al. 2016). Similar results have been found amongst juvenile offenders who describe fears of being seen as ‘’weak’’ and concerns about confidentiality as barriers to accessing care (Abram et al. 2008; Walsh et al. 2011).

The previous literature has described some common barriers such as distrust (Howerton et al. 2007; Skogstad, Deane & Spicer, 2005) and stigma concerns (Morgan et al. 2007). There are likely to be other barriers preventing access to mental health service in prison, identifying the full range of barriers would aid clinicians in developing interventions to increase access for this marginalised population. Vogel and Wester (2003) have found that avoidance

factors account for as much of the variance in help-seeking behaviour as approach factors do, yet there is currently little research specifically investigating avoidance factors (Vogel, Wester & Larson, 2007). It is as important to consider these avoidance factors, or barriers, as it is to consider approach factors, or facilitators. Further insight into these barriers may help to solve the discrepancy between high levels of psychological need but low treatment uptake amongst male prisoners. This systematic review was undertaken to increase our understanding of what barriers are preventing access to psychological treatments in prison.

To date there has been no published systematic review exploring the barriers to accessing psychological treatment for imprisoned male adult offenders. In fact, previous reviews in this area have often excluded studies with prisoners as participants (Gulliver, Griffiths & Christensen, 2010). This review aimed to investigate this gap in the literature and gathered data from a variety of empirical studies as to what barriers can prevent male prisoners from accessing psychological treatment whist in prison. Once the literature was systematically reviewed and quality assessed, this review summarised the most commonly arising barriers, or avoidance factors, and considered clinical implications and future research directions. In order to develop interventions to increase access to psychological treatment in prison it is necessary to first understand what is preventing access in the first place. Once the barriers to accessing treatment are more clearly understood, research can be developed to explore the facilitators to accessing treatment.

Methods

Inclusion and exclusion criteria

The inclusion criteria for the studies were:

1. All participants in included papers should be male adult offenders over the age of 18 with no upper age limit and sentenced or remand prisoners currently detained in a prison.
2. The study needs to be focusing specifically on mental health or psychological treatment in prison.
3. The study must contain reference to barriers to accessing treatment. Barriers were operationalised as: something that impedes, hinders or prevents access to treatment.
4. All measures of barriers, including self-report, interview and unvalidated measures, were included.
5. The study must be empirically based and not a review of the previous literature.
6. Due to the lack of research in this field, both quantitative, qualitative and mixed methods papers were included and there was no limit on publication date.
7. Due to the lack of research in the UK prison system, studies from other English speaking countries were included.

The exclusion criteria for the studies were:

1. Studies using female offenders. The majority of the UK prison population is made up of male offenders so it was felt appropriate to focus specifically on males.
2. Studies exploring primary care, physical healthcare or substance misuse treatments in prison were excluded.
3. Research carried out within the community, parole, probation or secure mental health services were excluded as this review is focused on prisons only.
4. If the study had no extractable data on barriers to accessing treatment it was excluded.

Search strategy

The following bibliographic databases were searched for relevant published and unpublished literature:

- PubMed
- PsychINFO
- Web of Science

An initial scoping search was carried out in September 2017 and the full searches were carried out between the 31st January and 28th February 2018. The reference lists of the included full text articles were also hand searched for further relevant literature.

Keywords were generated for each concept, based on typically used terminology in relevant literature as well as thesaurus based synonyms. The keywords included terms related to barriers (e.g. barriers, challenges,

obstacles, hurdles) accessing care (accessing, engaging), help seeking (help seeking, help-seeking, care seeking), psychological treatment (psychological treatment, mental health treatment, psychotherapy) and male offenders (e.g. male offenders, male prisoners, male inmates).

The following demonstrates the electronic search strategy used for PsychINFO, Boolean operators and truncations were used (The asterisk following the root term initiated the search for variations of the truncated term):

Barrier* OR Hurdle OR Obstacle OR Challenge OR Obstruct* OR refusal

AND

Access*ing OR Engag*ing OR Helpseek* OR Help-seek*OR Help Seeking Behaviour OR psychological treatment OR mental health treatment OR psychology service use OR mental health service use OR psychotherapy OR psychological counselling OR professional care OR professional help

AND

Male Offenders OR Male Inmate OR Male Prison*er OR Prison OR Jail OR Detained

Assessment of relevance for inclusion in the review

As recommended by PRISMA (Moher et al. 2009), the study selection process took place in two main stages. Firstly, after removing duplicates in the initial electronic database search, the reviewer screened all selected papers via their title and abstract. Studies that were not relevant to the current research question (barriers to accessing psychological treatment in prison for

male adult offenders) were excluded. Once this was completed stage two involved obtaining relevant full-text articles and reading them in full. The relevance of each study was assessed according to the inclusion criteria previously stated. Studies that did not meet the inclusion criteria were excluded. There was only one researcher reviewing the literature, they were not blind to the authors or journals.

Data Extraction Process

Data extracted from these final included studies consisted of: number of participants, participant's demographic characteristics, the location of the prison, the type of study design, primary outcome measure, secondary outcome measure if stated, and the results in terms of barriers reported.

Quality Assessment

In order to assess the methodological quality of the included studies The Mixed Methods Appraisal Tool (MMAT, Pluye et al. 2011) was used. The MMAT is a checklist that was developed to provide a quality appraisal tool for systematic reviews that include quantitative, qualitative and mixed methods studies. Unlike other tools, the MMAT specifically includes criteria for appraising mixed methods studies. Given the variety of studies potentially included in this review it was felt appropriate to find one efficient published tool that could appraise most types of empirical research (Crowe & Sheppard, 2011). The MMAT has been content validated for each domain and items were developed from the literature as well as consultations and workshops with experts (Pluye et al., 2009; Pace et al., 2012.) The MMAT checklist

includes two screening questions which are applied across all relevant studies. There are then 19 items to assess the quality of five different types of studies (qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies). An overall quality score is then generated for each included study. The tool was user-friendly and accompanied by comprehensive guidance which was useful for clarification in some sections. See Appendix 1 for The MMAT.

Results

Electronic searches identified 616 citations, which, once duplicates were removed, left 451 unique citations to be screened for inclusion, see Figure 1. Their titles and abstracts were assessed for their relevance to the review (Stage 1 screening), resulting in 26 potential citations being retained. The full-texts of these papers were obtained. After applying inclusion criteria to the remaining 26 full-text papers (Stage 2 selection), 21 citations were excluded, 7 were not specifically investigating barriers to accessing mental health treatment, for example investigating a new psychometric or attitudes or a theory instead, 5 studies had also included female offenders in the sample, 3 studies had also included participants under the age of 18, 2 were substance misuse and physical health focused rather than mental health, 2 were carried out in non-English speaking countries, 1 was a probation and parole study and 1 was focused specifically on ex-armed forces personnel. The bibliographic details of these excluded studies are listed in Appendix 2 alongside further details on reasons for exclusion. Following this screening

process, 5 citations were included in the final narrative systematic review, the full-text papers of these 5 citations were accessible electronically.

There was a high level of heterogeneity in the included study designs and a wide range of methodologies used, so a narrative synthesis was thought to be the most appropriate method for this review. A meta-analysis which compiles findings from quantitative studies or a meta-synthesis which compiles findings from qualitative studies were not appropriate due to a mix of quantitative, qualitative and mixed methods studies being included.

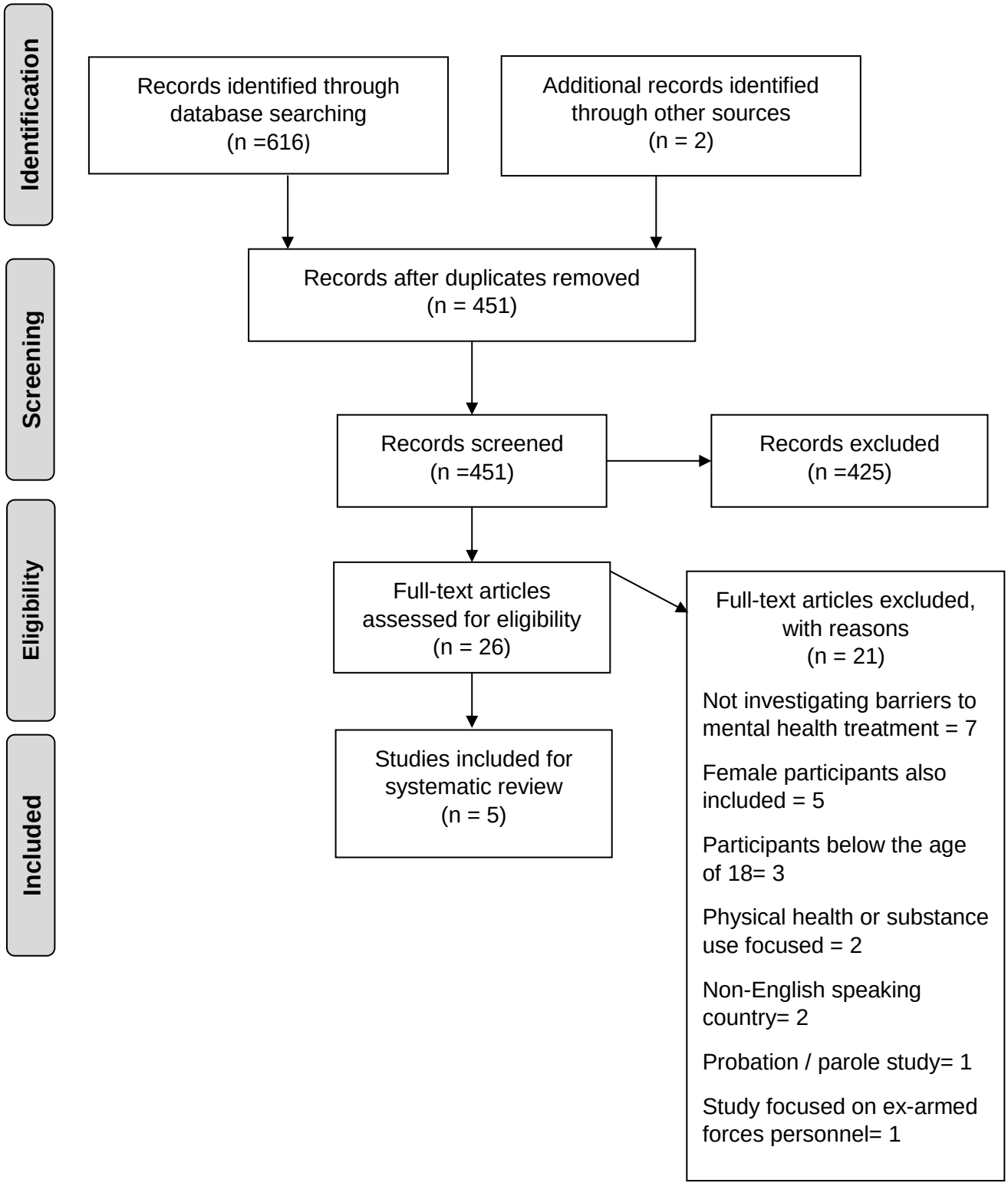

Figure 1. PRISMA flow diagram summarising the stages of selection of relevant papers for review

Summary of included studies

Please refer to Table 1 for details of included studies. Three of the studies took place in the USA, 1 in New Zealand and 1 in England. All of the studies were cross-sectional collecting the majority of data from prisoners at one point in time only but two did meet again with participants 4 weeks later to administer additional measures, they had retention rates of 54% and 80%. Sample sizes ranged from 12 to 418 participants. All of the studies used opportunity sampling and recruited from normal locations within adult male prisons, such as residential wings, work areas or educational classes. In 3 of the studies all prisoners were eligible to participate, in 1 study only prisoners scheduled for release were eligible to participate and in 1 study only participants reporting depression or sadness at intake were eligible to participate. Response rates amongst the prisoners approached by researchers ranged from 47% to 100%.

Sentence lengths of participants ranged from 1 month to 57.6 months and participants were convicted for a variety of violent, sexual, property and drug offences. In 1 study 97% of the participants were from a White ethnic group, in another study 100% of the participants were from a Black ethnic group and in the other 3 studies the participants were more evenly mixed between White, 46 to 47% and Minority ethnic, 50 to 53%.

Two studies used a qualitative approach and collected data via semi-structured interviews and analysed the data using grounded theory. Two studies used a quantitative approach and collected data via a newly designed unvalidated two page survey. One study used mixed methods and used both

a semi-structured interview and content analysis and then three existing quantitative measures with proven validity and reliability.

Table 1. Summary of data from included studies

Authors	Year	Location of study	Methodology	No. Participants	Mean age of Participants	Ethnicity of Participants	Barriers to accessing psychological treatment reported	MMAT Overall Score
Durrah	2013	Medium Security State Correctional Facility, Wisconsin, USA	Cross-sectional Qualitative. Grounded Theory. Semi-structured interviews.	12 imprisoned adult male offenders	25.3 years	100% African American	Identified four barriers: 1. Alternative coping styles (isolation, spirituality, and journaling). 2. Distrust and fear about mental health treatment and staff. 3. Unfamiliarity with the process of accessing mental health treatment 4. Past negative experiences of others when attempting to access mental health treatment.	Excellent ****

Authors	Year	Location of study	Methodology	No. Participants	Mean age of Participants	Ethnicity of Participants	Barriers to accessing psychological treatment reported	MMAT Overall Score
Howerton et al.	2007	Category B Local Prison, Southern England	Cross-sectional. Qualitative. Grounded Theory. Semi-structured interviews.	35 imprisoned adult male offenders	30 years	97% White British 3% BME	Identified three barriers: 1. Chaotic family background (drew connections between past experience of abuse and neglect and present inability to trust others). 2. Distrust (most common type was distrust towards the 'system' and healthcare professionals and a lack of confidence that they could help them). 3. Fear of a diagnosis of mental illness (feared being stigmatised because of this).	Good 75% ***

Authors	Year	Location of study	Methodology	No. Participants	Mean age of Participants	Ethnicity of Participants	Barriers to accessing psychological treatment reported	MMAT Overall Score
Morgan, Rozycki & Wilson (First study)	2004	Reception, Minimum & Maximum Security Correctional Facilities, Midwest USA	Cross- sectional Quantitative. Newly developed two page questionnaire. Responded via a 5-point Likert Scale regarding 15 potential barriers to accessing treatment	418 imprisoned adult male offenders	33 years	47% White, 31% Black, 7% Hispanic, 9% Asian, 6% Other	Newly incarcerated inmates reported the following 7 barriers: ''unsure how to access help'' ''length of treatment'' ''having to see a trainee'' ''being seen as weak'' ''being seen as snitch'' ''MH is for crazy people'' ''lack of confidentiality'' as being more influential in their decision to seek help than minimum or maximum security participants. Maximum security inmates were more concerned by ''information will be used against me by prison officials.”	Good 75% ***

Authors	Year	Location of study	Methodology	No. Participants	Mean age of Participants	Ethnicity of Participants	Barriers to accessing psychological treatment reported	MMAT Overall Score
Morgan, Steffan, Shaw & Wilson (Follow up study)	2007	Reception, Minimum & Maximum Security Correctional Facilities, Midwest USA	Cross-sectional Quantitative. Newly developed two page questionnaire. Responded via a 5-point Likert Scale regarding 15 potential barriers.	418 imprisoned adult male offenders	32.96 years	47% White, 31% Black, 7% Hispanic, 9% Asian, 6% Other	Identified four types of barriers: 1. Self-preservation concerns (confidentiality, appearing weak); 2.Procedural concerns (lack of knowing how, when, where to access services); 3. Self-Reliance (prefer to rely on self or close other). 4. Professional service provider concerns (qualifications of staff, dissatisfaction with previous services)	Good 75% ***

Authors	Year	Location of study	Methodology	No. Participants	Mean age of Participants	Ethnicity of Participants	Barriers to accessing psychological treatment reported	MMAT Overall Score
Skogstad, Deane & Spicer	2005	Minimum & Medium Security Prison, Wellington, New Zealand	Cross-sectional Mixed Methods. Content Analysis. Semi-structured interviews. Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS, Fischer & Farina, 1995). Hopkins Symptom Checklist (HSCL-21, Green et al. 1988) Suicidal Ideation Questionnaire (SIQ, Reynolds, 1988)	52 imprisoned adult male offenders	34.5 years	35% Maori 46% White, 15% Pacific Islander	Four types of barriers when suicidal: 1. Suicidal state of mind 2.Concerns about others reactions or opinions 3.Distrust of others 4. Prison suicide management procedures Four types of barriers for a general emotional problem: 1. Concerns about what inmates / staff may think (e.g. I am crazy), 2. Confidentiality concerns (and psychologist breaching these), 3. Systemic concerns (slow progress through system, increase security rating) 4.Organisational barriers (long waiting lists, relying on prison officers to refer)	Average 50% **

Summary of findings

Durrah (2013)

This qualitative thesis study was focused on exploring the factors that influence African American male inmate's decisions to seek mental health treatment whilst imprisoned. In order to investigate this the researcher conducted a grounded theory study of 12 African American male prisoners who were reporting depressive symptoms at intake. The core theme that emerged from this study was ''barriers to seeking mental health treatment whilst incarcerated''. Barriers identified included: Alternative Coping Styles, endorsed as a barrier by nine participants, where they preferred to self-isolate or seek spiritual or religious guidance rather than professional mental health services. Lack of Trust and Fear about mental health treatment was endorsed as a barrier by eight participants who described feeling that staff do not really care. Unfamiliarity with the process for accessing mental health treatment was endorsed as a barrier by five participants who felt that they did not understand the referral process or what would happen following assessment. Negative perceptions and beliefs of others was reported as a barrier by three participants who described concerns based on negative reports from other inmates who had accessed treatment. Participants also identified five factors that would increase their engagement with psychological treatment, these were: increased severity of emotional distress, increased availability of mental health individual and group programs, follow ups with prisoners who expressed depressive symptoms at intake, fostering trust between inmates and staff and increased length of sentence.

Howerton et al. (2007)

This qualitative study wanted to learn more about the barriers that can influence help-seeking behaviour among male offenders, 35 in-depth face to face interviews were carried out with imprisoned male offenders from a local Category B prison. They identified three interrelated themes as factors that can inhibit help-seeking for a mental health problem. These were: Chaotic Family Background (drawing connections between their past experiences of neglect and abuse and their present inability to trust others); Distrust (most commonly directed towards ‘’the system’’ and healthcare professionals, based upon negative past experiences and beliefs that professionals don’t really care); Fear of Diagnosis (fear of a mental health diagnosis and resulting stigma from family and friends as well as a personal reluctance to accept a diagnosis). Lack of trust emerged as the most prominent theme in the prisoners discourse about seeking professional psychological help, this was defined following thematic analysis of the transcribed interviews. Participants described factors that would promote help-seeking, these were: a previous positive relationship with a healthcare professional, being treated with respect in the past, attentive listening and being dealt with in a compassionate manner.

Morgan, Rozycki and Wilson (2004*)*

This quantitative study explored 418 male prisoner’s attitudes and perception of mental health services. The authors hypothesised that prisoners of differing security levels (reception, minimum, maximum) and differing ethnicities may describe different barriers to accessing psychological

treatment in prison. A two page survey was developed to assess previous experiences, attitudes and perceptions towards mental health services. The prisoners responded using a 5-point Likert scale to the questions regarding the barriers that would influence their decision to seek mental health services. The survey listed 15 possible barriers that might prevent them from seeking services.

The results indicated that the 15 barriers listed on the survey were not generally identified by prisoners as barriers that would heavily influence their decision with most prisoners scoring an average of '3-neutral' for most barriers. Across the entire sample, there were found to be no differences between ethnicities in the barriers described however there were differences identified between prisoners of differing security levels. Newly imprisoned reception prisoners identified the following barriers as being more influential in their decision to seek services than the minimum or maximum security prisoners: unsure how to access help, length of treatment, quality of services, being seen as weak, being seen as a 'snitch', mental health services are for crazy people, lack of confidentiality. Maximum security prisoners were more influenced than minimum security prisoners by concerns about the information presented in counselling sessions being used against them by prison officials. The prisoners in this study reported a preference for individual counselling and a preference for working with psychologists compared to other professionals.

Morgan, Steffan, Shaw and Wilson (2007)

This quantitative study aimed to expand on their previous study by further examining the barriers hindering 418 male prisoners' willingness to seek mental health treatment. Using the same newly designed two page survey, they gathered data about the potential problems for which prisoners would most likely seek mental health support and what barriers may hinder them from doing so.

Factor analysis indicated how various types of problems clustered, the authors then named five clusters of problems which may lead prisoners to seek mental health services. These were: Behavioural ''Dyscontrol'' (impulsivity, harmful behaviours); Negative Affect (depressed mood, sleep difficulties); Interpersonal Relationships (loss of personal relationships, problems with spouse or children); Institutional Relations (problems with staff or other prisoners); Physical Health Concerns (chronic pain, appetite changes).

The next Factor Analysis identified a four component solution of the barriers to accessing psychological treatment, this accounted for 66% of the variance. The first component identified was Self-Preservation Concerns (confidentiality, perceptions of weakness, fear of colluding with staff). The second component was Procedural Concerns (a lack of knowing how, when and why to access services and length of treatment). The third component related to Self-Reliance (preference to rely on self or close family and friends rather than professionals). The fourth component was Professional Service

Provider Concerns (queries about staff qualifications and dissatisfaction with previous mental health services).

Skogstad, Deane and Spicer (2005)

This mixed methods study was focused on exploring issues that can affect help-seeking amongst 52 male prison inmates, particularly help-seeking for suicidal thoughts. Using semi-structured interviews and content analysis the authors developed themes relating to potential barriers at baseline. Four weeks later, three standardised quantitative measures were used to examine attitudes towards help-seeking, general psychological distress and suicidal ideation.

In relation to seeking help from a prison-based psychologist for a personal-emotional problem, the participants named a range of concerns that could prevent them accessing treatment. These included Interpersonal Concerns (worries other prisoners or staff may view them in a negative way, worries other prisoners would see them as crazy); Personal Concerns (contact may increase their security rating, confidentiality concerns, fears of a negative psychological report); Organisational Concerns (low numbers of psychologists in prison, long waiting lists, complex referral procedures and inability to self-refer).

In relation to seeking help for suicidal thoughts participants described four specific types of barriers to accessing psychological support. These were: Suicidal state of mind (isolating self, depression, lack of motivation); Concerns about others' reactions or opinions (worries about being seen as ''attention

seeking’’, fear of being seen as a ‘’wuss’’, thinking others will not care); Lack of trust in others (thinking information could be used against them or passed on); Prison suicide management procedures (isolated in a safety cell, constant observation).

They found that prisoners were significantly more likely to seek help for a personal-emotional problem than for suicidal thoughts. Prisoners with more frequent thoughts about death and suicide were also significantly less likely to report that they would seek psychological help, suggesting that suicidal ideation can act as a substantial barrier to seeking psychological help in prison.

Quality Assessment

For each included study a descriptive summary using the MMAT criteria will be given as well as an overall quality score. As there are only a few criteria for each domain the overall score will be described according to how the much of the criteria they meet for each type of study:

- 100% = Excellent ****
- 75% = Good ***
- 50% = Average **
- 25% or less = Poor *

Qualitative Studies

Durrah (2013) met 100% of the MMAT checklist criteria for qualitative studies, see Table 2. This indicates that the study was of high quality. It was well written and easy to understand. Due to being a thesis study it included significantly more details on background literature, methodology and results than the other papers which were research articles. This level of detail meant that the reader could understand how to replicate the study in the future. Appropriate consideration to the context in which the research was carried out was given and there was also consideration given to the lead researcher and research team. The authors considered the researchers ethnicity, qualifications and other demographic variables and how this may have impacted on the results, for example the lead researcher was a 30 year old African American male who has family members currently imprisoned. Another strength of the study was that three out of the five members of the research team were responsible for analysing data and all three stages of coding which will have helped to reduce bias.

The participants were fairly representative of the target population in terms of index offence and sentence length and 100% of participants approached took part in the study. The authors justified why a qualitative grounded theory approach was used and given the lack of prior empirical research exploring mental health treatment amongst incarcerated African American adult men an exploratory qualitative approach seemed appropriate to gather rich and insightful data.

However the authors did not conduct follow up interviews with participants to allow them to clarify answers and they did not follow other recommended procedures for grounded theory studies such as sampling until saturation (Glaser & Strauss, 1967) which is a limitation of this study. It is also important to hold in mind that the small sample size (n=12) and homogenous participant group somewhat limits the generalisability of the results to the male prison population as a whole.

The study by Howerton et al. (2007) met 75% of the MMAT criteria indicating that the study was of good quality, see Table 2. Appropriate consideration of how the findings relate to the prison context was given. The selection of participants was clear and seemed appropriate to collect relevant and rich data in order to carry out a qualitative study, they also had a 100% response rate. Given the lack of research in this area the use of an exploratory grounded theory approach seemed appropriate. This study did improve on Durrah's (2013) methodology by carrying out more of the recommended procedures for grounded theory studies. Howerton et al. (2007) did sample until saturation and also conducted follow up interviews four weeks later to clarify responses.

A limitation of Howerton et al.'s (2007) study was that there was no consideration given to the researchers influence upon the results. Unlike Durrah (2013) there was no information provided on the characteristics of the researchers and how their interactions with participants may have influenced the findings. It was unclear who carried out and transcribed the interviews and who analysed the data thematically. Another limitation of this study is that the

sample were 97% White British offenders serving under one year in prison. This is not reflective of the UK prison population in which BME young men are overrepresented, this somewhat limits the generalisability of these results to the wider UK prison population.

Table 2. MMAT Appraisal Questions for Qualitative Studies

MMAT Appraisal Questions	**Durrah (2013)**	**Howerton et al. (2007)**
Are there clear qualitative research questions?	Yes	Yes
Do the collected data address the research question?	Yes	Yes
1.1 Are the sources of qualitative data relevant to address the research question?	p. 27 Yes	p. 303 Yes
1.2 Is the process for analysing qualitative data relevant to address the research question?	p.14 Yes	p. 304 Yes
1.3 Is appropriate consideration given to how the findings relate to the context, e.g, the setting, in which the data were collected?	p. 72 Yes	p. 305 Yes
1.4 Is appropriate consideration given to how findings relate to researcher's influence, e.g, through their interactions with participants?	p. 30 Yes	No
Overall score:	**100%******	**75% *****

Quantitative Studies

Morgan Rozycki and Wilson (2004) and the follow up study by Morgan, Steffan, Shaw and Wilson (2007) both scored 75% on the MMAT indicating the studies were of good quality, see Table 3. There were clear research questions and they collected appropriate data to answer these questions. The sample seemed representative of the USA prison population, in terms of age, ethnic mix, education level and index offence. Both studies had a good response rate of 70% and a good sample size of 418 participants. There was a possibility of selection bias in these studies. That is, the inmates that were approached and verbally agreed to take part in studies exploring perceptions of mental health services are also possibly more likely to be inmates who would engage in mental health treatment. It is possible that inmates who are less likely to engage in mental health treatment would also be less likely to take part in this type of research, somewhat limiting the conclusions that can be drawn. A significant flaw of both of these studies was that the main outcome measure used, a newly created two page survey, was an un-validated instrument. The authors did not explore the psychometric properties of this new measure which weakens the conclusions they can draw.

Table 3. MMAT Appraisal Questions for Quantitative Descriptive Studies

MMAT Appraisal Questions	**Morgan, Rozycki, Wilson (2004)**	**Morgan, Steffan, Shaw & Wilson (2007)**
Are there clear quantitative research questions?	Yes	Yes
Do the collected data address the research question?	Yes	Yes
4.1 Is the sampling strategy relevant to address the quantitative research question?	Yes p.391	Yes p.1182
4.2 Is the sample representative of the population understudy?	Yes p.391	Yes p.1182
4.3 Are the measurements appropriate? (clear origin, or validity known, or standardised instrument?)	No	No
4.4 Is there an acceptable response rate? (60% of above?)	70% Yes p.390	70% Yes p. 1182
Overall score:	**75% *****	**75%*****

Mixed Methods

The final included study by Skogstad, Deane & Spicer (2005) adopted a mixed methods approach. This study received the lowest MMAT score of 50%, indicating it is of average quality, see Table 4. The study was limited in that there was no consideration of the researchers influence upon the qualitative semi-structured interviews and there were no formal reliability checks carried out in the content analysis. However the semi-structured interview was good in that it was grounded in psychological theory and the items related to Azjen's (1991) Theory of Planned Behaviour. The overall response rate was only 47% and the relatively small number of participants (n=52) were unrepresentative of the New Zealand prison population with only 36% being convicted of violent offences compared to 60% of the New Zealand prison population as a whole. These limitations lowered the overall MMAT score for this study. However the quantitative component of this study was stronger than the previous quantitative studies described. The authors used standardised, well known measures, The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS, Fischer & Farina, 1995), The Hopkins Symptom Checklist (HSCL-21, Green et al. 1988) and The Suicidal Ideation Questionnaire (SIQ, Reynolds, 1988). They reported upon the previous internal consistency and validity for each measure. They also reported the Cronbach alpha and test re-test reliability scores specifically for this study which ranged from satisfactory to good.

Table 4. MMAT Appraisal Questions for Mixed Methods Studies

MMAT Appraisal Questions	**Skogstad, Deane & Spicer (2005)**
Are there clear research questions?	Yes
Do the collected data address the research question?	Yes
1.1 Are the sources of qualitative data relevant to address the research question?	Yes p.5
1.2 Is the process for analysing qualitative data relevant to address the research question?	Yes. p.6
1.3 Is appropriate consideration given to how the findings relate to the context, e.g, the setting, in which the data were collected?	Yes p.17
1.4 Is appropriate consideration given to how findings relate to researcher's influence, e.g, through their interactions with participants?	No
4.1 Is the sampling strategy relevant to address the quantitative research question?	Yes p.5
4.2 Is the sample representative of the population understudy?	No p.5
4.3 Are the measurements appropriate? (clear origin, or validity known, or standardised instrument?)	Yes p.7
4.4 Is there an acceptable response rate? (60% of above?)	No 47%
5.1 Is the mixed methods research design relevant to address the qualitative and quantitative research questions?	Yes p.5
5.2 Is the integration of qualitative and quantitative data relevant to address the research question?	Yes p.5
5.3 Is appropriate consideration given to the limitations associated with this integration?	Yes p.20
Overall Score	**50% ****

Discussion

This systematic review has investigated the barriers to accessing psychological treatment in prison for male adult offenders. Given the lack of previous research in this area all types of empirical prison based research using male adult offenders were included, the focus was on research from English speaking countries.

Main Findings

The included studies described a range of common barriers to accessing psychological treatment whilst in prison, this review collated these and considered which barriers are important to consider for this population. These barriers included: Distrust: this was often directed at the prison 'system' itself as well as health care professionals and related to concerns about confidentiality and worries about information being used against them; Stigma: often relating to fears of appearing weak, worries about what friends and family might think and fears of a mental health diagnosis; Personal Factors: preference for self-reliance, preference for alternative treatments, believing mental health services are for 'crazy' people and Environmental Barriers: long waiting lists, difficult referral processes, unfamiliarity with services, not knowing where to get help. Based upon the evidence gathered in this systematic review a preliminary model has been developed to illustrate the barriers to accessing psychological treatment in prison for adult male offenders, see Figure 2.

The findings from this review fit with the previously published literature which has described distrust and stigma as having a negative impact upon seeking help for psychological problems in prison (Howerton et al. 2007; Williams, Skogstad & Deane, 2001) and personal and environmental factors also impacting upon access to psychological treatment (Morgan et al. 2007). Kushner and Sher's (1989) theory could also be applied to the findings, it is possible that as levels of treatment fearfulness and psychological distress increase the range of barriers to accessing treatment could also increase. Skogstad, Deane and Spicer's (2005) finding that the prisoners with more frequent thoughts about death and suicide were significantly less likely to seek psychological help, suggests that greater psychological distress and suicidal ideation can act as a barrier to seeking psychological help in prison. However previous literature has found that greater psychological distress can increase help-seeking in prison rather than hinder it (Diamond et al. 2008; Bulten, Nijman & van der Staak, 2009). It is not clear to what extent psychological distress acts as a barrier to seeking help, this inconsistency in the literature means psychological distress was not included as a variable in the model, Figure 2. However the other barriers that arose in this systematic review, Distrust, Stigma, Personal Factors and Environmental Factors do appear consistently in the literature and were included in the model.

It is important to note that due to the small number of heterogeneous studies included in this review some of the data included in this model were reported from risk level between group analyses in Morgan, Rozycki and Wilson, 2004 or only endorsed by a small percentage of the sample in Durrah (2013) so

these barriers need to be interpreted cautiously, these results will be indicated by an asterisk in Figure 2.

Although facilitators to engagement in treatment are also important to consider (Vogel & Wester 2003) they are not included in this preliminary model. This model is specifically focusing on barriers only, in line with the focus of this review and the data gathered from the literature. Future research could aim to add facilitators to engagement in treatment to this model.

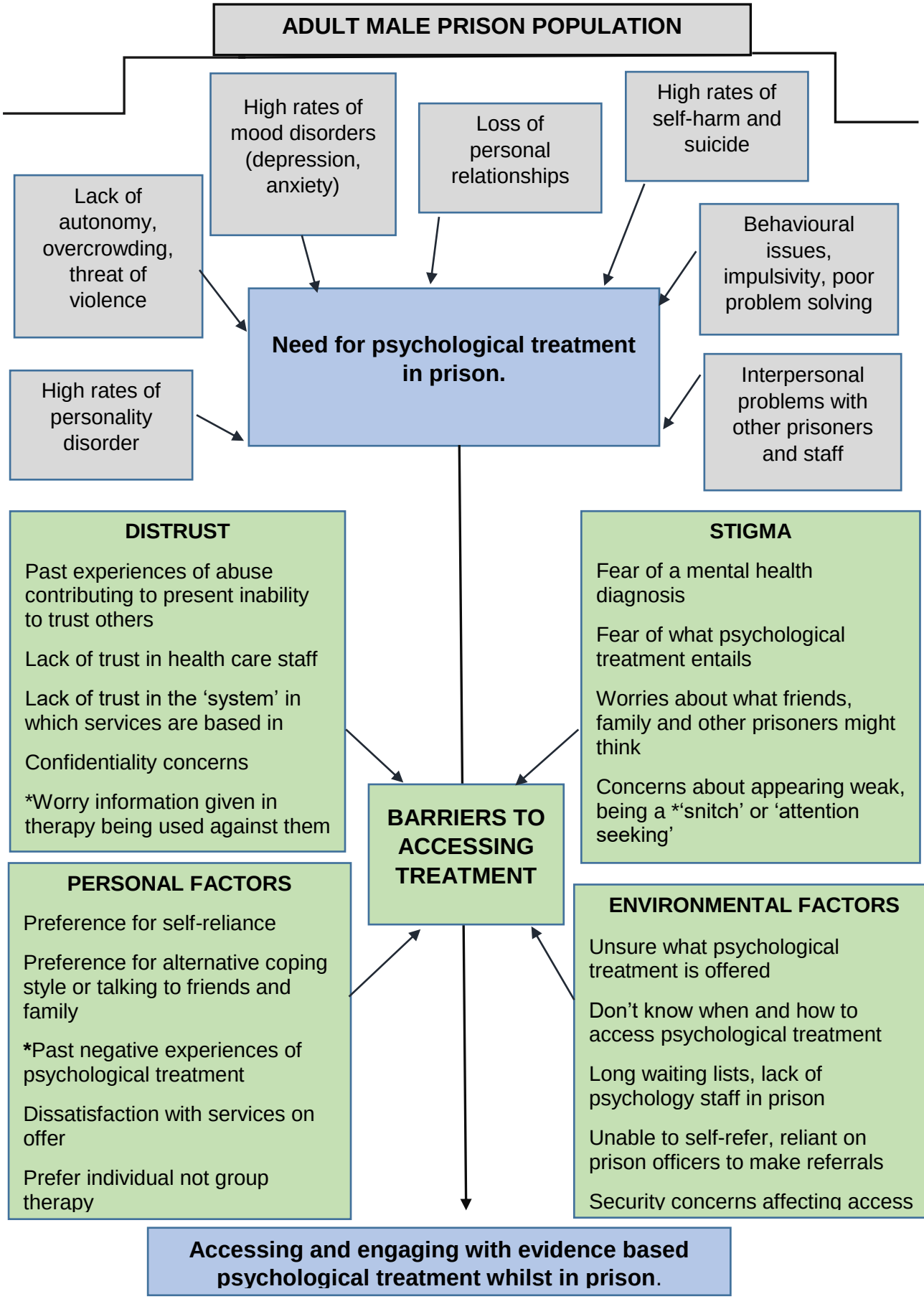

Figure 2. Model of barriers to accessing psychological treatment in prison for adult male offenders (* = barrier reported in subgroup or by small percentage of sample)

Overall the methodological quality of the included studies was good, the MMAT scores ranged from excellent (Durrah, 2013), to good, (Howerton et al. 2007; Morgan, Rozycki & Wilson, 2004; Morgan, Steffan, Shaw & Wilson, 2007) to average (Skogstad, Deane & Spicer, 2005). Despite some limitations none of the studies would be classed as poor quality. The findings were fairly consistent across all the studies, common barriers of distrust, stigma, personal factors and environmental factors arose despite the variation in participant characteristics, methodology, outcome measures and study location. The good quality of the included studies and the consistency of the findings, despite heterogeneity in methodologies, means that the preliminary model created as part of this review and the conclusions drawn should be relatively reliable and applicable across Western prisons containing adult male offenders.

The findings may not be applicable to prisons in non-English speaking countries or to young (aged 18-21) or juvenile (aged 10-18) offenders as all the participants in included studies were over the age of 18, with a mean age of 31.15 years. The findings also do not apply to female offenders as this review was focused on male offenders only.

Three of the studies were self-selecting and offenders who chose to participate in psychological research may have different characteristics and needs to offenders who decline to participate, this also limits the generalisability of the findings. The results from this review can only be applied to adult male offenders over the age of 18 who are detained in prison in a Western, English speaking country. All of the studies in the review were

cross-sectional, this design is limited in that it is capturing the views of a particular population at only one point in time. It is always possible that other confounding variables may have influenced the results, for example sentence length or history of mental health treatment.

Strengths and limitations of review

Application of the inclusion criteria to the results of the searches identified five papers for inclusion in this review, this is a relatively small number but was expected given the lack of empirical research in this area. The use of three electronic databases, the piloting of the search strategy and supplementing the final electronic search with hand searching reference lists of included papers allows reasonable confidence that all relevant research was included in this systematic review and the conclusions arising from this review are based on a synthesis of all the current available evidence in this field. Another strength of this review was the use of a quality appraisal tool to assess the included studies, this is a standardised measure which can be applied across quantitative, qualitative and mixed methods. The methodology and search terms used have been sufficiently described so that this review should be reproducible in the future.

It is also important to consider the limitations of this review. There was no second reviewer to assist with screening, selection, data extraction or quality assessment which means the results could have been biased by the single reviewer's interpretation, especially as they were not blind to the authors or journals. No non-English papers were included which may have limited the generalisability of the findings. It is also important to consider the

limitations of the MMAT tool, this is a tool that is still undergoing development and the authors advise it should be used with caution (Pluye et al. 2011) so this may have impacted upon the quality assessment section of this review. However the MMAT has been used worldwide for over 50 systematic reviews and early research has shown that the updated 2011 version is an efficient tool which has acceptable standards of validity and reliability (Souto et al., 2015)

There are limitations to the narrative synthesis used in this review, the reliability of this is only as good as the data available in the included studies. The included studies were of good quality however there were significant differences in study design and the measurements used, for example validated versus unvalidated quantitative measures and then qualitative interviews. There were also some samples which only focused on specific populations, for example all African American or all White British which does limit the generalisability. These differences mean that the results of this review and the resulting model needed to be tentatively interpreted. Future reviews of the literature and more empirical research is required to confidently understand the barriers to accessing psychological treatment in prison for adult male offenders.

Future research

In terms of future research directions, longitudinal research would help to clarify actual behaviour in terms of treatment seeking and engagement. Howerton et al (2007) followed up participants but only four weeks later to re-

administer interviews in line with best practice for grounded theory studies. Skogstad, Deane and Spicer (2005) also met again with participants four weeks later to administer additional quantitative measures. Future research should endeavour to follow up for a longer period of time. Six months is likely to be realistic given the amount of movement and change within the prison population (NOMS, 2015). This would allow greater clarity on how barriers to accessing treatment are perceived over time and also would allow comparisons between treatment and no treatment groups. Longitudinal research would also enable researchers to explore whether the impact of the four types of barriers in the model, Stigma, Distrust, Personal Factors, Environmental Factors, remain static or change over time, possibly as a consequence of receiving treatment. It would also allow for research to be developed which explores the predictive validity of the barriers identified.

Research which examines actual behaviour in terms of treatment engagement would also be an improvement as this would clarify the extent to which male adult offenders would seek help when faced with real life problems rather than hypothetical situations, for example in Morgan, Steffan, Shaw and Wilson's (2007) study, participants were asked about what problems they would seek help for in the future and what barriers could prevent them doing so. It may have been more useful to have asked what problems they have sought help for in the past, what hindered them accessing appropriate treatment and whether or not they were able to overcome the barriers to accessing treatment.

Environmental and institutional barriers to accessing treatment were often mentioned, for example having to rely on prison officers to make referrals for treatment (Skogstad, Deane & Spicer, 2005). Prison officers often act as the 'gate keepers' to services in terms of making referrals on behalf of offenders and facilitating movements around the prison to access services. Given their integral role in an offender's life it may be worth exploring the beliefs and attitudes of prison officers in relation to psychological treatment in prison. This type of study would indicate directions for training for this staff group.

As already noted, there was a distinct lack of research exploring this issue with male young offenders, aged 18-21. Given that young black minority ethnic males are overrepresented in the UK prison population future research should explore this issue with a young offender population.

Future research in this area should also endeavour to address the methodological limitations of the current published findings such as: using standardised outcome measures with reported validity and reliability, following correct protocols for grounded theory studies, considering how the findings relate to the researchers influence, achieving a higher response rate and recruiting a more ethnically representative sample. None of the studies reported power calculations, future research should calculate and report this to make sure the study is adequately powered.

As well as future research on barriers, more research is required to explore the facilitators which allow barriers to be overcome. It is more realistic

to develop ways to make services accessible despite the barriers which exist in the prison environment rather than removing the barriers altogether.

Clinical Implications

The results of this review indicates a number of clinical implications with regards to barriers to psychological treatment in prison. Interventions could be developed to target each of the four domains of the preliminary model. In order to target Distrust, services could conduct more outreach work on the prison wings to build rapport with prisoners and offer more transparency about what psychological treatment is on offer and what it involves, for example how long a particular intervention is. Once someone engages with a service, more time could be spent on building a sense of trust, safety and stability before beginning an intervention. In regards to the Personal Factors, psychoeducation, perhaps being peer led or co-produced with service users, could help create understanding about the benefits of psychological treatment and start to shift some of the negative attitudes and challenge the myths surrounding treatment.

Targeting Stigma could also involve developing campaigns within prisons to raise awareness of mental health issues, what treatments are offered and reduce stigma in the prison population. It may be more powerful for such a campaign to be peer led, for example current or ex-service users offering insights into how they overcame barriers to accessing treatment. Peer to peer support may help break down some of the stigma around being seen as ‘weak’ and help to challenge the culture of hyper-masculinity in male prisons. This type of intervention could follow similar strategies used in the

national ‘Time to Change’ campaign lead by mental health charity ‘Mind’. This campaign was empirically investigated and found to be effective in reducing stigma and improving public attitudes towards mental health in the community population (Henderson et al., 2016).

In order to overcome Environmental Factors, services could offer more information at prison receptions about how and when to access help. Staff training could help support prison officers in making referrals and spotting when someone on their wing is in need of psychological support. More importantly, psychological services within prisons could consider allowing self-referrals and make the self-referral process easier. Within the community, an evaluation of an Increasing Access to Psychological Therapy (IAPT) service in Newham, London showed that people who self-referred had high levels of psychological morbidity and were more ethnically representative of the area than GP referrals (Clark et al., 2009). This study suggests that introducing self-referrals can increase access for black and minority ethnic groups who may be reluctant to consult with their GP about mental health problems (Brown et al., 2010). Implementing a self-referral process similar to this in prisons could help to facilitate access by allowing male prisoners to bypass the prison officers, who are traditionally the ‘gate keepers’ to accessing psychological treatment.

Conclusions

This systematic review has explored the barriers to accessing psychological treatment for male adult offenders detained in prison. The findings of this review do need to be considered within its limitations, in

particular the lack of a second reviewer. Due to the lack of empirical research in this area the inclusion criteria was relatively broad however only five studies were included in the final review, reflecting the large gap in the literature. Despite the studies varying in terms of methodology and participant demographics four categories of barriers were identified, these were Distrust, Stigma, Personal Factors and Environmental Factors. Based upon the findings in this review a preliminary model was developed to tentatively illustrate the barriers to accessing treatment in prison for male adult offenders. This model could be used to start to guide clinical interventions to overcome these barriers and increase access for this marginalised population. Future research is needed to explore these barriers further, in particular for young adult offenders (aged 18-21) and black minority ethnic offenders, this would increase ecological validity as these groups are currently overrepresented in the UK prison population.

III. Empirical Study

Barriers to accessing psychological treatment for medium to high risk male young offenders detained in a UK prison

Abstract

Within the young offender population, rates of personality disorder and mood disorders are considerably higher than both the general and adult offender population. Despite this high level of need and high risk of harm psychological services within prisons are widely underutilized. No research to date has explored the barriers to accessing psychological treatment for male young offenders, aged 18-21, detained in a UK prison. This study was aiming to address this gap in the literature. It compared self-reported barriers and psychological distress levels for Black Minority Ethnic (BME) and White young offenders not accessing treatment as well as those who are. This study was a quantitative cross-sectional design, 128 participants were recruited in order to achieve a medium effect size. Service user consultation guided the recruitment strategy.

BME young offenders not engaged in treatment reported significantly more barriers, including more stigma related barriers, to accessing treatment than BME young offenders who were engaged in treatment, but both groups had equal levels of psychological distress. This result was not found among the White young offenders. There was no significant difference between BME and White young offenders in the number of barriers reported, including stigma barriers. Higher scores on an antisocial personality screen increased the likelihood of an offender being in treatment and a higher number of self-reported barriers to accessing treatment decreased the likelihood of an offender being in treatment.

While these findings need to be considered within their limitations, this study has addressed a number of gaps in the clinical forensic literature in terms of sample characteristics, recruitment location and methodology. Future research

should seek to explore the subgroup of BME young offenders who seem to face additional barriers as well as further predictors of engagement in treatment whilst in prison.

Introduction

Young Offender Population

In the young offender population prevalence rates for mental health problems are considerably higher than both the adult offender and general community population. Antisocial Personality Disorder is diagnosable in 81% of sentenced male young offenders compared to 46% of sentenced male adult offenders. Rates of depression and mood disorders are also troublingly high (Lader et al., 2000). Her Majesty's Prison & Probation Service (HMPPS) have noted that young offenders have higher attrition rates from accredited treatment programmes compared to adult offenders and that more research is required to explore the accessibility of these treatments for young offenders (NOMS, 2015).

In England and Wales, children who commit a criminal offence aged 10-17 are defined as juvenile offenders, from ages 18-21 they are classed as young offenders and over the age of 21 they are classed as adult offenders (NOMS, 2015). There are services within young offender and adult prisons offering a variety of psychological treatments but these seem to be widely underutilized by male offenders (Howerton et al., 2007). There is therefore a discrepancy between these high levels of need and actual service use.

Young offenders, particularly those from BME backgrounds, seem to face a number of barriers to accessing treatments whilst in prison, for example being less likely to be treated for personality disorder than White offenders (Coid et al.,

2002).The costs of not investigating and attempting to overcome these barriers are high. Young offenders have the highest reconviction rates of any group and 75% are reconvicted within two years of release from prison (Allen, 2013). Over the last five years 86% of the deaths amongst 18-24 year old detained young adult offenders were classified as ‘self-inflicted’. Self-inflicted deaths are defined as any death of a young prisoner who has apparently taken their own life irrespective of intent (Inquest, 2018). In order to start tackling these high rates of reconvictions and self-inflicted deaths in the young offender population we need a better understanding of what is preventing this population from accessing evidence based psychological treatments.

It has been argued that a lack of service use amongst young offenders means they simply do not want to receive help or treatment. However, a study which investigated coping strategies amongst 107 incarcerated young offenders has shown an overwhelming preference to use ‘approach type’ strategies such as seeking guidance from staff, rather than ‘avoidance type’ strategies to cope with stress (Mohino, Kirchner & Forns, 2004). The results of this study would suggest that young offenders do want to receive support whilst in prison and that low rates of treatment uptake are potentially due to barriers preventing them from accessing treatment, rather than a personal inclination to avoid such help.

The Chief Inspector of Prisons in the UK has acknowledged the lack of empirical research with the young offender population and states that research with the young offender prison population ‘’should be urgently undertaken’’ (Prison Reform Trust, 2012). Research is needed to explore the distinct needs of this vulnerable and marginalised population and find out what barriers are preventing some young offenders, particularly those from a BME background, from engaging

with evidence based psychological treatment whilst in prison. Within the community population there has been a vast amount of research exploring barriers to accessing treatment and this will be briefly considered here before moving onto a more detailed synthesis of the forensic literature.

Barriers to Accessing Psychological Treatment, Community Population

Stigma, embarrassment, preference for self-reliance and a lack of emotional competence have been found to act as barriers to help seeking for young adults in the community (Ciarrochi & Deane, 2001; Gulliver, Griffiths, & Christensen, 2010; Rickwood et al., 2005). Young men in particular are affected by these barriers, they are less likely to seek help than young females even when experiencing high levels of psychological distress (Biddle et al., 2004; Rickwood & Braithwaite, 1994.) Amongst people with existing mental health problems stigma acts as a strong deterrent to seeking help and engaging with treatment. (Corrigan, 2004). Stigma, distrust and imbalance in power have been identified as barriers to accessing mental health care within the community BME population (Hines-Martin et al., 2003; Memon et al., 2016; Mishra et al., 2008). It is clear from this literature that stigma is a common issue that can deter many groups from accessing psychological treatment in the community (Clement et al. 2015).

Due to the vast differences in physical environment and culture it is not possible to generalise results from these community studies to the forensic population. The prison environment encourages aggression and limited emotional expression where seeking help is viewed as a sign of weakness (Deane, Skogstad & Williams, 1999). Research has shown that some young offenders believe seeking help and support contradicts the prison social norms (Woodall, 2007).

These social norms and the culture of hyper-masculinity are likely to hinder access to psychological help and treatment whilst in prison (Kupers, 2005). In order to start considering the barriers to accessing treatment in prison it is necessary to explore research with forensic populations.

Barriers to Accessing Psychological Treatment, Adult Forensic Population

Adult offenders have been found to be significantly more likely to seek professional help for a mental health problem than young offenders, as offenders age their rates of help-seeking increase (Mitchell & Latchford, 2010; Nesset et al.,2011; Skogstad, Deane & Spicer, 2006). Reinsmith- Meyer et al. (2014) has found that amongst prisoners found to be in need of treatment as assessed by personality and mood measures, 18.5% did not participate in any formal treatments or services at all and this untreated group were disproportionately young and male. This reflects the community research which suggests young males in particular can face difficulties with accessing treatment.

Stigma has been found to act as a significant barrier to accessing psychological treatment amongst the adult offender population. Concerns about what other inmates may think and worries about being seen as ‘’weak’’ or a ‘’snitch’’ have been found to influence decisions to seek mental health care in prison, with newly incarcerated prisoners being particularly affected by social perceptions (Morgan, Rozycki & Wilson, 2004; Williams, Skogstad & Spicer, 2005) More stigma related fears have been found to reduce the likelihood of adult male offenders seeking psychological help (Williams, Skogstad & Deane, 2001). As with the community research it appears that stigma related concerns commonly arise as a barrier to accessing psychological treatment in prison.

Distrust is another commonly named barrier to accessing psychological treatment whilst in prison (Durrah, 2013; Morgan et al. 2007). A lack of trust in prison psychologists was identified as a barrier to disclosure of suicidal thoughts amongst adult male offenders in New Zealand (Skogstad, Deane & Spicer, 2005) and concerns about information given in therapy being ‘’used against them’’ has also been named as a concern (Morgan, Rozycki & Wilson, 2004). A qualitative study in a UK prison also found distrust was a major barrier to accessing care amongst male adult offenders, with distrust often related to negative beliefs that healthcare professionals ‘’don’t really care’’ (Howerton et al., 2007). However the generalisability of this UK study is limited as the participants were recruited from a prison in southwest England that holds mostly White British offenders sentenced to less than one year, 97% of their sample were White British which is not reflective of the UK prison population where young men from BME backgrounds are disproportionately over-represented (Hagell, 2002).

Ethnicity can also have an impact on accessing psychological treatment whilst in prison, with prisoners requesting psychological help upon admission being more likely to be from a White ethnic group than non-requesters (Diamond et al. 2008). Steadman, Holohean and Dvoskin (1991) found that a greater proportion of White prisoners received mental health services than Black or Hispanic prisoners in a New York State prison. Within the UK, Black prisoners with personality disorders are less likely to receive treatment than White prisoners (Coid et al., 2002). This is despite offender screening approaches for personality disorder identifying high levels of need across all ethnicities (Minoudis et al., 2012). Another UK study found that feelings of isolation and powerlessness acted as barriers to engagement for BME male adult offenders living in a prison based

therapeutic community (Brookes, Glynn & Wilson, 2012. These results suggest that offenders from BME backgrounds face additional barriers to accessing psychological treatment compared to offenders from White backgrounds.

Levels of psychological distress can act as an important factor in seeking psychological help whilst in prison. Higher levels of psychological distress have been found to increase help seeking amongst adult male offenders (Williams, Skogstad & Deane, 2001). Male prisoners with more emotional instability and reported generalized fear are also more likely to express a need for psychological help in prison (Bulten, Nijman & van der Staak, 2009). Diamond et al. (2008) found that the majority of male prisoners who self-refer for psychological help upon admission report significant psychological symptoms such as nervousness, racing thoughts and depression. This suggests that adult offenders who seek psychological treatment do so because they are more psychologically distressed.

The most common barriers arising in the adult offender population are stigma concerns and distrust, with ethnicity and level of psychological distress also having an influence. There is a distinct lack of quantitative research in this area within the UK prison system. Many of the adult forensic studies described were not carried out in the UK, with the majority being American studies (Diamond et al., 2008; Durrah, 2013; Morgan et al., 2004, Morgan et al. 2007; Reinsmith-Meyer 2014 et al.; Steadman et al., 1991) where the criminal justice system and prison system varies widely from state to state and is not comparable with the UK prison system.

The forensic literature described here has all used adult offenders as participants, none of these studies focused specifically on the young offender

population (aged 18-21). Young offenders differ across many variables compared to adult offenders, they are still cognitively developing, are more challenging to manage, are more likely to violently re-offend and have higher attrition rates from treatment programmes (NOMS, 2015). Due to these differences it is unlikely that they will face the same barriers as adult offenders. Previous studies explain that results from investigations into barriers to help-seeking among adult offenders may not be generalizable to young offenders and that more research is needed to understand the specific needs of young offenders and of BME populations (Chitaseban et al., 2011; Morgan et al., 2007). The barriers to accessing treatment for detained young offenders have not yet been empirically investigated. There is no previous literature to draw upon which has used young offender (aged 18-21) participants. Given this lack of research, studies which have used juvenile offenders (aged 10-18) will be briefly explored.

Barriers to Accessing Psychological Treatment, Juvenile Forensic Population

Stigma has also been described as a barrier in the juvenile offender population (Shelton, 2004). A UK study recruiting imprisoned juvenile offenders found that embarrassment and fears about being laughed at acted as barriers to using mental health services (Mitchell et al. 2016). Stigma is a common theme also arising in community and adult offender populations. It is fair to hypothesise that stigma may also act as a barrier in the young offender population too.

As well as stigma, other barriers to accessing psychological treatment are described in the juvenile population. These barriers include a lack of trust in professionals and a lack of insight into their own emotions. (Shelton, 2004).

Believing that problems would go away without receiving professional help was also mentioned. (Abram et al. 2008). Finally, a preference for talking to family and friends and a dislike of formal talking therapies were also described as barriers (Mitchell et al. 2016). There were weaknesses in the methodology of some of these studies which limits the conclusions that can be drawn. Abaram et al. (2008) used a measure which lists only five barriers to accessing care which would have restricted participant's responses and Shelton (2004) offered incentives, ''a pizza party'' (Shelton, 2004, p.131), each day focus groups were held, which may have influenced who participated and what they chose to say to researchers.

As noted earlier, there is a clear lack of research with young offenders aged 18-21. Child and adolescent offenders are at a different developmental stage to young offenders aged 18-21 who are transitioning into adulthood and will have different emotional needs (NOMS, 2015). The results from these juvenile offender studies cannot be automatically generalised to the young offender population. As with the adult forensic literature, there is a lack of research within the UK prison system and a lack of research focusing on high risk youths and exploring ethnic differences in service use.

Existing psychological theory and models may help to understand the current adult forensic literature relating to barriers to accessing care and also lead to hypotheses about what we may expect to find in the young offender population.

Theoretical literature relating to previous forensic findings

Ajzen's Theory of Planned Behaviour (1991) could be applied to the previous findings in the forensic literature. This theory describes how intention to perform a behaviour is influenced by attitudes towards the behaviour, subjective

norms and perceived behavioural control. Within a prison population attitudes towards help-seeking are generally negative, with it being seen as a sign of weakness, a subjective norm of hyper-masculinity pervades the environment and imprisonment restricts control over one's behaviour. It may be that negative attitudes, a subjective norm of hyper-masculinity and lack of perceived behavioural control may contribute to the low levels of help-seeking and treatment uptake in forensic populations. Skogstad, Deane and Spicer (2006) examined whether adult prisoners intentions to seek help for a personal emotional problem can be predicted using variables from the Theory of Planned Behaviour (Azjen, 1991). They found that general attitudes to seeking professional psychological help did influence intentions to seek help. In addition, interpersonal factors such as social pressures and a lack control over accessing help also affected prisoner's intentions to seek psychological help.

The Theory of Reasoned Action predicts that behavioural intent is caused by our attitudes and our subjective norms (Fishbein & Azjen, 1977) and Anderson's Behavioural Model (1995) incorporates predisposing factors, enabling factors and level of need to explain health care service use. Both of these theories have also been applied to help seeking for mental health problems but no single theory has been widely accepted within the literature. More recently, Clement et al. (2015) developed a model to describe the processes underlying the relationship between stigma and help-seeking for mental health problems. The model highlights how different stigma variables deter help-seeking, such as anticipation of social judgement, rejection and embarrassment. The model also highlights variables which enable help-seeking, such as normalising mental health problems and non-judgemental professionals. This model describes groups who

are disproportionately deterred by stigma, such as males, youths and ethnic minority groups which echoes the literature already described. Clement et al. (2015) note that future studies are needed to add to the literature about these groups particularly likely to be deterred from help seeking by stigma.

Stigma

Stigma has been found to act as a deterrent to help-seeking for mental health problems in the community (Clement et al. 2015) this effect is observable across both the BME (Hines-Martin et al., 2003; Memon et al., 2016; Mishra et al., 2008) and young adult populations (Cirrochi & Deane, 2001; Gulliver, Griffiths, & Christensen, 2010; Rickwood et al., 2005). Within the forensic population stigma can also act as a barrier to engaging in treatment. Stigma concerns are related to negative attitudes towards psychological treatment (Williams, Skotsgad and Deane, 2001). Concerns about being viewed as ‘’weak’’ for seeking help in prison is a common theme that arises in the literature (Deane, Skogstad & Williams, 1999; Morgan, Rozycki, and Wilson, 2004; Woodall, 2007)

The concept of stigma can be broken down into: anticipated stigma, experienced stigma, internalized stigma, perceived stigma, stigma endorsement and treatment stigma (Clement et al. 2015). With regards to barriers to accessing psychological treatment, ‘treatment stigma’ is the most relevant to consider. This relates to the stigma and discrimination individuals believe are associated with receiving care or treatment for a mental health issue or other psychological problem and is strongly associated with help-seeking (Clement et al., 2012).

Based on the previous research and the Clement et al. (2015) model of stigma variables, it is fair to hypothesise that treatment stigma may act as a strong

deterrent to engaging in treatment for BME male young offenders in particular. Young men from BME and lower socio-economic backgrounds make up much of the UK prison population (Ministry of Justice, 2018) and are known to be particularly reluctant to seek help, these demographic characteristics have all been associated with negative attitudes towards seeking psychological treatment and support (Biddle et al. 2004; Mitchell & Latchford, 2010; Rickwood et al. 2005). As noted by Morgan, Rozycki and Wilson (2004), it is important to identify specific barriers experienced by ethnic minority prisoners that will hinder their access to psychological treatment. There is currently no empirical research which has explored the concept of treatment stigma amongst BME young offenders and how this impacts on engagement in psychological treatment in prison.

Rationale for present study

This study was attempting to address the substantial gaps in the literature by investigating what barriers to accessing psychological treatment exist for male young offenders (aged 18-21) detained in a UK prison. This population are known to be high risk and high harm towards themselves and others, it is important to understand what barriers may be preventing effective rehabilitation for this group. There is a lack of research examining stigma in a young, male, ethnic minority population and this study also addressed this gap.

In line with future research recommendations in the literature (Abram et al. 2008; Chitaseban et al., 2011; Morgan et al., 2007), the present study adopted a quantitative methodology, recruited a larger sample size, recruited from a UK prison, focused on high risk young offenders and explored the impact of treatment stigma and psychological distress as well as pathological personality traits.

Pathological personality traits were included as a variable as it is known that BME prisoners with personality disorders are less likely to receive formal psychological help than White prisoners with personality disorders (Coid et al. 2002) despite having equivalent levels of need (Minoudis et al. 2012). A diagnosis of personality disorder is also associated with higher rates of treatment dropout (Craissati & Beech, 2001). A report from Her Majesty's Inspectorate of Prisons (2007) found that BME prisoners report being distrustful of what they perceive to be 'White services' in prison. In response to this, the present study also investigated differences between BME and White young offenders in terms of barriers to accessing treatment in prison.

Most of the forensic studies previously described have used hypothetical formats to assess intentions to seek psychological help. For example Skogstad, Deane and Spicer (2006) asked participants about the likelihood of wanting to see a prison psychologist if they were experiencing a personal emotional problem in the future. Although there is a link between attitudes and behaviour using reports of actual treatment participation is likely to provide a more accurate insight into the reasons why certain prisoners do not participate in psychological treatment (Skogstad, Deane & Spicer, 2006). The present study improved on much of the previous forensic literature by collecting data about actual treatment engagement whilst in prison, not hypothetical engagement in the future. In order to explore barriers to accessing treatment for male young offenders in prison the following hypotheses were investigated.

Hypotheses

1. BME young offenders not engaged in treatment will report significantly more barriers to accessing treatment than BME young offenders who are engaged in treatment.

2. BME young offenders will report significantly more barriers to accessing treatment than White young offenders.

3. BME young offenders will report significantly more treatment stigma related barriers than White young offenders.

4. Ethnicity, level of psychological distress, number of treatment barriers, number of stigma related barriers and pathological personality traits will act as significant predictors to engagement in treatment.

With regards to each predictor it is expected that coming from a BME background, having higher numbers of treatment barriers and higher numbers of stigma related barriers would decrease the likelihood of engagement in treatment. In contrast coming from a White background, having higher rates of psychological distress and lower rates of pathological personality traits would increase the likelihood of engagement in treatment.

Methods

Design

This study was a quantitative cross-sectional design. The independent variables for the regression analysis were ethnicity, psychological distress, barriers to accessing treatment, stigma related barriers and pathological personality traits. The dependent variable was whether or not the young offender

was engaged in treatment. 'Engaged in treatment' was defined as any young offender who is currently enrolled on or has completed an Offender Personality Disorder (OPD) or HMPPS treatment programme. 'Not engaged in treatment' was defined as any young offender not enrolled on an appropriate treatment programme or any young offender who has disengaged from or refused OPD or HMPPS treatment programmes.

Stigma was defined as 'treatment stigma' which is the stigma and discrimination individuals believe are associated with receiving care or treatment for a mental health issue or other problem (Clement et al. 2012). Ethnicity was grouped into either 'White' or 'BME'. White covering White British, White Irish, Gypsy/Irish Traveller and Other White. BME covering Black British, Black Caribbean, Black African, Mixed white and black Caribbean, Mixed white and black African, Indian, Pakistani, Bangladeshi, and Other.

Recruitment Setting

Participants were recruited from a young offenders prison in Southern England. It holds up to 444 young adult men aged 18 to 21 who are serving among the longest sentences for this age group in the country. Around 60% of the prison population are BME (HMIP, 2017). Over 80% of those held are serving more than four years and 30% are serving more than 10 years to life. Recruitment was facilitated through the OPD service based within the prison. This service is a partnership between the National Health Service and Criminal Justice System and is aimed at those who are not able to access the normal services already available in the prison due to their emotional or behavioural difficulties. Service users are offered a range of treatments which may include either Mentalization Based

Therapy or Schema Therapy. In addition to the OPD treatments HMPPS offers accredited offender behaviour treatments such as the 'Thinking Skills Programme' (TSP), a cognitive skills programme which addresses the way offenders think and their behaviour associated with offending and 'Resolve', a moderate intensity cognitive-behavioural intervention that aims to reduce violence. No participants were recruited from the 'Sex Offender Treatment Programme' (SOTP) as at the time of recruitment this programme was suspended in the prison, prior to the introduction of a new programme for sex offenders, 'Horizon'. Verbal and written information about treatments and services are provided to each young offender upon induction to the prison.

Sample

A total of 128 participants were recruited: 32 BME young offenders in treatment, 32 White young offenders in treatment, 32 BME young offenders not in treatment and 32 White young offenders not engaged in treatment. All participants were convicted male young offenders detained in prison and were all eligible for either an OPD treatment programme or one of two HMPPS treatment programmes (TSP or Resolve). They were all between the ages of 18-21 with a mean age of 19.82 years. Risk level data was available for 92% of participants who were all either medium, high or very high risk. Risk level is defined using the national Offender Assessment System (OASys) tool. The risks addressed are: risk of serious harm to others, risks to children, risks to the individual, suicide, self-harm, coping in custody, vulnerability, other risks, escape/abscond, control issues and breach of trust. There are 4 levels of risk: low, medium, high and very high. In terms of offences, 50% of the sample were violent offenders who had committed offences such as murder and grievous bodily harm; 26% were sexual offenders

who had committed offences such as rape and sexual assault and 24% had committed ‘other’ offences, such as drug misuse or burglary. In terms of prison location, the majority of the participants were housed on the main prison wings, 98.4% of the BME participants and 59.4% of the White participants. There were more White participants, 40.6%, housed on the vulnerable prisoner wing. Only 1.6% of the BME participants were housed on the vulnerable prisoner wing. The ethnic profile of the vulnerable prisoner wing is predominantly White. See Table 5 for the demographic and clinical characteristics of the sample.

Table 5. Demographic and clinical characteristics of sample

Variable	Categories	Engaged in Treatment *n*-64		Not Engaged in Treatment *n*- 64	
		N	%	*N*	%
Ethnicity	BME	32	50.0	32	50.0
	White	32	50.0	32	50.0
Risk Level	Very High	5	7.81	1	1.5
	High	50	78.1	40	62.5
	Medium	7	11.0	15	23.5
	Low	0	0	0	0
	Not Available	2	3.1	8	12.5
Offence Type	Violent	36	56.3	28	43.8
	Sexual	16	25.0	17	26.6
	Other	12	18.7	19	29.6

Ethics

Ethical approval was obtained via the Royal Holloway Ethics Committee (REC Project ID: 401) and HMPPS Ethics Committee (Ref: 2017-113) prior to data collection, Appendix 8 and 9 shows copies of the approval notifications. Conducting research within a prison environment raises a number of ethical issues including the capacity to give informed consent, limits of confidentiality and issues of power and control. Young offenders are a vulnerable population with restricted autonomy. The information sheet clearly stated that participation was voluntary and participants have the right to withdraw at any time without this affecting their sentence or parole in any way, see Appendix 3. Due to poor literacy in this population the information sheet was explained verbally to help participants to provide informed consent especially to the limits of confidentiality which were listed on the information sheet.

Power

Within the forensic and help seeking literature effect sizes are variable ranging from small/medium to large (Chitsabesan et al. 2006; Smith et al. 2008; Clement et al. 2015). This study is powered for t-tests for hypothesis one, two and three. Given the range of effect sizes reported a medium effect size was selected for this study. An a-priori power analysis ($\beta=0.80$, $\alpha=0.05$) showed for a medium effect size of 0.5 a total of 128 participants were required with 64 in each group, BME and White (Soper, 2016).

Measures

Two self-report measures were used in this study. See Appendix 6 and 7.

Barriers To Accessing Treatment in Prison measure (BATP)

To measure barriers to accessing treatment an adapted version of the Barriers to Accessing Care Evaluation (BACE) was used, this was originally developed for adults using secondary care mental health services and has also been adapted for use with carers (Dockery et al. 2015).The BACE is a 34 item self-report questionnaire which has a separate treatment stigma subscale. This scale has been found to have good test-retest reliability and validity (α= 0.89) (Clement et al. 2012). In order to be used in a prison setting the scale required significant adaptations in terms of wording, adding some items and removing others. Permission to adapt the scale was granted by the authors in writing, see Appendix 10. The authors agreed for the scale to be used in the current study but due to the significant adaptations not to refer to it as 'The BACE'.

The adapted self-report scale for use in this study was called 'Barriers to Accessing Treatment in Prison' (BATP). It had 32 items covering a range of potential barriers. Ten items covered treatment stigma (3, 4, 7, 8, 10, 14, 16, 18, 22, 24), for example *''feeling embarrassed or ashamed''*. Five items from the original BACE were removed as they were not applicable, for example *''having problems with childcare while I receive mental health care.''* Fifteen items had minor amendments to the wording (1,3,4,5,11,12,16,17,18,19,23,24,25,28,29) to make the items applicable for a prison population, for example item 27 of the BACE *''Difficulty taking time off work''* was adapted to *''Difficulty taking time off from prison job or education (if applicable)''*. Fourteen items remained the same as

in the original BACE (2,6,7,8,9,10,13,14,15,20,21,22,26,27), for example *''Thinking I did not have a problem''.* Finally, 3 items were added (30, 31, 32) these include *''Lack of trust in the professionals providing care and treatment'', ''Lack of trust in the prison system which these services are based in''* and *''Concern about my personal safety whilst participating in a treatment programme''*. An open ended question was also added to allow participants to describe additional barriers not listed on the measure *'' If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here''.* See Table in Appendix 11 for full details on the adaptation of the BACE items and creation of the BATP items.

There are no validated measures specifically created for use in the prison population which is why it was necessary to create the new BATP measure for this study. This measure provided three sets of scores. A total score which reflects how many barriers the participant reported as relevant for them (maximum 32), a mean rating score which reflects to what extent the participant reported the barrier as affecting them: not at all, a little, quite a lot, a lot (maximum 96) and a treatment stigma score which reflects how many stigma barriers the participant endorsed (maximum 10).

BATP Reliability Analysis

The internal consistency of the new BATP measure was investigated by looking at the average inter-item correlation for the questionnaire as a whole as well as the treatment stigma subscale. The 32 item BATP scale as a whole was found to have a high level of internal consistency (α=.858) The 10 item treatment stigma subscale of the BATP was also found to have a good level of internal consistency (α= .825).

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM)

To measure psychological distress the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) was used. This is a 34 item self-report questionnaire which asks participants to rate how they have been feeling over the last week using a five point scale ranging from ‘not at all’ to ‘most or all of the time’. The measure covers four dimensions: subjective wellbeing, problems/symptoms, life functioning, risk/harm. The responses are averaged to produce a mean score to indicate the level of current psychological distress from ‘healthy’ to ‘severe’. This measure is frequently used in the recruiting setting and has been found to have good internal and test- retest validity (α= 0.75-0.95) for large clinical and non-clinical samples (Evans et al. 2000).

Service User Consultation

Prior to recruiting, a service user consultation was set up to consult with young offenders about recruitment strategy and procedures for participation. The importance of service user involvement in research is well recognised in the UK (Clinks, 2011; Department of Health, 2006). It was considered important to recognise this in the current study and encourage feelings of empowerment in an imprisoned population, which typically has low levels of power and autonomy.

This can be a challenging population to conduct research with (Lučić-Ćatić, 2015) and it was felt that service user input at this stage would help maximise participation. Two young offenders, one BME and one White, aged 19 and aged 21 took part in the consultation. Both were serving long sentences in the recruiting prison and had committed violent offences. The key points from this consultation

are summarised below in Table 6. This service user consultation directly informed the recruitment strategy for this study.

Table 6. Service user consultation on recruitment strategy

Consultation Categories	Service User Responses
Encouraging participation	‘’Show a genuine interest in their answers and be respectful towards participants.’’
Locations to approach participants	‘’You could approach people in the prison library as it is quiet and safe there’’ ‘’You could also approach people on the wings but don’t approach them in education or in the workshops’’
Times of day to approach participants	‘’Don’t approach people when they are on association or exercise as they won’t want to talk to you then, check the core prison day before recruiting’’
Potential barriers to participating	‘’People might not see what is in it for them, so take the time to explain the study and what it is trying to investigate’’ ‘’People might be suspicious of you as a new person in the prison’’
Helping participants feel comfortable	‘’Take time to build up rapport and a sense of trust by having a chat with participants before doing the questionnaires’’ ‘’Read out information sheets and consent forms, highlight confidentiality to make people feel comfortable but also be honest and clear about limitations to this.’’ ‘’Be clear about what participating involves and that it is just a one off meeting and they won’t be seeing you again unless they have any concerns or questions.’’
Encouraging honesty on the questionnaires	‘’ Be clear about what will happen to the information they give you. So explain it is stored securely to reassure them their answers will not be used against them in anyway.’’ ‘’See people individually to encourage honest answers without staff or other prisoners present.’’

Data Collection

Following on from the service user consultation, an opportunity sampling approach was taken and participants were approached in the prison library, on residential wings or in the OPD service. Collection was carried out by one researcher who would approach service users and ask if they would like to discuss a new research study in the prison. If they said yes the researcher would see them individually in a quiet location, read the information sheet out and ask for any questions, if they were happy to proceed they signed the consent form which was also read out. The researcher then read the questions on the two measures and service users indicated their responses. Data collection took place in one meeting and time was made to have informal discussions with each participant to build up rapport and help them feel comfortable. In accordance with HMPPS policy no incentive or payment was offered to participants. See Appendix 3 for the information sheet and Appendix 4 for the consent form.

After these data were collected, clinical data were also extracted from electronic HMPPS records including treatment status, index offence, age, ethnicity and risk level. All participants were screened for pathological personality traits using a national screening tool (Ministry of Justice, 2015), the OASys Antisocial Personality Disorder Screen (OASys ASPD), see Appendix 5 for detailed screening algorithm. This is used as part of the UK Government OPD strategy to identify traits strongly associated with sexual and violent offending risk. The initial 10 screening questions are used to identify individuals with a high number of anti-social and psychopathic traits and gives a score ranging from 0-10, with higher scores on these questions indicating higher levels of anti-social personality traits. Those individuals with personality disorders other than anti-social are less likely to

be identified through these questions alone. The participants in this study had scores ranging from 2-10, with the average score being 7.

Results

Data analysis

All analyses used IBM SPSS Statistics version 21. Unless otherwise stated, findings are reported to two decimal places and exact p-values are given. The threshold for statistical significance was set at $p < .05$, a standard conservative level to control for Type I errors. A series of independent t-tests compared differences between ethnicities and treatment status in terms of barriers to accessing care, stigma related barriers and psychological distress. For all independent t-tests Levene's test for equality of variance was examined and homogeneity of variance assumptions were consistently met meaning equal variance estimates were used. A logistic regression model investigated a range of variables and whether or not they predict engagement in treatment for young offenders, these variables were ethnicity, number of treatment barriers, number of stigma related barriers, level of psychological distress and number of antisocial personality traits on the OASys ASPD screen. This model used the participant's treatment status as the categorical dependent variable

Data Screening

Prior to carrying out the statistical analyses the dataset was screened for errors in data entry, missing values and to check the data met assumptions for parametric tests. Examination of frequencies revealed that there were no missing data for any of the two main continuous outcome measures, the BATP and CORE-OM, and no missing data for two of the categorical variables, ethnicity and

treatment status. There was a small amount of missing data on the OASys ASPD screen variable. This information was not available for 10 participants at the time of recruitment. Given the overall low frequency of missing values in the dataset, no specific statistical method was chosen to replace missing data. Instead, missing data were managed using SPSS' default procedure of pairwise deletion, removing specific missing values from the analysis rather than whole cases (Field, 2009).

Data distribution: normality

All continuous variables were checked for normality using histograms and by calculating skewness and kurtosis z-scores using the following formulae:

$$\text{Z skewness} = \frac{S - 0}{\text{SE Skewness}} \qquad \text{Z kurtosis} = \frac{\sqrt{K} - 0}{\text{SE Kurtosis}}$$

A distribution was considered normal if a z-score for both skewness and kurtosis were less than 2.58 ($p < .01$) (Field, 2009). Ethnicity, Treatment Status, the OASys ASPD screen and the CORE-OM were all found to have acceptable levels of skew and kurtosis, with skewness Z scores ranging between 0.19 and -2.65 and kurtosis Z scores ranging between 0.06 and 1.06. The BATP total score (z= 6.36), BATP rating scores (z=5.41) and BATP stigma subscale (z=4.90) were all found to be positively skewed. Application of a square root transformation (Fidell & Tabachnick, 2003) reduced skewness and resulted in the scores being normally distributed, BATP total score (z=0.25), BATP rating score (z=-0.26) and BATP stigma subscale (z=0.11). Following the application of these square root transformations, all variables met assumptions for using parametric statistics. The transformations were maintained for all statistical analyses using these variables. See Table 7 for the Means (M) and Standard Deviations (SD) of the pre-

transformed study variables. The overall average CORE-OM score for the participants in this study fell in the ‘mild range’ indicating that self- reported levels of psychological distress were not particularly high.

Table 7. Means and Standard Deviations of Pre-transformed Study Variables

	Whole sample		BME in treatment		BME no treatment		White in treatment		White no treatment	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
BATP. Total No. Barriers (max 32)	12.33	7.57	8.41	6.31	15.31	8.96	12.75	6.67	12.84	6.66
BATP Total No. Stigma Barriers (max 10)	2.56	2.58	1.47	1.88	2.91	2.79	2.81	2.48	3.06	2.85
BATP Total Mean Rating Score (max 96)	21.73	14.18	15.34	12.06	28.25	16.34	20.06	12.20	23.28	13.05
CORE-OM Total Clinical Score (max 40)	10.17	6.65	8.56	5.44	9.25	6.20	10.50	8.04	11.96	6.33
OASys ASPD Score (max 10)	7.13	1.31	7.06	1.46	6.27	1.72	7.29	1.86	6.60	1.50

Descriptive Statistics

Frequency of Barriers

The top 20 treatment barriers for the sample as a whole is reported in Table 8 with the most commonly reported treatment barrier being item *2 ''wanting to solve the problem on my own''* which 78.9% of participants endorsed. The next most commonly reported treatment barrier was related to trust issues, item 31, *''Lack of trust in the prison system which these services are based in'',* which 73.4% of participants endorsed.

The treatment stigma barriers were not as common, with less than 50% of participants endorsing any of the stigma barriers. The most frequently reported stigma barrier was item *18 ''not wanting details of my treatment or problems to be on my notes''* which 40.6% of the sample reported. The least frequently reported barrier was item 12 *'' Care from my own ethnic or cultural group not being available''* which only 12.5% of participants endorsed.

Table 8. Top 20 Treatment barriers reported from the sample as a whole n=128

BATP Item No.	Treatment Barrier	Total No. of participants reporting barrier to any degree	% of participants reporting barrier to any degree
2	Wanting to solve the problem on my own	101	78.9
31	Lack of trust in prison system which these services are based in	94	73.4
27	Having asked for help but having to wait a long time before receiving it	85	66.0
15	Dislike of talking about my feelings, emotions or thoughts	82	64.0
6	Thinking the problem would get better by itself	75	59.0
11	Thinking that treatment would probably not help	74	58.0
20	Preferring to get help from family or friends	73	57.0
21	Thinking I did not have a problem	61	47.6
26	Having asked for help but not receiving it	60	46.8
1	Being unsure where to go to get help	58	45.3
30	Lack of trust in professionals providing care and treatments	53	41.4
28	Concern that staff will not understand cultural issues that are important to me	52	41.0
18 Stigma	Not wanting details of my treatment or problems to be on my notes	46	40.6
7 Stigma	Concern about what my family might think, say, do or feel	45	35.1
25	Having no one who could help me access treatments	42	32.8
5	Problems with movements across the prison needed to access the services	41	32.0
17	Concerns about the therapies or treatments available.	40	31.2
10 Stigma	Concern that I might be seen as ‘crazy’	36	28.1
8 Stigma	Feeling embarrassed or ashamed	35	27.3
16 Stigma	Concern that people might not take me seriously if they knew I was receiving professional help	29	22.6

Tables 9 and 10 show the top 10 treatment barriers for the BME and White young offenders. Both groups shared 8 common treatment barriers (items 2, 6,11,15,20, 27, 30, 31) none of which were treatment stigma barriers. Item 28 *''concern staff will not understand cultural issues that are important to me''* and item 26 ‘*’having asked for help but not received it''* were in the top 10 treatment barriers for BME young offenders only. Item 21 ‘*’thinking I did not have a problem''* and item 1 *''being unsure where to go to get help''* were in the top 10 treatment barriers for White young offenders only. The least frequently reported barrier by BME young offenders was item 22 *''concern about what my friends might think, say or do''* which only 7 participants endorsed. The least frequently reported barrier by White young offenders was item *12 “care from my own ethnic or cultural group not being available''* which only 4 participants endorsed. Within both the BME and White groups, the treatment and no treatment participants reported the same top 10 treatment barriers.

Table 9. Top 10 Treatment Barriers for BME young offenders, (n=64)

BATP Item No.	Treatment Barrier	Total No. of BME participants reporting barrier to any degree	% of participants reporting barrier to any degree
2	Wanting to solve the problem on my own	50	78.3
31	Lack of trust in prison system which these services are based in	46	71.9
20	Preferring to get help from family or friends	40	62.5
27	Having asked for help but having to wait a long time before receiving it	39	60.9
15	Dislike of talking about my feelings, emotions or thoughts	38	59.4
6	Thinking the problem would get better by itself	37	57.8
28	Concern that staff will not understand cultural issues that are important to me	34	53.1
11	Thinking that treatment would probably not help	33	51.6
26	Having asked for help but not receiving it	28	43.8
30	Lack of trust in professionals providing care and treatments	27	42.2

Table 10. Top 10 Treatment Barriers for White young offenders, (n=64)

BATP Item No.	Treatment Barrier	Total No. of White participants reporting barrier to any degree	% of participants reporting barrier to any degree
2	Wanting to solve the problem on my own	51	79.7
31	Lack of trust in prison system which these services are based in	48	75.0
27	Having asked for help but having to wait a long time before receiving it	46	71.9
15	Dislike of talking about my feelings, emotions or thoughts	44	68.8
11	Thinking that treatment would probably not help	41	64.1
6	Thinking the problem would get better by itself	38	59.4
21	Thinking I did not have a problem	36	56.3
20	Preferring to get help from family or friends	34	53.1
1	Being unsure where to go to get help	32	50.0
30	Lack of trust in professionals providing care and treatments	26	40.6

Additional barriers listed by participants

At the end of the BATP measure there was a space to list additional barriers not mentioned on the questionnaire in response to the open ended question: ‘’*If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here”*. Forty-six participants chose to fill in this optional question. The majority of the answers echoed the barriers already listed on the questionnaire such as lack of trust, having to wait a long time for help, not knowing where to go to get help and thinking they did not require treatment. However an additional barrier not listed on the questionnaire was described by some participants. This seemed to relate to having conflict with other prisoners and wanting to avoid this. Please see Table 11 for the answers given that highlighted this additional barrier.

Table 11. Additional barrier described by participants relating to conflict with other prisoners (n=11)

	If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here.
Participant No.	**Answer**
1	‘’Not knowing which prisoners will be involved in the group with you…’’
43	‘’Groups with other prisoners tend to wind me up so I have to avoid them’’
59	‘’Having non-associates on the same group would put me off’’
61	‘’Trying to keep away from certain people and keep your head down out of trouble’’
81	‘’If conflict has happened on the wing then it puts me off coming’’
104	‘’In the past I was fighting so that’s a barrier for me’’
106	‘’I ended up down the block (segregation unit) after fighting so couldn’t complete Resolve.’’
110	‘’Going on shops (movements) to Pathways (OPD service) is anxiety provoking in case of running into people I don’t like’’
118	‘’People from the main prison being in the group ‘’
125	‘’Going on movements to TSP was hard ‘coz I always got into fights, and being in this environment makes it hard, I am still fighting so they are like '' he has learnt nothing from groups'' but I have it's just here in this prison. What can I do? Always running into people who want to fight me.’’
127	‘’I have concerns about running into people I have conflict with and I want to avoid trouble at the moment, I don't want to get into fights’’

Statistical Analysis of Hypotheses

Hypothesis 1: BME young offenders not engaged in treatment will report significantly more barriers to accessing treatment than BME young offenders who are engaged in treatment.

An independent t-test was used to compare BME young offenders engaged in treatment and BME young offenders not engaged in treatment on the number of treatment barriers reported. BME young offenders not engaged in treatment reported significantly more barriers (*M*=3.78, *SD*= 1.03) to accessing treatment than BME young offenders who are engaged in treatment (*M*= 2.67, SD=1.13), *t*(62)= -4.09, *p*< .001. It was also found that these BME young offenders who are not engaged in treatment had significantly higher mean ratings of the barriers (*M*=5.14, *SD*= 1.38) than BME young offenders who are engaged in treatment (*M* =3.55, *SD* = 1.66), *t*(62)= -4.13, *p*<.001.

BME young offenders not engaged in treatment also endorsed significantly more stigma related barriers (*M*=1.46, *SD*= .89) than BME young offenders who are engaged in treatment (*M*= .90, *SD*= .82), *t*(62)=-2.61, *p*=.011. Equal levels of psychological distress were reported across BME young offenders engaged in treatment (*M*= 8.65, *SD*= 5.44) and not engaged in treatment (*M*= 9.25, *SD* = 6.01), *t*(62)= .48, *p*=.632. These results supported hypothesis 1.

Hypothesis 2: BME young offenders will report significantly more barriers to accessing treatment than White young offenders.

An independent t-test was used to compare the BME young offenders (*M*=3.23, *SD* = 1.21) and White young offenders (*M*= 3.45, S*D* = .94) on the number of treatment barriers reported, there was no significant difference between

the ethnicities on number of treatment barriers reported, *t*(126) = -1.16, *p*= .248. There was no significant difference between BME young offenders (*M*= 4.35, *SD*= 1.71) and White young offenders (*M*= 4.42, *SD* = 1.44) on the mean ratings of the barriers, *t*(126) = -.29, *p* =.769. There was a slight significant difference found on psychological distress, with White young offenders (*M* = 11.22, *SD* =7.34) reporting slightly more psychological distress than BME young offenders (*M*= 8.90, *SD* = 5.69), *t*(126)= -1.99, *p*=.048, however this could be a chance result given how close *p* is to the critical value of .05. These results did not support hypothesis 2.

Hypothesis 3: BME young offenders will report significantly more treatment stigma related barriers than White young offenders.

An independent t-test was used to compare the BME young offenders (*M* =1.18, *SD* = .89) and White young offenders (*M* = 1.44, *SD* = .92) on the number of stigma related barriers reported. There was no significant difference between the ethnicities in the number of stigma related barriers reported, *t*(126) = -1.66, *p*= .099. This result does not support hypothesis 3.

Hypothesis 4: Ethnicity, level of psychological distress, number of treatment barriers, number of stigma related barriers and antisocial personality traits will act as significant predictors to engagement in treatment

Prior to carrying out the multiple logistic regression, the variables were entered into separate simple logistic regressions to see how each variable related to treatment engagement on its own. The aim was to see whether there is a change when all the variables are considered together in the multiple logistic regression. So as not to include the same variables twice in the multiple

regression, the BATP stigma barriers (total 10) were removed from the Number of Treatment Barriers score (total now 22) which will be renamed ‘’BATP non-stigma barriers’’ for this analysis.

For the simple logistic regressions there were no significant associations with Ethnicity (*B* = .00, *SE*= .17, *p*= 1.00) or Psychological Distress (*B* = -.03, *SE*=0.27, *p*= .360) or BATP stigma barriers (*B* = -.37, *SE* = .19, *p*=.063) and engagement in treatment. However there were significant associations for Antisocial Personality Traits (*B*=.29, *SE*= .12, *p*= .014) and BATP non-stigma barriers (*B* = -.086, *SE*= .7, *p*= .014) with engagement in treatment.

A multiple logistic regression analysis was then carried out in order to assess the degree to which each of the variables (Ethnicity, Psychological Distress, Antisocial Personality Traits, BATP non-stigma barriers, and BATP stigma barriers) independently predicted whether male young offenders engage in psychological treatment in prison. A model based on all five variables entered together was significantly accurate in predicting whether or not male young offenders engage in treatment or not ($X^2(5) = 17.19$, $p=.005$). Overall this model correctly predicted whether or not male young offenders would engage in treatment in 65% of the cases (overall case prediction). The treatment group was the target category. This model correctly classed 71% of the treatment cases as ‘in treatment’ (sensitivity) and correctly classed 57% of the no treatment cases as ‘not in treatment’ (specificity).

After controlling for shared variance with the other three variables, Antisocial Personality Traits (*B*= .36, *SE*= .13 *p*=.007) and BATP non-stigma treatment barriers (*B*= -.09, *SE*= .05, *p* =.033) showed significant predictive status

with regard to engagement in psychological treatment. Ethnicity, (*B*= -.19, *SE*= .41, *p*= .630), Psychological Distress (*B*= .05, *SE*=.04, *p*= .884) and BATP stigma barriers (*B*= -.16, *SE*=.28, *p*=.563) were not independently predictive of engagement in psychological treatment, see Table 12. Therefore antisocial personality traits as measured by the OASys ASPD Screen and number of self-reported non-stigma treatment barriers on the BATP were independently predictive of treatment status among male young offenders. Higher scores on the OASys ASPD screen increased the likelihood of being engaged in treatment whereas higher scores on the BATP non-stigma barriers decreased the likelihood of being engaged in treatment.

Table 12. Multiple Logistic Regression Variables for Hypothesis 4

	B	**S.E**	**Sig.**	**Exp(β)**
Ethnicity	-.19	.41	.630	.82
CORE-OM Total Clinical Score	.05	.04	.884	1.01
OASys ASPD Score	.36	.13	.007	1.43
BATP non-stigma barriers	-.09	.05	.033	.91
BATP stigma barriers	-.16	.28	.563	.85

A post-hoc power analysis of the multiple logistic regression (Faul et al. 2009) showed that for a medium effect size and sample size of 128 this test was slightly underpowered (β=0.60).

Additional Analyses

White young offenders analysis

It was felt that exploring the treatment and no treatment groups amongst the White ethnic groups would be a useful additional analysis. Unlike the BME young offenders there were no differences between treatment and no treatment groups for the White young offenders. An independent t-test was used to compare White young offenders engaged in treatment (*M*= 3.46, *SD*= .89) and White young offenders not engaged in treatment (*M*=3.44, *SD* = 1.01) on number of treatment barriers reported and no significant difference was found, *t*(62)=.322, *p*= .938. There was no significant difference on the mean ratings of barriers between the treatment (*M*= 4.28, *SD*= 1.35) and no treatment groups (*M*= 4.58, *SD*= 1.53), *t*(62)= .450, *p*=.398. There was no significant difference in number of stigma barriers reported between the treatment (*M*= 1.42, *SD*= .89) and no treatment groups (*M* = 1.47, *SD*= .96), *t*(62)=.200, *p*= .842. Finally, equal levels of psychological distress was reported over both the treatment (*M*= 10.49, *SD*= 8.04) and no treatment group (*M*= 11.95, *SD*= 6.63), *t*(62)= .794, *p* =.430.

Index offence analysis

It is possible that the type of offence committed by the young offender (violent, sexual, other) could influence engagement in treatment. To examine this potential confounding variable a one-way independent ANOVA was used to compare scores on the BATP, CORE-OM and OASys ASPD screen for violent, sexual or other offenders. There was no significant difference between these three groups on measures of barriers to accessing treatment (*F*(2, 125) = .03, *p*= .967), including stigma barriers (*F*(2, 125)= 2.65, *p*= .074), or psychological distress

(*F*(2,125)= 2.53, *p*= .083.) However the three groups did differ significantly on the OASys ASPD screen (*F*(2,113)= 13.33, *p* <.001). Fisher's protected t-tests showed that both the violent offender group (*t*(28.29) = 4.51, *p*= <.001) and sexual offender group (*t*(53) = 2.83, *p* = .007) scored significantly higher on the OASys ASPD screen than the offenders who had not committed violent or sexual offences. There was no significant difference between the violent and sexual offender groups on the OASys ASPD screen (*t*(39.19) = 1.10, *p*= .189).

Discussion

Main findings of current study

This study has investigated the barriers to accessing psychological treatment for medium to high risk male young offenders (aged 18-21) serving a custodial sentence in a UK prison. The most commonly named barriers were *''wanting to solve the problem on my own'' and ''lack of trust in the prison system which these services are based in''* which were endorsed by over 70% of participants. This is consistent with previous research with adult offenders which reported that a lack of trust, particularly against 'the system', can act as a barrier to engaging in treatment for adult offenders too (Howerton et al., 2007; Skogstad, Deane & Spicer, 2005). The most commonly reported barriers tended to reflect a general reluctance to talk about emotions, a preference for self-reliance and institutional barriers. These results echo previous research which also found that preference for self-reliance was reported as a barrier to accessing professional psychological help in prison (Morgan et al. 2007). Environmental barriers, such as having to wait a long time to receive help, are also commonly reported amongst adult offenders (Mitchell & Latchford, 2010) as well as the belief that when faced

with a psychological problem prisoners should ‘’man up and deal with it’’ (Cobb & Farrants, 2014, p.50).

Hypothesis 1 was supported, within the BME group, BME young offenders who are not currently engaged in or who have refused treatment, reported significantly more barriers to accessing treatment than BME young offenders who are currently engaged in an OPD or HMPPS treatment. The no treatment BME group also reported the barriers affecting them to a greater extent, with more ‘a lot’ and ‘quite a lot’ responses, they also reported more treatment stigma barriers than the BME treatment group. However both groups reported equal levels of psychological distress.

Despite presenting with equal levels of psychological need, and meeting criteria for treatment, the no treatment BME group were not engaged in psychological treatment and it is possible that this is due to facing a greater number of barriers, including stigma barriers, to accessing this treatment in prison. This effect was not seen for the White treatment versus no treatment comparisons so it seems that this effect was unique to the BME young offenders only. Within the BME group, the treatment and no treatment group’s 10 most commonly reported barriers were the all same: items 2, 6, 11, 15, 20, 26, 27, 28, 30, 31. This indicates that the difference between the BME groups is one of magnitude, a higher number of reported barriers and ratings of the barriers, rather than a difference in the type of barriers reported.

The results did not support Hypothesis 2 or 3. No significant difference was found between the ethnicities in either the total number of treatment barriers reported or total number of stigma barriers reported. Looking at the descriptive

data of the top 10 treatment barriers, the BME and White young offenders seemed to have more barriers in common than not, with 8 out of the top 10 being the same for both groups. These findings contrast with much of the previous research which suggests that BME groups may face a greater number of barriers to accessing care and report more stigma concerns (Hines-Martin et al., 2003; Memon et al., 2016; Mishra et al., 2008; Steadman, Holohean & Dvoskin, 1991).

White young offenders were found to report slightly higher levels of psychological distress than the BME young offenders. Findings from Diamond et al. (2008) can help to explain this, they found that the majority of male prisoners who self-refer for psychological help upon admission to prison reported significant psychological symptoms such as anxiety and were significantly more likely to be from a White ethnic group. In this population it seems that young offenders cannot be differentiated by their ethnicity in terms of barriers to accessing treatment and that both groups face similar numbers of self-reported barriers.

With regards to Hypothesis 4, two variables were found to act as independent significant predictors of whether or not a young offender was engaged in psychological treatment whilst in prison. Firstly, a higher number of self-reported non-stigma treatment barriers decreased the likelihood of an offender being in treatment. Based on previous forensic literature (Morgan, Rozycki & Wilson, 2004; Williams, Skogstad & Deane, 2001) this result was expected and suggests that the more psychological and structural barriers a young offender faces, the less likely they are to be engaged in treatment. Secondly, a higher score on the OASys ASPD screen increased the likelihood of an offender being in treatment. This result was surprising given that the literature has traditionally considered antisocial personality traits to act as a significant hindrance to

engagement (Shaw & Edelmann, 2017) leading many offenders to being excluded from treatments (Benjamin, 1996). The finding in this study is potentially an artefact of the OPD and HMPPS screening practices. These services specifically target medium to high risk young offenders so we may expect that the young offenders engaged in treatment would be more likely to have high levels of antisocial personality traits.

In terms of index offence, the results showed that that violent, sexual and 'other' offenders all faced similar numbers of barriers to accessing care and equal levels of psychological distress. There was no difference between the violent and sexual offenders on the OASys ASPD screen but both groups scored higher on this screen than the 'other' group. This result was expected given that this screening tool has been specifically developed to identify high risk and high harm offenders (Ministry of Justice, 2015).

In terms of treatment stigma, the results of this study would suggest that this may not be a primary barrier to accessing treatment for this population, out of the top ten barriers reported none were treatment stigma related, the average number of treatment stigma barriers reported per participant was only three, out of ten possible treatment stigma barriers. The most commonly reported stigma barrier was *''not wanting details of my treatment or problem to be on my notes''* but this was endorsed by less than half of the sample. This contrasts with much of the previous forensic research using adult offenders where stigma related concerns were commonly reported to act as barriers to accessing treatment (Deane, Skogstad & Willaims, 1999; Williams, Skotsgad & Deane, 2001; Woodall, 2007).

The results of this study link with Morgan, Rozycki & Wilson's (2004) research, they also found that concerns about stigma were not endorsed as significant barriers amongst male prisoners. Instead, barriers such as not being sure how to access services were more commonly endorsed. The results of this study would suggest that for the young offender population treatment stigma is less problematic and that there are other barriers more likely to discourage them from engaging in treatment. Young offenders report less stigma related concerns than the adult offender population.

Strengths of current study

This study addressed the substantial gaps in the forensic literature by using a quantitative methodology and recruiting a male young offender (18-21) population from a UK prison. Most other forensic research in this area has used adult offenders, qualitative methodology and has been largely carried out in the USA. This study has provided a unique contribution to the UK clinical forensic literature and can inform future research with young offenders. To the author's knowledge, this is the first investigation of the barriers to accessing psychological treatment for medium to high risk male young offenders serving a prison sentence in the UK.

The current study has been able to improve upon the methodology of the previous forensic literature in this area. The use of the BATP measure allowed participants to respond to a list of 32 treatment barriers plus report on any other barriers not listed at the end, which revealed an additional barrier relating to conflict with other prisoners. This is an improvement on Abram et al.'s (2008) measure which was fairly limited and lists only 5 barriers to accessing care. Unlike

Morgan et al.'s research (2004, 2007) which did not explore or discuss the properties of a newly developed measure, which listed only 15 barriers, the current study examined and reported upon the psychometric properties of the new BATP measure. Both the BATP measure as a whole and the treatment stigma subscale were found to have high levels of internal consistency. Participants also reported good face validity, the general consensus being that it was easy to understand and not too long to complete. All participants were able to answer all of the items on the BATP. The present study also examined actual behaviour in terms of treatment engagement rather than using hypothetical scenarios or examining intentions to engage in treatment in the future, this is likely to have enhanced the validity of the findings.

The results from the current study are likely to be more generalizable than Howerton et al.'s (2007) UK based qualitative study in which the majority of the participants (*n*=35) were White British offenders serving less than 1 year in prison. The participants in the current study were all serving 4 years or longer and 50% were young BME males (*n*=64) which is more reflective of the UK prison population as a whole (Hagell, 2002) meaning the results from the current study are likely to be more widely applicable.

Another noteworthy strength of this study was that it was well powered for the three main hypotheses and managed to recruit the 128 participants required to achieve a medium effect size of 0.5. During participant recruitment the researcher was embedded within the prison environment in which these young men live, work and socialise which would have greatly enhanced the ecological validity of this study. The consistent researcher presence during the course of this study allowed for informal conversations and discussions outside of recruitment meaning that

research participants were familiar with the researcher and felt comfortable with participating. This is an improvement on the recruitment strategy employed by Shelton (2004) in which prisoners were rewarded with incentives during the course of their study which may have influenced participant responses. In line with HMPSS policy the current study did not entice participants to take part by offering incentives.

A potential concern regarding Hypothesis 1 was that the study could end up simply comparing a distressed group accessing treatment with a non-distressed group not accessing treatment, that is, BME young offenders not accessing treatment are simply not as distressed as the BME young offenders who are accessing treatment. However the results of this study has shown this is not the case as there was equal levels of psychological distress across both BME groups.

Limitations of current study

Although the study was well powered for t-tests for the three first hypotheses, a post-hoc power analysis (Faul et al. 2009) of the logistic regression showed that this was slightly underpowered (β=0.60) with the final sample size of 128. This means the results of this analysis need to be cautiously interpreted as the risk of a Type II error is increased. If this study was to be replicated in the future a sample size of 217 (Faul et al. 2009) would increase power (β=0.80) for the logistic regression analysis.

This study was limited due to the self-report methodology used. Both the BATP measure and CORE-OM measure could have been affected by social desirability bias or response bias (e.g. 'mid-point' responding; Furnham & Henderson, 1982) which are limitations of all self-report measures. The

participants may have denied or exaggerated their psychological problems or barriers to accessing treatment. These self-report biases are particularly relevant to hold in mind when conducting research in a prison with a disempowered group of participants who may be fearful of the consequences of giving truthful answers. The CORE-OM was perhaps not a sensitive enough measure for this population, the average CORE-OM score for the participants in this study fell in the 'mild range' despite there being many clear indicators of high levels of psychological distress being present. For example 50% of participants living on the vulnerable prisoner wing, taking psychiatrist prescribed medication for mood difficulties, being known to be actively self-harming or being on an ''Assessment, Care in Custody and Teamwork'' (ACCT) plan for a suicide attempt. Future research should explore an alternative measure of psychological distress as it is possible the CORE-OM has underestimated the levels of psychological distress in this population

The participants live in an environment where masculinity and strength is valued above most other traits (Kupers, 2005). They may have struggled to acknowledge some of the barriers they perceive as reflecting 'weakness', for example item 3 *''concern I might be seen as weak''* and item 24 *'' Concern about what people on my wing might think say or do''.* It was noted by the researcher that the treatment stigma subscale barriers (items 3, 4, 7, 8, 10, 14, 16, 18, 22, 24) elicited a negative response from the majority of participants who were keen to emphasise that they ''don't care what people think''. It is likely that the results of this study were affected by the young men's social desire to portray themselves as strong and masculine, explaining why the most popular barrier reported was item 2 *''wanting to solve the problem on my own''.*

Selection bias is another limitation that needs to be considered in relation to this study. The young offenders who are most avoidant of professional psychological treatment are probably less likely to agree to participate in a study being carried out by a doctoral psychology student. This limitation may have impacted on the results, there is a chance that this study 'missed' some important data due to potential participants being reluctant to participate.

There were some limitations with the sample in this study. The participants were fairly homogenous in terms of age, risk level and gender. However there were other potentially confounding variables such as sentence length and treatment history that were not controlled for and could have affected the results. For example young offenders on an indeterminate sentence (IPP) may be more motivated to engage in treatment to bring their release date forward whereas young offenders on a determinate sentence may be less motivated as they will be released whether they engage in treatment or not. Young offenders given life sentences may not see the point of engaging in psychological treatment at this stage in their sentence given how long they have left to serve. These variables were not controlled as the information was not readily available on the participant's electronic HMPPS records and the time constraints of the study limited the number of data sources that could be searched.

Another limitation was that the majority of the BME participants came from a Black British Caribbean or Black British African background, only 19% came from an Asian background. However this was likely due to the proportion of Asian young offenders detained within the recruiting prison, recent figures suggest that the majority of the BME young offenders in the recruiting prison come from a Black British Caribbean or African background and less than 20% come from an Asian

background (HMIP, 2015). So the participants in this study are likely to be representative of this particular prison's population however future research could aim to use more than one prison to recruit a more varied BME participant group and explore differences between Asian and Black ethnicities.

The finding that the White young offenders had higher levels of psychological distress than the BME young offenders may have been confounded by the recruitment strategy. The opportunity sampling approach meant a large number, 40.6%, of the White participants were living on the vulnerable prisoner wing at the time of the study. This wing has high rates of self-harm and mood disorders. In comparison only 1.6% of the BME participants recruited came from the vulnerable prisoner wing. It is possible that this has skewed the results and future research should endeavour to take a more targeted approach to recruitment to make sure there are equal numbers of participants from both the main prison wings and vulnerable prisoner wing. This would help to explain whether White young offenders really do have higher levels of psychological distress than BME young offenders in the prison population.

Due to security concerns it was not possible to recruit young offenders housed in the Segregation Unit of the prison, this was disappointing as this unit houses the highest risk and most challenging young men in the prison who would likely have faced significant environmental barriers to accessing psychological treatment whilst living on this unit. Future research should seek to collaborate with a prison officer to facilitate access to these young men who are ostracised from the main prison population.

This study has been able to highlight that BME young offenders not engaged in treatment appear to face a greater number of treatment barriers and stigma barriers than BME young offenders who are engaged in treatment, however this study has not been able to explain why this group seem to face more barriers and be more affected by them.

It is important to consider reverse causality, that is, perceived barriers and stigma may have changed as a consequence of having accessing treatment which could explain this finding. This study has also not been able to comment on why young offenders with high levels of antisocial personality traits are more likely to be engaged in treatment, when previous literature would suggest high levels of antisocial traits would decrease likelihood of engaging in treatment. Both of these areas need to be explored further in order to be able to comment on the underlying mechanisms. It is important to note that the 'not engaged group' included offenders who have dropped out of treatment, offenders who have initially refused treatment and offenders who have yet to seek out or be offered treatment. It is possible that there are subtle differences between these offenders which this study did not account for. Future research should also seek to explore these subgroups further.

Future research directions

It is possible the results of this study could be affected by the limitations outlined above. Future research should seek to address these limitations by recruiting a more representative sample in terms of BME ethnicities and wing location in the prison. Future research could also explore additional variables such as index offence, sentence length and treatment history to see whether these

variables have any impact on engagement in treatment whilst in prison. These variables would be accessible from the young offenders' HMPPS and OASys records, due to the time constraints of the current study it was not possible to explore these additional variables on this occasion. The current study only recruited from one prison so a replication study, potentially recruiting from additional young offender prisons would confirm if the results are generalizable to the wider UK young offender prison population.

Within the BME participants there was a subgroup of BME young offenders who despite having equal levels of psychological distress and living in the same environment as other BME young offenders, face additional psychological, structural and social barriers to accessing treatment. This exploratory study has served to highlight this issue and future research should endeavour to explore why these BME young offenders face more barriers to accessing care than other BME young offenders and also see if there are any other characteristics that distinguish the two BME groups from each other. This research could also start to consider the facilitators to accessing treatment in prison, the current study only explored the barriers, and it will be important to explore what may help facilitate access to psychological treatment for this marginalised group of young men.

Although the current study found the new BATP measure has good levels of internal consistency and face validity it is necessary to carry out further research to confirm the validity and reliability of this measure in a prison population. Once this is confirmed the BATP could be used as a tool to evaluate interventions designed to reduce barriers and increase access to psychological treatment in prison. A small number of participants used the open ended question at the end of the BATP to report that conflict with other prisoners can act as a

barrier to accessing treatment for them. It may be worth exploring this more in future research by adding a barrier to the main questionnaire relating to this theme, for example *''concerns about running into other prisoners I have conflict with''.*

Clinical implications

The results of this study suggest that treatment stigma is not a primary barrier to accessing treatment in prison for young offenders. It seems that their internal beliefs for example about not needing treatment, were more problematic barriers than perceived stigma. These results link with Fishbein & Azjen's (1977) Theory of Reasoned Action. In this study it does seem that the young offenders behavioural intent (engaging in treatment or not) was influenced by the negative attitudes and subjective norms they hold regarding treatment, which were generally negative or of the view that treatment was unnecessary.

Azjen's Theory of Planned Behaviour (1991) may also help to explain these findings, the young offenders in this study held a variety of negative attitudes towards engaging in treatment, for example thinking treatment will not help; live in an environment where a subjective norm of hyper-masculinity exists, for example wanting to solve problems on their own and feel control over their behaviour is restricted, for example having asked for help but not received it. Interventions targeted at helping offenders modify their negative attitudes towards treatment may help to facilitate access. It would also be useful to help increase young offenders sense of control over seeking and engaging in treatment, for example allowing self-referrals and clear communications about how to do this.

Vogel, Wester and Larson (2007) have described ‘’anticipated utility and risk’’ as being particularly influential in psychological help-seeking and treatment engagement. Anticipated utility refers to the perceived usefulness of the treatment and anticipated risk refers to the individual’s perception of the dangers of sharing personal thoughts with another person. In this sample two barriers relate to this ‘’thinking treatment would probably not help’’ (anticipated utility) and ‘’dislike of talking about my feelings, emotions or thoughts’’ (anticipated risk), these barriers were reported by over 58% of the sample. In relation to these barriers psychoeducation to explain the benefits of psychological treatment could help to increase access. Part of this psychoeducation should however acknowledge the potential ‘risks’ of engagement in treatment, for example having to discuss painful emotions or traumatic memories.

The results from this study suggest there were a number of environmental barriers preventing young offenders from engaging in treatment, such as not knowing where to get help or having to wait a long time for help which likely reduced their sense of behavioural control. The onus here would be on services within the prison to conduct more outreach work to identify prisoners in need of psychological support and perhaps also provide more literature on the residential wings to signpost people towards how to seek help in the prison environment.

This study suggests, for the most part, there is little intrinsic difference between BME and White young offenders in terms of the barriers to accessing treatment, which means services could apply interventions to increase access to both groups. Staff training could also help operational staff identify those prisoners in need of support and make referrals more quickly. A surprising result from this study was that young offenders displaying high levels of antisocial personality

traits were more likely to be engaged in psychological treatment demonstrating that antisocial personality traits do not necessarily act as a hindrance to engagement in treatment whilst in prison. Further research exploring the impact of other pathological personality traits (e.g. borderline, narcissistic or schizotypal) on engagement in treatment in prison could be considered.

Conclusions

This study has added to the forensic knowledge base by exploring a range of behavioural, normative and control beliefs that the young offender may hold which may influence his decision to engage in psychological treatment

This study has addressed a number of gaps in the clinical forensic literature in terms of sample characteristics, recruitment location and methodology. The young offenders in this study did not report being affected by stigma concerns to the same extent as the adult offender population. Treatment stigma barriers were reported by less than half of the sample. Internal beliefs and attitudes about psychological treatment and environmental and institutional barriers were more commonly reported in this sample.

Equal levels of psychological distress was reported across both groups of BME young offenders, those engaged in treatment and those not engaged in treatment. This would suggest the BME group not accessing treatment are not simply less distressed but instead face a greater number of barriers to accessing treatment than the BME group who are engaged in treatment. This needs to be explored further in future research. There were no differences found between White and BME young offenders in terms of barriers to accessing treatment and stigma. A higher number of reported barriers decreased the likelihood of a young

offender being in treatment and a higher number of antisocial personality traits increased the likelihood of a young offender being in treatment. Future research should also continue to explore predictors of engagement in psychological treatment whilst in prison.

It is hoped that these novel findings, in addition to the recommended future research, will increase understanding of the barriers to accessing psychological treatment for young offenders in prison and lead the way for the development of interventions to facilitate access for this marginalised population.

IV. Integration, Impact and Dissemination Summary

Integration

The systematic review and empirical study were integrated relatively well in this thesis. They both explored the same topic, barriers to accessing psychological treatment in prison. The results of the systematic review were able to directly inform and highlight the need for the empirical study. The systematic review demonstrated the lack of research in this field, the average age of the participants in the included studies in the review was 31.15 years. No studies were found which focused on the aged 18-21 young offender population. The empirical study was able to address the gap in the literature highlighted in the systematic review by specifically recruiting from a young offenders prison.

Hypothesis one and three in the empirical study were developed based on the existing literature gathered in the systematic review, which demonstrated that stigma consistently arose as a barrier for adult offenders. At the start of the study it seemed reasonable to hypothesise that stigma would also arise in the young offender population too, however this was not the case. Hypothesis two was looking at ethnic differences in terms of barriers to accessing treatment. Although the included papers in the systematic review gathered data on ethnicity only one of them explored differences between ethnic groups (Morgan, Rozycki & Wilson, 2004), it was felt that this gap needed to be addressed. The empirical study showed that amongst the young offenders recruited there were no differences between ethnicities in terms of barriers to accessing treatment or stigma related barriers. After reviewing the literature it seemed there were some papers exploring both barriers and facilitators to accessing treatment in prison but little to no research exploring predictors of engagement in treatment in prison, Hypothesis four in the empirical study addressed this gap. It found that higher levels of

antisocial personality traits meant an offender was more likely to be engaged in treatment and a higher number of self-reported treatment barriers meant the likelihood of engagement in treatment was lower. Ethnicity, stigma related barriers and psychological distress were not independently predictive of engagement in treatment. Future research should continue to explore predictors of engagement in treatment whilst in prison and consider variables not entered into the current model, for example sentence length, offence type, treatment history and borderline personality traits.

The model that was created after synthesising the literature gathered in the systematic review highlighted that Stigma, Distrust, Personal Factors and Environmental Factors are common barriers to accessing psychological treatment for adult offenders. The empirical study found that unlike the adult offender population, Stigma was not a primary barrier to accessing treatment for the young offender population. However the other three components, Distrust, Personal Factors and Environmental Factors were found to act as barriers for young offenders too. The top three barriers reported on the BATP in the empirical study clearly correspond with these three components of the model developed following the systematic review, see Table 13.

Table 13. Linking the top three barriers in the empirical study with the systematic review model

No. Participants reporting (%)	BATP barrier reported in empirical study	Component from systematic review model
101 (78.9)	Wanting to solve the problem on my own	Personal Factors
94 (73.4)	Lack of trust in prison system which these services are based in	Distrust
85 (66.0)	Having asked for help but having to wait a long time before receiving it	Environmental Factors

Based on the results gathered in the empirical study it is possible to present a revised model to illustrate the barriers to accessing psychological treatment in prison for the young offender prison population, see Figure 3. In relation to Hypothesis one, the BME young offenders not engaged in treatment did report more stigma related barriers than BME young offenders who were engaged in treatment. So it is possible that this subgroup of BME young offenders are more affected by stigma, future research needs to explore this. However the preliminary model in Figure 3 is designed to illustrate the young offender population as a whole so stigma will not be included at this stage. Going forward, both of these models can be used to guide clinical interventions to increase access for both the adult and young offender population and also to inform future research directions in the field. This research has highlighted that there are similarities between the

two groups but also differences, namely the impact of stigma. This project is the first to empirically investigate barriers to accessing psychological treatment in prison for male young offenders. Following on from this it is hoped that the disparity in the forensic literature will start to reduce and more researchers will be willing to develop new and exciting research projects with the young offender population.

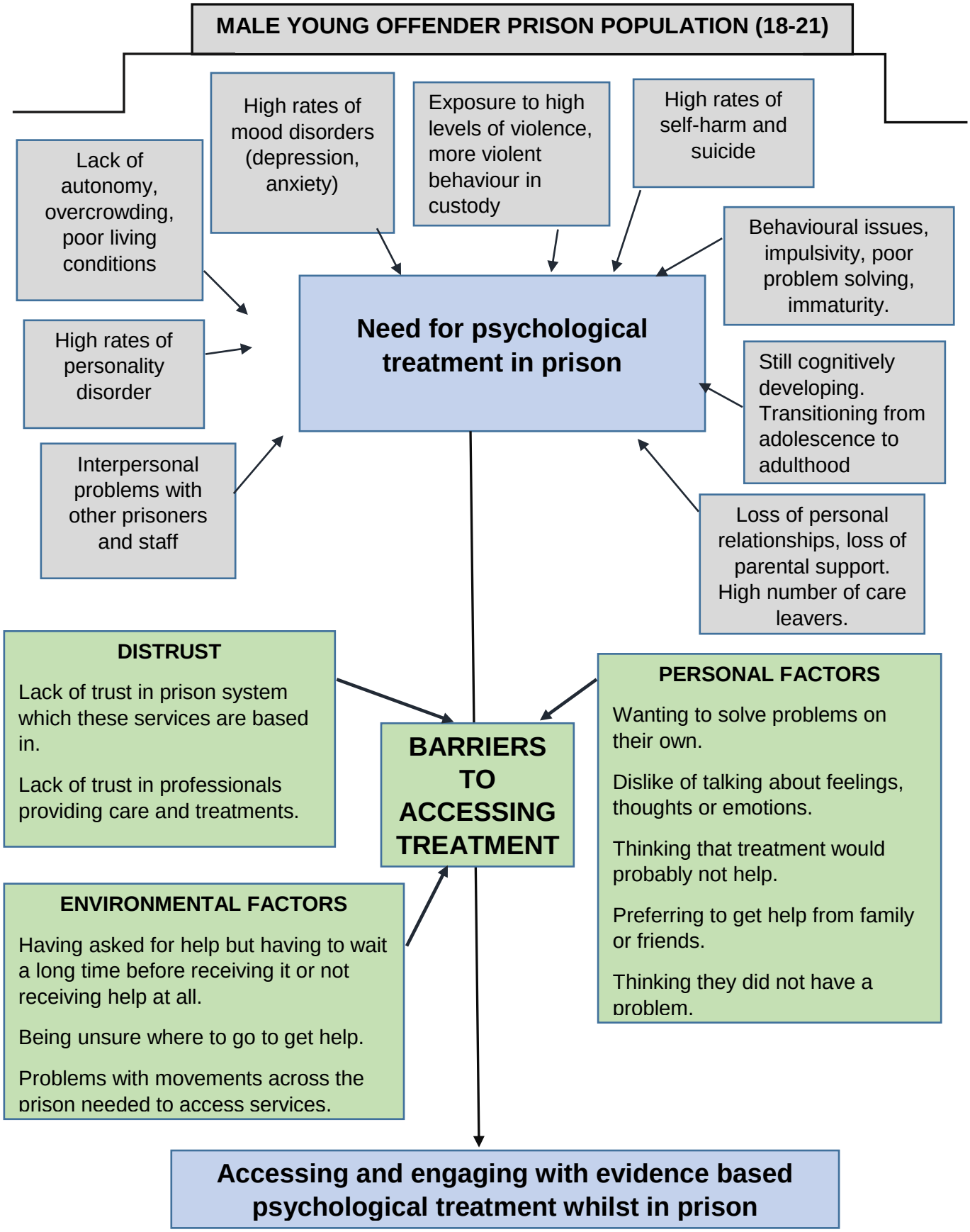

Figure 3. Model of barriers to accessing psychological treatment in prison for male young offenders.

Impact

National and International Impact: Future theory, research and practice

This study is the first to systematically review the literature relating to barriers to accessing psychological treatment in prison and the first to empirically investigate this issue with the young offender population. The young offenders recruited are representative of the UK prison population in terms of gender, age and ethnicity, this means the results can be generalised to other young offender prisons within the UK. The results offer an important contribution to the clinical and forensic psychology literature and this study has explored an under researched population. The beneficiaries of this research include professionals working clinically with this population, academics conducting research within the forensic population, policy-makers and commissioners who are responsible for developing psychological services within prison and offenders who are entitled to receive psychological treatments whilst in prison.

The results can be applied to enhance best practice and increase access and inclusion for this high risk population. For example the result that there is no significant difference in the barriers experienced by BME and White young offenders means that services can apply interventions and ideas to increase access across the young offender prison population as a whole.

The empirical study specifically investigated ethnicity and explored differences between BME and White young offenders. Exploring ethnicity in prison is a current and timely issue in the UK following on from an independent review by MP David Lammy into the treatment of, and outcomes, for Black, Asian and Minority Ethnic individuals in the criminal justice system. This review highlighted

that the BME proportion of youth prisoners has risen from 25% to 41% in the decade 2006 to 2016 (Lammy, 2017).

The empirical study revealed a subgroup of BME young offenders who face additional barriers to accessing treatment, despite presenting with equal levels of psychological need as other BME young offenders. This result could have further impact in terms of influencing future research directions. It is important to investigate this subgroup further and perhaps consider exploring gang affiliations and whether this impacts on accessing treatment in prison as we know that BME young offenders face considerably more gang concerns compared to White young offenders (Lammy, 2017).

Local Impact: Service user council

The recommendations from this research seem to be feasible, acceptable and realistic at a local level. Changes have already been made based upon the results and new projects and interventions are being developed in the prison.

Following on from this project and a concurrent qualitative project in the OPD service a service user council has been set up to try and tackle some of the issues raised in the research. A staff team including a trainee (myself), a clinical psychologist, an assistant psychologist and a prison officer are taking the lead on this new development. Three service user representatives (reps) have been recruited, they attend meetings with us every other week.

The empirical study demonstrated that there were a number of environmental barriers preventing young offenders from engaging in treatment, such as not knowing where to get help or having to wait a long time for help. The service user reps recognised this and have suggested ways to overcome these

barriers, their ideas have included: developing new posters to advertise services, making sure these posters are displayed in the 'information' section of the wing, re-designing the OPD service leaflet to highlight what the benefits of treatment are, making it easier to self-refer by re-designing the 'prison application system' and creating new application forms in different colours for different services. These ideas are now being put into practice in this prison.

In the future, once the council is more established, the service user reps plan to become more involved in facilitating interventions and groups in the service. It is thought that this peer to peer influence could help to overcome some of the personal and internal barriers the young offender's experience, such as thinking treatment won't work or preferring to deal with problems by themselves. In order to overcome the lack of trust the young offenders have with services and professionals the OPD staff team have agreed to spend more time on the assessment and relationship building process. During a recent staff meeting the OPD clinical lead highlighted that the eight week window for assessment should be fully utilised in order to reduce the sense of distrust and suspicion surrounding the service. With less pressure to bring people in quickly to the intervention service staff now feel more able to spend time building this relationship before beginning any treatments. The service user reps are in agreement with this new process and have highlighted how important it is to build trust before beginning any psychological intervention.

Dissemination

Presentations

The preliminary results of the empirical study were disseminated in February 2018 to the OPD staff team in the recruiting prison. The staff team found the results useful and felt that they were what they expected based on their clinical experience with this population. This presentation allowed the results to be shared directly with professionals working in a young offender's prison and increase the 'real world' local impact of the research. They will be able to act upon these findings in their day to day clinical work to reduce the barriers to accessing treatments and therapies offered in the service.

The results of the empirical study were again disseminated in March 2018 at the British and Irish Group for the Study of Personality Disorder (BIGSPD) yearly conference in Cardiff and an abstract was published in the BIGSPD conference abstract booklet. This presentation was part of a symposium with clinical psychologists from the recruiting prison and one of the supervisors for this project, Dr Jake Shaw. The title of the symposium was ''working with complex young men in prison: barriers, engagement and change'', the presentation was well received and has increased the national impact of the study. The audience included clinical psychologists, forensic psychologists, prison officers, probation workers and ex-service users. Some of the ex-service users ''tweeted'' about the empirical study saying they found it interesting, this was then ''retweeted'' on the BIGSPD twitter feed. This informal dissemination of the study has increased public awareness and access for service users and other beneficiaries. This presentation was a chance to disseminate the findings to professionals working within the

forensic field who will be able to take forward the results to inform their own clinical work and future research projects.

The results of the empirical study and the systematic review were presented in May 2018 at the Royal Holloway University third year clinical psychology trainee presentation day. The attendees here included clinical staff and trainee clinical psychologists. This presentation enabled the results to be disseminated to an academic audience who may take forward the new knowledge gathered from this research to inform their future research projects.

The results of the empirical study were finally presented in May 2018 to the newly developed service user council in the recruiting prison, the attendees were the three service user reps, ranging from age 19-21, one from a Black Caribbean background, one from a Bangladeshi background and one from a White British background, their sentences ranged from seven to ten years. One service user rep has been in the service for eight months, one for twelve months and one for eighteen months. In addition to the three service user reps, an experienced service user consultant employed by the London Pathways Partnership Trust also attended, he had previously served a 25 year prison sentence and received treatment through Offender Personality Disorder services. This presentation served to directly inform the beneficiaries of this research themselves. The study was well received and the service user reps thought the results were interesting.

The service user reps felt that ‘lack of trust’ was a key barrier to engaging in treatment and reflects the culture and environment within the UK prison system at the moment which is characterised by low staffing levels, long periods of being locked up and high levels of violence. They also recognised ‘personal factors’ as

being a barrier they faced, for example believing they should ‘man up’ and deal with problems alone. In terms of ‘environmental factors’ the service user reps felt that these were the most problematic barriers for them why is why they are choosing to tackle these first by increasing knowledge and understanding on the wings and improving the self-referral process in the prison.

Publications

Both the empirical study and the systematic review will be prepared for publication in academic journals. Both of these sections can stand alone as separate articles which again increases the academic impact of the thesis as a whole, ideally at least two publications will be achieved. Articles will be submitted to high impact journals in the field in the first instance. The impact factor is the frequency of which an article in a particular journal has been cited in a particular year, so a higher number of citations means the journal has a higher impact factor. It is also possible to rank a journal using the resource www.scimagojr.com . The rank indicator is a measure of the journals impact, influence or prestige. The journals are then divided into four quartiles, with Q1 comprising journals with the highest values, Q2 the second highest, Q3 the third highest and Q4 the lowest values (SCImago, 2007). Please see Table 14 for the journals that will be approached for publication and the order of preference in which they will be submitted to. Both national and international journals will be approached to increase the academic impact of this research.

Table 14. Potential journals for publication and impact factors (SCImago, 2007)

Preference	Journal	No. citations per document published in the last two years (2016)	SCImago journal rank indicator (2016)	Country
1	Criminal Justice and Behaviour	1.993	Q1	United States
2	International Journal of Forensic Mental Health	1.500	Q2	United Kingdom
3	Legal and Criminological Psychology	1.400	Q2	United States
4	Prison Journal	1.298	Q2	United States
5	Criminal Behaviour and Mental Health	1.277	Q2	United States
6	Journal of Forensic Psychology and Psychiatry	0.918	Q2	United States
7	International Journal of Prisoner Health	0.810	Q2	United Kingdom
8	Journal of Offender Rehabilitation	0.750	Q2	United States
9	Journal of Criminal Psychology	0.529	Q3	United Kingdom

A research summary, project review form and planned publications will also be sent to the approver of the HMPPS ethics committee. This is a standard ethical requirement for conducting research in prison settings in the UK. This summary will also be sent to the OPD service, HMPPS programmes department and HMPPS psychology within the recruiting prison in order to further disseminate results directly to professionals and beneficiaries working with a young offender population. It is hoped that the dissemination activities already achieved and the dissemination activities planned will increase the impact of this research and make the results more widely accessible to relevant professionals, academic researchers and service users.

Personal Reflections

My background in prison services

Having previously worked in the OPD service in the prison I was aware of the inequity of access between BME and White young offenders. I was also aware that this population as a whole seemed to face a number of barriers to initially accessing psychological treatment, but once engaged seemed to be able to make good use of the therapies and programmes on offer. I remembered that there was a lack of research within this population and little literature for me to draw upon as a clinician. This personal experience and exiting contacts with psychologists in the prison helped shape and develop the idea for this project. Unlike other trainees I had to write a proposal and try and ‘sell’ the project to internal academic supervisors, I was keen to carry out research in an area I was passionate about and had experience with. Despite this study not being in their usual field of research I was lucky enough to find supervisors willing to take the project on.

My previous experience and existing relationships with staff meant HMPPS ethical approval was granted within 48 hours which allowed me to set up the project quickly and with little difficulty, staff were supportive of my study, I was able to take into consideration how staff perceived research in this setting. I made efforts to be as unobtrusive as possible and was able to make sure my project did not impact upon the day to day running of the prison. Many of the young men I had previously worked with in 2015 with were still residing in this prison, these previous therapeutic relationships allowed me to quickly re-build rapport as a researcher and easily recruit participants during the summer of 2017.

Shortly after completing participant recruitment I began my third year 12 month specialist placement in the OPD service in the same prison. This ongoing presence has allowed me to relatively quickly disseminate the findings of the research to the beneficiaries and increase impact by contributing to interventions and projects following on from this research.

Ethical considerations

Conducting research within a prison environment raises a number of ethical issues including the capacity to give informed consent, limits of confidentiality and issues of power and control. I was acutely aware that young offenders are a vulnerable population with restricted autonomy, this meant I took great efforts to clearly explain that participation was voluntary and they had the right to withdraw at any time without this affecting their sentence or parole in any way.

I was also aware of issues of power whilst conducting research in this setting and the power differential that existed between the young offenders and myself. I am a White middle class highly educated person, I hold prison keys and have the

power to leave whenever I like. My participants are socially excluded, marginalised young men with low education levels and their daily life is completely controlled by the prison down to when they eat, exercise or shower. In order to overcome this power differential I planned time into participant recruitment for informal chats and discussions to build rapport and let them know that I was interested in what they had to say outside of the two questionnaires I was giving them. The importance of building this rapport was highlighted during the service user consultation.

Service user consultation

I think a strength of the empirical study was the initial service user consultation prior to recruiting, this consultation directly informed the recruitment strategy and was instrumental in facilitating rapid recruitment of 128 research participants over a period of two months. It is unlikely that recruitment would have been as quick and successful if the service user consultation had not taken place.

This consultation aided the study by helping me to consider the location of the participant recruitment. The library was suggested to me. This was not a place I had ever previously considered and in the end the vast majority of participants were recruited from this location. This location is a calm and safe place within a relatively volatile environment. The quiet, secluded library office offered participants privacy whilst participating and allowed them to fully engage in the study away from their peers and prison officers on the wing. The library is also a place that is not associated with mental health services or psychological treatment meaning it was not obvious to other people what type of study they were participating in. Going forward, service user input and consultation will be vital in increasing the impact of this study and disseminating the findings.

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VI. Appendices

Appendix 1. The Mixed Methods Appraisal Tool (2011)

Mixed Methods Appraisal Tool (MMAT) – Version 2011

For dissemination, application, and feedback: Please contact pierre.pluye@mcgill.ca, Department of Family Medicine, McGill University, Canada.

The MMAT is comprised of two parts (see below): criteria (Part I) and tutorial (Part II). While the content validity and the reliability of the pilot version of the MMAT have been examined, this critical appraisal tool is still in development. Thus, the MMAT must be used with caution, and users' feedback is appreciated. Cite the present version as follows.

> Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.* Retrieved on [date] from http://mixedmethodsappraisaltoolpublic.pbworks.com. Archived by WebCite® at http://www.webcitation.org/5tTRTc9yJ

Purpose: The MMAT has been designed for the appraisal stage of complex systematic literature reviews that include qualitative, quantitative and mixed methods studies (mixed studies reviews). The MMAT permits to concomitantly appraise and describe the methodological quality for three methodological domains: mixed, qualitative and quantitative (subdivided into three sub-domains: randomized controlled, nonrandomized, and descriptive). Therefore, using the MMAT requires experience or training in these domains. E.g., MMAT users may be helped by a colleague with specific expertise when needed. The MMAT allows the appraisal of most common types of study methodology and design. For appraising a qualitative study, use section 1 of the MMAT. For a quantitative study, use section 2 or 3 or 4, for randomized controlled, non-randomized, and descriptive studies, respectively. For a mixed methods study, use section 1 for appraising the qualitative component, the appropriate section for the quantitative component (2 or 3 or 4), and section 5 for the mixed methods component. For each relevant study selected for a systematic mixed studies review, the methodological quality can then be described using the corresponding criteria. This may lead to exclude studies with lowest quality from the synthesis, or to consider the quality of studies for contrasting their results (e.g., low quality vs. high).

Scoring metrics: For each retained study, an overall quality score may be not informative (in comparison to a descriptive summary using MMAT criteria), but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as *, **, ***, and ****. For qualitative and quantitative studies, this score can be the number of criteria met divided by four (scores varying from 25% (*) -one

criterion met- to 100% (****) -all criteria met-). For mixed methods research studies, the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 25% (*) when *QUAL=1 or QUAN=1 or MM=0*; it is 50% (**) when *QUAL=2 or QUAN=2 or MM=1*; it is 75% (***) when *QUAL=3 or QUAN=3 or MM=2*; and it is 100% (****) when *QUAL=4 and QUAN=4 and MM=3* (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).

Rationale: There are general criteria for planning, designing and reporting mixed methods research (Creswell and Plano Clark, 2010), but there is no consensus on key specific criteria for appraising the methodological quality of mixed methods studies (O'Cathain, Murphy and Nicholl, 2008). Based on a critical examination of 17 health-related systematic mixed studies reviews, an initial 15-criteria version of MMAT was proposed (Pluye, Gagnon, Griffiths and Johnson-Lafleur, 2009). This was pilot tested in 2009. Two raters assessed 29 studies using the pilot MMAT criteria and tutorial (Pace, Pluye, Bartlett, Macaulay et al., 2010). Based on this pilot exercise, it is anticipated that applying MMAT may take on average 15 minutes per study (hence efficient), and that the Intra-Class Correlation might be around 0.8 (hence reliable). The present 2011 revision is based on feedback from four workshops, and a comprehensive framework for assessing the quality of mixed methods research (O'Cathain, 2010).

Conclusion: The MMAT has been designed to appraise the *methodological quality* of the studies retained for a systematic mixed studies review, not the quality of their *reporting* (writing). This distinction is important, as good research may not be 'well' reported. If reviewers want to genuinely assess the former, companion papers and research reports should be collected when some criteria are not met, and authors of the corresponding publications should be contacted for additional information. Collecting additional data is usually necessary to appraise *qualitative research and mixed methods studies*, as there are no uniform standards for reporting study characteristics in these domains (www.equator-network.org), in contrast, e.g., to the CONSORT statement for reporting randomized controlled trials (www.consort-statement.org).

PART I. MMAT criteria & one-page template (to be included in appraisal forms)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	☐ Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	☐ Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative nonrandomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				

4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Appendix 2. Excluded studies and reasons

Citation	Reason for exclusion
Abram, K. M., Paskar, L. D., Washburn, J. J., & Teplin, L. A. (2008). Perceived barriers to mental health services among youths in detention. *Journal of the American Academy of Child & Adolescent Psychiatry,* 47(3), 301-308	Participants were all aged 10-18 years with a mean age of 14.9
Bulten, E., Nijman, H., & van der Staak, C. (2009). Psychological Predictors of Help Needs in Male Dutch Prisoners. *International Journal of Forensic Mental Health*, *8*(2), 71-80.	Study carried out in a non-English speaking country.
Cobb, S., & Farrants, J. (2014). Male prisoners' constructions of help-seeking. *Journal of Forensic Practice,* 16(1), 46-57.	Study was not investigating barriers to accessing mental health treatment.
Deane, F. P., Skogstad, P., & Williams, M. W. (1999). Impact of attitudes, ethnicity and quality of prior therapy on New Zealand male prisoners' intentions to seek professional psychological help. *International Journal for the Advancement of Counselling*, *21*(1), 55-67.	Study was not investigating barriers to accessing mental health treatment
Diamond, P. M., Magaletta, P. R., Harzke, A. J., & Baxter, J. (2008). Who requests psychological services upon admission to prison? *Psychological Services,* 5(2), 97.	Participants were male and female offenders
Durbeej, N., Palmstierna, T., Berman, A. H., Kristiansson, M., & Gumpert, C. H. (2014). Offenders with mental health problems and problematic substance use: Affective psychopathic personality traits as potential barriers to participation in substance abuse interventions. *Journal of substance abuse treatment*, 46(5), 574-583.	Study was focusing on access to substance misuse treatment, not mental health treatment
Feron, J. M., Hong Nguyen Tan, L., Pestiaux, D., & Lorant, V. (2008). High and variable use of primary care in prison. A qualitative study to understand help-seeking behaviour. *International journal of prisoner health*, 4(3), 146-155.	Study was focusing on access to primary care physical health appointments only, not mental health treatment

Citation	Reason for exclusion
Kupers, T. A. (2005). Toxic masculinity as a barrier to mental health treatment in prison. *Journal of Clinical Psychology*, 61(6), 713-724.	Not a research study with experimental design or participants. But rather an article linking theories about masculinity and prison life.
Mitchell, J., & Latchford, G. (2010). Prisoner perspectives on mental health problems and help-seeking. *The Journal of Forensic Psychiatry & Psychology*, *21*(5), 773-788.	Study was not investigating barriers to accessing mental health treatment.
Mitchell, P., Whittle, N., Shaw, J., & Law, H. (2016). Removing the barriers; adolescent coping and attitudes towards mental health services in custodial settings–Can we improve services? *The Journal of Forensic Psychiatry & Psychology*, *27*(2), 248-264.	Participants were all aged 15-18, with a mean age of 16.5
Nesset, M. B., Rustad, Å. B., Kjelsberg, E., Almvik, R., & Bjørngaard, J. H. (2011). Health care help seeking behaviour among prisoners in Norway. *BMC health services research*, 11(1), 301.	Carried out in a non-English speaking country. Participants were male and female offenders. Study was focusing on access to general health care not mental health care
Owens, G. P., Rogers, S. M., & Whitesell, A. A. (2011). Use of mental health services and barriers to care for individuals on probation or parole. *Journal of Offender Rehabilitation*, 50(1), 37-47.	Participants were on parole or probation not in prison
Reingle- Gonzalez, J. M., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American journal of public health*, *104*(12), 2328-2333.	Participants were male and female offenders
Reinsmith-Meyer, C.L. (2008). Barriers to mental health and substance abuse treatment among incarcerated offenders. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 69, 1-56.	Participants were male and female offenders
Reinsmith- Meyer, C. L., Tangney, J. P., Stuewig, J., & Moore, K. E. (2014). Why do some jail inmates not engage in treatment and services?. *International journal of offender therapy and comparative criminology*, 58(8), 914-930.	Participants were male and female offenders

Citation	Reason for exclusion
Shaw, L. B., & Morgan, R. D. (2011). Inmate attitudes toward treatment: Mental health service utilization and treatment effects. *Law and human behavior,* 35(4), 249-261.	Study was examining link between help-seeking and institutional behaviour, not barriers to accessing mental health treatment
Skogstad, P., Deane, F. P., & Spicer, J. (2006). Social-cognitive determinants of help-seeking for mental health problems among prison inmates. *Criminal Behaviour and Mental Health*, 16(1), 43-59.	Study was investigating the link between help-seeking and The Theory of Planned Behaviour, not barriers to accessing mental health treatment
Wainwright, V., McDonnell, S., Lennox, C., Shaw, J., & Senior, J. (2017). Treatment barriers and support for male ex-armed forces personnel in prison: professional and service user perspectives. Qualitative health research, 27(5), 759-769.	Study was specifically focused on ex-armed forces personnel.
Walsh, J., Scaife, V., Notley, C., Dodsworth, J., & Schofield, G. (2011). Perception of need and barriers to access: The mental health needs of young people attending a Youth Offending Team in the UK. *Health & social care in the community*, 19(4), 420-428.	Participants were all aged 10-18 years with a mean age of 15.64 and the study was carried out in the community not a prison
Williams, M. W., Skogstad, P., & Deane, F. P. (2001). Attitudes of male prisoners toward seeking professional psychological help. *Journal of Offender Rehabilitation,* 34(2), 49-61.	Study was focused on examining the validity and utility of short form of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)
Youman, K., Drapalski, A., Stuewig, J., Bagley, K., & Tangney, J. (2010). Race differences in psychopathology and disparities in treatment seeking: Community and jail-based treatment seeking patterns. *Psychological services,* 7(1), 11.	Participants were male and female offenders

Appendix 3. Information Sheet

Approved by HMPPS and Royal Holloway ethics committees
Version Number: 3 Date: 14/03/2017

Participant Information Sheet

Research Study: Barriers to Accessing Treatment in Prison for Young Offenders

Hello, my name is Katherine McGrath; I am a researcher working at Royal Holloway University of London and in partnership with the Pathways Service at Aylesbury HMYOI. We are working on a project to investigate what barriers exist which may prevent young offenders from accessing help and support whilst in prison. We are interested in talking to people who are engaged in or have completed a treatment programme whilst at Aylesbury HMYOI and also people who are not engaged in or have declined a treatment programme whilst at Aylesbury HMYOI. We are recruiting people who have fairly long standing difficulties with things like offending, managing strong feelings (including anger), acting on the spur of the moment and may have a history of hurting themselves or others.

What will I have to do if I take part?

If you agree to take part, I will ask you to answer some questions. One questionnaire will ask you about what barriers you think exist for accessing care and treatment and one questionnaire will ask you about your mood over the last week. There aren't any right or wrong answers – I just want to hear about your opinions. The discussion should take about half an hour at the longest. If there is a member of prison staff you wish to be present whilst participating please let me know.

Do I have to take part?

No, taking part is voluntary. If you don't want to take part, you do not have to give a reason and there will be no pressure to try and change your mind. You can pull out of the discussion at any time. Please note, if you choose not to participate, or pull out during the discussion this will **not** affect your current prison sentence or your chances of parole.

If I agree to take part what happens to what I say?

All the information you give me **will be confidential** and used for the purposes of this study only. The data will be collected and stored in accordance with the Data Protection Act 1998 and will be disposed of in a secure manner. The information will be used in a way that will not allow you to be identified individually. Prison authorities will not be able to link any information provided by you and I do not personally work for the prison service. **However, I must inform management if:**

1. You disclose details of any potential offence within this institution, which could lead to adjudication.

2. You disclose details of any offence for which you have not yet been arrested, charged or convicted.

3. Something you have said leads me to believe, that either your health and safety, or the health and safety of others around you, is at immediate risk.

4. Something you have said leads me to believe that there is a threat to security.

In these situations, I will inform a member of prison staff, who may take the matter further.

What do I do now?

Think about the information on this sheet, and ask me if you are not sure about anything. If you agree to take part, sign the consent form. The consent form will not be used to identify you. It will be filed separately from all other information. If, after the discussion, you want any more information about the study, tell your personal officer, who will contact me.

If you feel upset after the discussion and need help dealing with your feelings, it is very important that you talk to someone right away. You can talk to someone from the Pathways team if you wish.

The contact details for the person to talk to are: ……..

Appendix 4. Consent Form

Approved by HMPPS and Royal Holloway ethics committees
Version Number: 3 Date: 14/03/2017

Participant Consent Form

Research Study: Barriers to Accessing Treatment in Prison for Young Offenders

By signing below I am confirming that (please tick):

- ☐ **I have read the information sheet for the above study and understood what it says.**
- ☐ **I have had the opportunity to ask any questions.**
- ☐ **I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason.**
- ☐ **I understand that participating in this study will not affect my current prison sentence or chances of parole.**
- ☐ **I am agreeing to take part in this research study voluntarily (without coercion).**

Participant's name:……..

Signed:……

Date:……

Researcher's name:……..

Signed:……

Date:……

Thank you very much for consenting to take part in this study.

Appendix 5. OASys Screening Algorithm to screen for high risk, high harm offenders with personality disorder

Step 1: Check risk level	Check one or more boxes to progress
a. Indeterminate sentence (IPP or life)	
b. Determinate sentence for sexual or violent offence [1]	
c. OASys risk of harm (RoH) rating high or very high	
d. Medium RoH, with current/previous sexual or violent offences [1]	
Step 2: Check for personality disorder indicators	Check one or more boxes to progress
a. 7+ DSPD items endorsed	
b. Childhood difficulties	
c. History of mental health difficulties	
d. Self-harm/suicide attempts	
e. Challenging behaviour	
Step 3: Screen in/out	
Step 1 (a-d) + Step 2 (a)	Screen in
Step 1 (a-d) + Step 2 (2x b-e)	Screen in

Explanatory notes for algorithm

All cases should be screened for personality disorder. The following method describes the process and where to find relevant information. Cases are screened in two stages (steps 1 and 2) relating to risk of harm and personality disorder respectively. It is recommended cases are screened with the offender manager present; this allows them to learn the method, develop their understanding of personality disorder, make immediate pathway recommendations and familiarise themselves with their caseload.

Step 1:

- Print out an offender manager's caseload of offenders via the officer diary in Delius
- Step 1 (a. + c.) sentence and risk of harm are listed on the Delius printout for each offender

[1] For female offenders, include a current offence of arson, criminal damage or offences against children

- Step 1 (b.) for all medium and high-risk cases check page 1 of the most recent OASys for the index offence.
- Always read the Offence Analysis (OASys item 2.1) for a detailed account of the index offence.
- Step 1 (d.) past sexual or violent offences can be checked in the Pattern of Offences (OASys item 2.12), the Risk of Harm Full Analysis (OASys item R6.2 Previous Behaviour) or via a printout of the list of convictions (MG-16, in the offender's paper file). Less serious offences (e.g. Common Assault), unlikely to result in a custodial sentence would not be scored here.

Step 2:

- Step 2(a. + b.) score the OASys DSPD items using the checklist (see overleaf)
- Step 2 (c.) refers to childhood abuse experiences (physical, sexual, emotional abuse and neglect) and/or childhood behavioural problems. Check Childhood difficulties (OASys item 6.3) and Education section (OASys page 4), ensuring you read the text box below), Childhood behavioural problems (OASys item 10.7, ensuring you read the text box below). Check for and read psychiatric or psychology reports in the paper file. The Presentence Report may contain further information on background.
- Step 2 (d. + e.) check the history of mental health difficulties (OASys item 10…?) and self-harm/suicide attempts (OASys item 10…?), also reading the text box below OASys section 10 for further information. Check for psychiatric and psychology reports in the paper file. The Presentence Report may also contain further information on mental health difficulties. Checking these items requires presence of self-harm or mental health problems that are *persistent* over time. Isolated incidents related to adjustment problems (e.g. arriving in prison at the beginning of a long sentence) would not be scored here.
- Step 2 (f.) challenging behaviour must be *persistent* and/or *pervasive* and may include litigiousness (e.g. making frequent written complaints), adjudications for violence (to staff or inmates), frequent periods in segregation, dirty protests in custody, breaches or recalls (or other failures while under supervision), very persistent offending, dismissal from treatment programmes, discharge from mental health services (where this is linked to disruptive behaviour).

OASys PD screen

Item	Present (Y/N)
1.5 One or more convictions aged under 18 years?	
2.2 Did any of the offences include violence/threat of violence/coercion?	
2.2 Did any of the offences include excessive violence/sadism?	
2.6 Does the offender recognise the impact of their offending on the victim/community/wider society? (Reverse score)	
5.5 Over-reliance on friends/family/others for financial support?	
7.4 Manipulative/predatory lifestyle?	
7.5 Reckless/risk taking behaviour?	
10.7 Childhood behavioural problems?	
11.2 Impulsivity?	
11.3 Aggressive/controlling behaviour?	
Total Number of Items:	

Appendix 6. Barriers to Accessing Treatment in Prison (BATP)

Barriers to Accessing Treatment in Prison (BATP)

Instructions:

Below you can see a list of things which can stop, delay or discourage people from seeking professional care or treatment whilst in prison.

By professional care, we mean help from staff such as a psychologist or counsellor. By treatment, we mean programmes and groups in both the Pathways service and the HMPPS treatment programmes (e.g. SCP, TSP, RESOLVE and SOTP).

Have any of these issues ever stopped, delayed or discouraged you from getting or continuing with professional care or treatment whilst in prison?

		Please circle one number on each row to indicate the answer that best suits you			
Item	**Barrier**	This has stopped, delayed or discouraged me **NOT AT ALL**	This has stopped, delayed or discouraged me **A LITTLE**	This has stopped, delayed or discouraged me **QUITE A LOT**	This has stopped, delayed or discouraged me **A LOT**
1	Being unsure where to go to get help	0	1	2	3
2	Wanting to solve the problem on my own	0	1	2	3
3	Concern that I might be seen as weak	0	1	2	3
4	Concern that it might harm my chances when applying for a job in prison	0	1	2	3
5	Problems with movements across the prison needed to access the services	0	1	2	3
6	Thinking the problem would get better by itself	0	1	2	3
7	Concern about what my family might think, say, do or feel	0	1	2	3
8	Feeling embarrassed or ashamed	0	1	2	3

9	Preferring to get alternative forms of care (e.g. traditional / religious healing)	0	1	2	3
10	Concern that I might be seen as 'crazy'	0	1	2	3
11	Thinking that treatment would probably not help	0	1	2	3
12	Care from my own ethnic or cultural group not being available	0	1	2	3
13	Being too unwell to ask for help	0	1	2	3
14	Concern that people I know might find out	0	1	2	3
15	Dislike of talking about my feelings, emotions or thoughts	0	1	2	3
16	Concern that people might not take me seriously if they knew I was receiving professional help	0	1	2	3
17	Concerns about the therapies or treatments available.	0	1	2	3
18	Not wanting details of my treatment or problems to be on my notes	0	1	2	3
19	Having had previous bad experiences with health care professionals	0	1	2	3
20	Preferring to get help from family or friends	0	1	2	3
21	Thinking I did not have a problem	0	1	2	3
22	Concern about what my friends might think or say or do	0	1	2	3
23	Difficulty taking time off from prison job or education (Not applicable)	0	1	2	3
24	Concern about what people on my wing might think say or do	0	1	2	3

25	Having no one who could help me access treatments	0	1	2	3
26	Having asked for help but not receiving it	0	1	2	3
27	Having asked for help but having to wait a long time before receiving it	0	1	2	3
28	Concern that staff will not understand cultural issues that are important to me	0	1	2	3
29	Concern I will be treated unfairly by staff because of my ethnic background	0	1	2	3
30	Lack of trust in professionals providing care and treatments	0	1	2	3
31	Lack of trust in prison system which these services are based in	0	1	2	3
32	Concern about my personal safety whilst participating in a treatment programme	0	1	2	3

If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here:

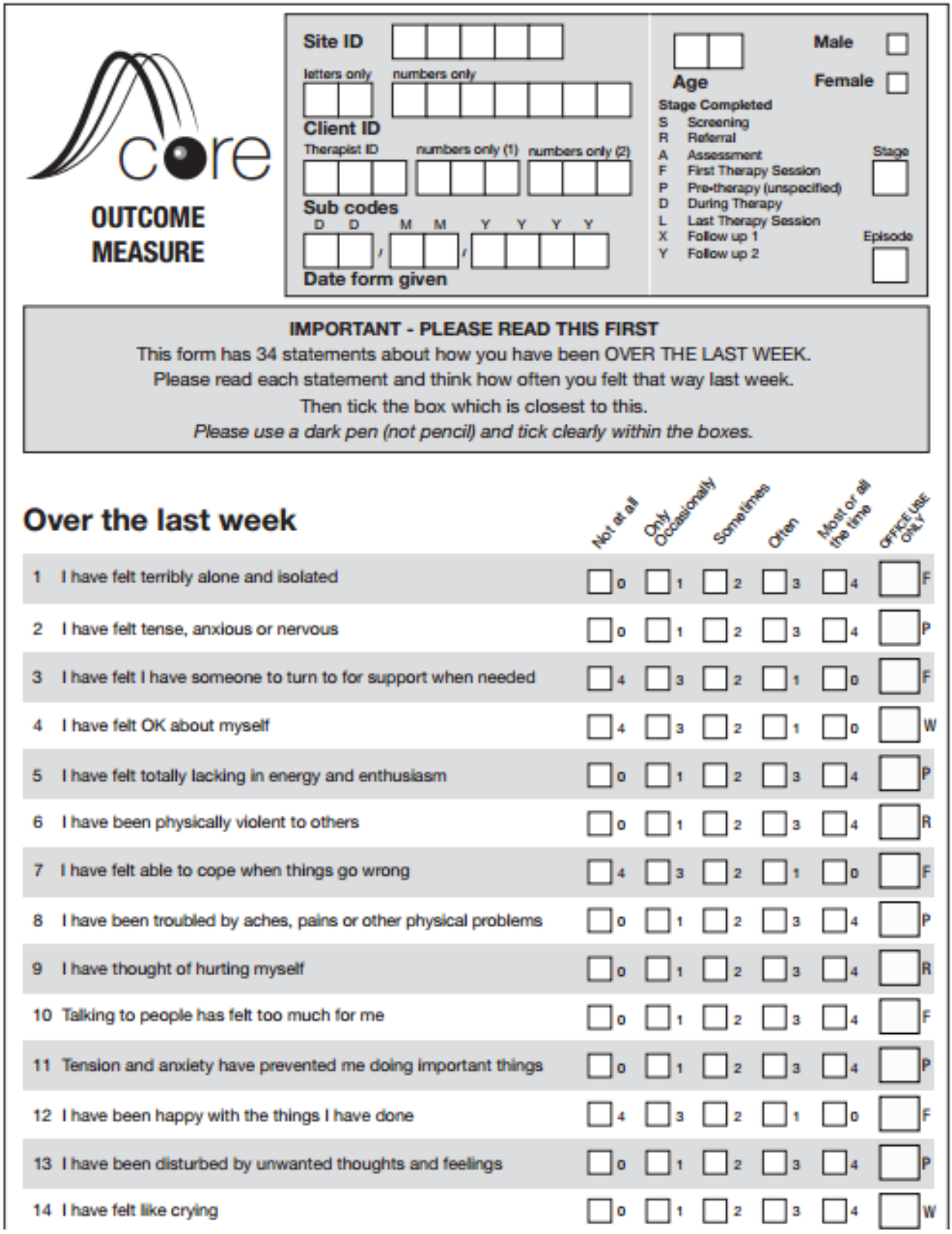
……
……

If there is anything you think would make it easier for you to access and continue with treatment whilst in prison describe it here:

……
……

Thank you for taking the time to complete this questionnaire.

Appendix 7. The Clinical Outcomes in Routine Evaluation (CORE-OM)



core

OUTCOME MEASURE

Site ID

letters only

numbers only

Client ID

Therapist ID

numbers only (1)

numbers only (2)

Sub codes

Date form given (D D / M M / Y Y Y Y)

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt OK about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
16 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
17 I have felt overwhelmed by my problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W
18 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
19 I have felt warmth or affection for someone	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
20 My problems have been impossible to put to one side	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
21 I have been able to do most things I needed to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
22 I have threatened or intimidated another person	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
23 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
24 I have thought it would be better if I were dead	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
25 I have felt criticised by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
26 I have thought I have no friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
27 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
28 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
29 I have been irritable when with other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
30 I have thought I am to blame for my problems and difficulties	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
31 I have felt optimistic about my future	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
32 I have achieved the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
33 I have felt humiliated or shamed by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
34 I have hurt myself physically or taken dangerous risks with my health	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

	(W)	(P)	(F)	(R)	All items	All minus R
Total Scores	☐	☐	☐	☐	☐	☐
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)	☐	☐	☐	☐	☐	☐

Appendix 8. HMPPS Ethics Committee Approval Notification

O'rourke, Rachel [HMPS] <Rachel.O'rourke@hmps.gsi.gov.uk>

Fri 07/04/2017, 08:29

Hello,

HMP YOI Aylesbury is happy to support this project **Ref:** 2017-113 once the university ethics board approval is received.

Katherine, simply make contact with Jake Shaw who you know of course once you are in receipt of this and you can initiate your research. Please let me know if I can be helpful in any way whilst you're carrying out your project, otherwise good luck with it and we look forward to reading the final report.

Many thanks - Rachel

Rachel O'Rourke CPsychol AFBPsS CSci
Registered Forensic Psychologist
Cluster Lead Psychologist [Thames Valley prisons]

HMPPS Psychology Service [London & Thames Valley region]
Public Sector Prisons Directorate
Base: HMPYOI Aylesbury
✆ *Desk: 01296 44 4171 / VPN: 7003 4171*
✆ *Mobile:* 07875 696 313

Appendix 9. Royal Holloway Ethics Committee Approval Notification

Ethics Application System <ethics@rhul.ac.uk>

Sun 14/05/2017, 22:27
McGrath, Katherine (2015);
Farquharson, Lorna;
ethics@rhul.ac.uk

PI: Dr Lorna Farquharson
Project title: Barriers to accessing treatment in prison for BME male young offenders with emerging personality disorder

REC ProjectID: 407

Your application has been **approved** by the Research Ethics Committee.

Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

Appendix 10. Permission to adapt The BACE for use this study

TG

Thornicroft, Graham <graham.thornicroft@kcl.ac.uk>

Mon 11/07/2016, 15:13

Thanks katherine
This is a nice study
I understand your need to adapt the scale
At the same time the modifications are substantial
And the psychometric properties for the bace scale will not apply

Therefore I suggest you go ahead
But do not describe the measure as the bace
But rather say that the items were adapted from those in the bace, and changed with permission
Ie you use your versions of the items and do not say that you used the bace scale
I hope that this is accepatable to you
best wishes

graham

MK

McGrath, Katherine (2015)

Fri 08/07/2016, 11:12

PotentialBACEAdapataionPrisonPopulation.docx18 KB

Dear authors,

I am a first year trainee on the doctorate in clinical psychology course at Royal Holloway. I am in the process of developing my thesis at the moment which is looking at barriers to accessing care for black minority ethnic male young offenders.

I have been looking for some appropriate measures to use and the BACE seems most appropriate for this study, it covers a lot of information we are interested in. I can see from the 'conditions of use' that no changes to the wording can be made. This is the reason I am contacting you, some of the questions in the BACE would maybe need slight alterations to be able to be used in a prison population, and a couple of the questions would be non-applicable for all participants. Your colleague Jheanall kindly sent me the 34 item BACE, I have attached it to this email with the proposed adaptations for certain items, the majority would stay the same.

I was wondering if you would be able to have a quick look at the proposed adaptations and let me know your opinions? I am on leave now until 24th July but I have copied in my supervisor Dr Lorna Farquharson and she will able to answer any questions over the next two weeks until I am back. I look forward to hearing from you,

Kind Regards,

Katherine McGrath Trainee Clinical Psychologist

Appendix 11. Table showing how the BATP was adapted from the BACE

BACE Item No.	BACE Barrier Item (Clement et al. 2012)	BATP Item No.	BATP Barrier Item
1.	Being unsure where to go to get mental health care	1.	Being unsure where to go to get help
2.	Wanting to solve the problem on my own	2.	Wanting to solve the problem on my own
3.	Concern that I might be seen as weak for having a mental health problem	3.	Concern that I might be seen as weak
4.	Fear of being put in hospital against my will		*Removed as non-applicable*
5.	Concern that it might harm my chances when applying for jobs. Not applicable □	4.	Concern that it might harm my chances when applying for jobs in prison.
6.	Problems with transport or travelling to appointments	5.	Problems with movements across the prison needed to access the services.
7.	Thinking the problem would get better by itself	6.	Thinking the problem would get better by itself
8.	Concern about what my family might think, say, do or feel	7.	Concern about what my family might think, say, do or feel
9.	Feeing embarrassed or ashamed	8.	Feeing embarrassed or ashamed
10.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)	9.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)
11.	Not being able to afford the financial costs involved		*Removed as non-applicable*
12.	Concern that I might be seen as ‘crazy’	10.	Concern that I might be seen as ‘crazy’
13.	Thinking that mental health care probably would not help	11.	Thinking that treatment would probably not help

14.	Concern that I might be seen as a bad parent Not applicable □		*Removed as non-applicable*
15.	Mental health care from my own ethnic or cultural group not being available	12.	Care from my own ethnic or cultural group not being available
16.	Being too unwell to ask for help	13.	Being too unwell to ask for help
17.	Concern that people I know might find out	14.	Concern that people I know might find out
18.	Dislike of talking about my feelings, emotions or thoughts.	15.	Dislike of talking about my feelings, emotions or thoughts
19.	Concern that people might not take me seriously if they found out I was having mental health care	16.	Concern that people might not take me seriously if they knew I was receiving professional help
20.	Concerns about the treatments available (e.g. medication side effects)	17.	Concerns about the therapies or treatments available.
21.	Not wanting a mental health problem to be on my medical records	18.	Not wanting a details of my treatment to be on my notes
22.	Having had previous bad experiences with mental health staff	19.	Having had previous bad experiences with health care professionals
23.	Preferring to get help from family or friends	20.	Preferring to get help from family or friends
24.	Concern that my children may be taken into care or that I may lose access or custody without my agreement Not applicable □		*Removed as non-applicable*
25.	Thinking I did not have a problem	21.	Thinking I did not have a problem
26.	Concern about what my friends might think, say or do	22.	Concern about what my friends might think or say or do

27.	Difficulty taking time off work Not applicable □	23.	Difficulty taking time off from prison job or education (if applicable to you)
28.	Concern about what people at work might think, say or do Not applicable □	24.	Concern about what people on the wing might think say or do
29.	Having problems with childcare while I receive mental health care Not applicable □		*Removed as non-applicable*
30.	Having no one who could help me get mental health care	25.	Having no one who could help me access treatments
31.	Having asked for help but not receiving it	26.	Having asked for help but not receiving it
32.	Having asked for help but having to wait a long time before receiving it	27.	Having asked for help but having to wait a long time before receiving it
33.	Concern that mental health staff will not understand cultural issues that are important to me	28.	Concern that staff will not understand cultural issues that are important to me
34.	Concern that I will be treated unfairly by mental health staff or services because of my ethnic background	29.	Concern I will be treated unfairly by staff because of my ethnic background
		30.	Lack of trust in professionals providing care and treatments
		31.	Lack of trust in prison system which these services are based in
		32.	Concern about my personal safety whilst participating in a treatment programme