Audit of a mindfulness based cognitive therapy (MBCT) course within a prison

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Abstract:

This article examines the effectiveness of the Eight week Mindfulness Based Cognitive Therapy course for Depression within the prison population. Prisons see higher rates of mental ill health across the spectrum and we were interested to see how a manualised mindfulness approach to treating depression, a major cause of ill health, would affect this cohort.

Introduction

This audit evaluates the effectiveness of an eight week MBCT programme conducted in a prison environment. It considers, the value of running a similar programme in future, what lessons can be learnt and how the programme could be improved. The impetus for this project originated from members of a prison-reading group. A lecturer form London South Bank University was asked to attend a book club for a professional mental health perspective on the topic of discussion. The value of mindfulness was raised and participants were very keen to start up a mindfulness programme within the prison. They believed that it would be a valuable tool in learning to cope with the stress of the prison environment and they were hopeful of learning new skills in dealing with life in general.

Fig A: Table showing a quick reference to levels of mental health, self-harm and suicide within the prison population 2017/18 as compared with the general population, where numbers are available. According to the recent parliamentary review, the prison population in England and Wales in May 2018 was 83,430 (Sturge, 2018). The same report highlighted that prisoners were receiving longer sentences, with 46% being over 4 years in 2018, compared with 33% in 2010. Additionally, 58% of prisons were reported as being overcrowded causing increased incidents of mental health problems and suicide (Hey and McNulty 2015). In summary,

offenders are a group with a significant prevalence of pre-existing trauma and mental health problems, who are being incarcerated for longer periods in more crowded conditions. They are experiencing a concomitant increase in emotional distress and mental health problems, expressed through substance misuses, self-harm, violent incidents and suicide attempts.

Percentage of prison population with a mental disorder v general population 2017/8 per 1000 population		
	(Male & Female)	General Population
Self-harm	81%	-
Suicide	0.8 %	0.16%
affective disorders	40%	16%
Personality disorders	64%	5%
Psychosis	10%	0.5%
Multi-morbidity	76%	7.9%
Substance misuse	49%	-
Dual diagnosis	72%	0.05%

Background

The environment

According to the recent parliamentary review, the prison population in England and Wales in May 2018 was 83,430 (Sturge, 2018). The same report highlighted that prisoners were receiving longer sentences, with 46% being over 4 years in 2018, compared with 33% in 2010. Additionally, 58% of prisons were reported as being overcrowded causing increased incidents of mental health problems and suicide (Hey and McNulty 2015).

There was also a 13% increase in reported assaults from 2016 to 2017 (29500 assaults), which in turn was 44% more than 2015. Additionally, there were 8429 reported assaults on prison staff, with 864 being in the 'serious' category (National Audit Office, 2017).

Mental health

Mental health problems are very common in people in contact with the criminal justice system. An estimated 39% of people detained in police custody had some form of mental disorder, and over 25% of residents in approved premises (previously known as bail hostels) had been found to have a psychiatric diagnosis (National Audit Office 2017). Government does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives. It is therefore hard to see how Government can be achieving value for money in its efforts to improve the mental health and well being of prisoners, according to a report by the National Audit Office. Her Majesty's Prisons and Probation Service (HMPPS), NHS England and Public Health England have set ambitious objectives for providing mental health services but do not collect enough or good enough data to understand whether they are meeting them. We have included several studies on trauma and PTSD, as numbers were not included in recent National Prison Audits (2017) and more information on suicide and self harm as this is where our interests lay

Trauma

Howard et al (2017) reported high rates of trauma in the prison population, with 97.8% of participants report having experienced traumatic events and 60.5% meeting DSM-5 criteria for a diagnosis of Post Traumatic Stress Disorder. James and Todack (2018) found slightly lower rates of PTSD (19%) but stated that this rate was equal to that of soldiers who served in Afghanistan and/or Iraq. Finally, Fazel (2018) completed a mental-analysis of data going back to 1980 and found that prisoners had diagnosis rates of PTSD of between 0.1 and 27% for men,

with the pooled rate for men being 6.2% (95% CI: 3.9, 9.0). Stensrud et al (2018) found that 65% of male sex offenders and 42.7% of low risk male offenders, within their study, had experienced 4 or more traumatic events. This is higher than the normative average rate of 9.2% for males in the general population.

PTSD is seen as situational: being held hostage, witnessing violent deaths, and prolonged personal assault: incarceration would fit this description for many prisoners, and our cohort would at times refer to their environment with real horror.

Complex PTSD is thought to be the more severe type of PTSD and this is diagnosed when:

- traumatic events happened early in life,
- if trauma was caused by a parent or carer,
- the person experienced the trauma for a long time,
- the person was alone at the time of the trauma and there is still contact with the person responsible for the trauma.

It also recognises that it can take years for complex trauma to be recognised and that behaviour, including self-confidence can be altered as the child grows up. Symptoms include marked feelings of guilt or shame, difficulty-controlling emotions, periods of losing attention and concentration, physical symptoms, relational difficulties and destructive or risky behaviour such as self-harm, alcohol or drug self-medicating and suicidal thoughts (NICE 2013).

Research on complex trauma is focussing on how the brain retains memory: essentially, there is explicit memory (conscious, verbal awareness) and implicit memory (unconscious sensory awareness) (Rothschild 2000). Sensory memory is central to understanding of traumatic memory. Individuals with complex trauma feel the memory of their trauma, the felt sense of it, (implicit) but will be missing the awareness to make sense of this, the explicit memory of it.

The world is experienced with a radically different nervous system (Rothschild 2000, Van der Kolk 2007 Ogden & Fisher 2015), one which is continually wound up, leading to states of hyper arousal (seen through the lens of anger) or withdrawal.

Self-harm

There were 44,600 instances of deliberate self-harm between 2016 and 2017, a rise of 11%. These acts of self-harm were related to 11,600 individuals, a rate of 3.8 instances per individual. The rates of reported self-harm in male prisons has risen from 50% of reported instances in 2009 to 81% in 2017. The rate of males reporting self-harm has doubled in the 10 years to 2017 (National Audit Office, 2017).

Suicide

There were 299 prisoner deaths in 2017 of which 23% (69) were deemed to be self-inflicted, with 21% currently awaiting outcome. The 'self-inflicted' death rate of 0.8 per 1000 in the male prison population is significantly higher than the general population's rate of 0.16 per 1000 (Prison reform Trust, 2017).

Re-offending

The Prison Reform Trust 2017 identified that 47% of adults were reconvicted within one year of release from prison. For those serving sentences of less than 12 months, this increased to 58%. Nearly three quarters (73%) of under 18 year olds were reconvicted within a year of release. The impact of prison goes beyond the offender, approximately 200,000 children in England and Wales had a parent in prison at some point in 2009.

The strongest dynamic predictors of any reoffending for men and women were class 'A' drugs and binge drinking. The strongest dynamic predictors of violent reoffending were; a lack of accommodation, being the victim of domestic violence (more women than men), problem

drinking, weak family ties, binge drinking & issues with temper control. The latter three being strongest predictors for women. All the predictors correlate strongly with early childhood issues with attachment or early traumatic childhood experiences (Van der Kolk, Mcfarlane & Weisaeth 2007, Odgen, Minton & Pain 2006). Less than 1% of all children in England were in care, but looked after children make up 30% of boys and 44% of girls in custody.

In summary, offenders are a group with a significant prevalence of pre-existing trauma and mental health problems, who are being incarcerated for longer periods in more crowded conditions. They are experiencing a concomitant increase in emotional distress and mental health problems, expressed through substance misuses, self-harm, violent incidents and suicide attempts.

Mindfulness cannot address the wider socio-economic antecedents to their situation, but it has potential to enable offenders to find more adaptive ways to respond to their trauma and dally stresses.

What is mindfulness?

Mindfulness Based Stress Reduction (MBSR), (Kabat-Zinn1990) and Mindfulness Based Cognitive Therapy (MBCT) for Depression (Williams, Teasdale & Segal 2002) were developed as clinical interventions establishing mindfulness as a way to treat both physical and psychological symptoms (Harrington & Dunne 2015, Creswell 2016, Baer 2018, Shapiro & Carlson 2009). Since then, the popularity of mindfulness interventions has advanced into many other realms of Western medicine and psychology. The key difference between MBCT and MBSR is that in the MBCT programme, there is an explicit focus on turning toward low mood and negative thoughts early in the program. This enables participants to gain experience with recognizing these symptoms and confidence in their ability to respond skilfully.

MBCT is a proven care pathway for chronic depression in the NHS (National Institute of Clinical Excellence: NICE, guidelines 2018). Mindful practice is concerned with changing the function or relationship to events. Teasdale (1999) suggested that sad moods reactivate thinking styles associated with previous sad moods. Previously depressed patients would be particularly vulnerable to this 'differential activation,' since they have relatively easy access to negative material (e.g., thoughts, attitudes, assumptions). MBCT focuses on thoughts as process rather than the content of individual thoughts. It seeks to help practitioners to develop the ability to step outside of negative thinking patterns by being mindful and to let go of the constant striving to escape unhappiness. This gives a very different feel to the group dynamic and facilitates the idea of inquiry and journey as opposed to problem solving and resolving.

This change from "doing" (discrepancy based model, used in striving to avoid/or achieve, with key qualities of rumination and problem solving) to a "being" mode (Williams 2008) means that the key skills of mindfulness and mode change are: awareness of what the current state of mind is and the ability to disengage from the dysfunctional modes of mind. This can best be explained by examining in more detail a particular mode of mind, rumination.

Many studies have shown that ruminations maintain or intensify depressive symptoms and impair problem-solving abilities (Teasdale et al 2000; Bockting, et al 2005; Hollan, et al 2005; Jarrett, et al 2000; Fava et al 1994, 1996, 1998; Scott et al 2000). The "doing" mode of mind (goal oriented, problem solving non-accepting of how things are) is particularly damaging as it naturally seeks evaluations and judgements on body sensations and thoughts. Mindfulness, by engaging with "being" mode fosters a decentred relationship to negative thoughts and feelings. Thoughts can be viewed as analogous to clouds in the sky. Just as clouds are not the sky, so thoughts are not the person. This approach encourages direct experience and intuitive "wisdom". A mindful approach has been shown to be useful in both mental health and physical health disorders and meta-analysis of standardised mindfulness practice showed that the

evidence supports the use of MBSR and MBCT to alleviate symptoms, both mental and physical, in the adjunct treatment of cancer, cardiovascular disease, chronic pain, depression, anxiety disorders and in prevention in healthy adults and children. (Gotink et. 2015).

The Role of Mindfulness in the Criminal Justice System

The research on mindfulness in prisons primarily comes from the USA. This has found that mindfulness is beneficial in reducing hostility, reducing mood disturbance and increasing self-esteem and impulse control (Banerjee et al 2007, Himelstein 2011, Lyons & Cantrell 2016, Michaelson et al 2005, Samuelson et al 2007, Shonin et al 2013, Sumpter et al 2009). Mindfulness has also been associated with a decrease in the rates of recidivism in youth and adult (Dafoe & Stermac, 2013, Sharma & Haider 2013,).

Auty, Cope and Liebling (2017) completed a systematic review and 2 meta-analysis' on the impact of mindful mediation and yoga for prison populations. They found a correlation between the intervention and improved psychological wellbeing and behavioural functioning of prisoners. Shonin et al. (2013) also completed a systematic review on Buddhist derived interventions (BDI; including mindfulness) and noted the overall poor quality of available literature. They examined 85 papers but only included 8 in the review due to quality appraisal issues. Nevertheless, they concluded that BDI including Mindfulness are an effective intervention for prisoners.

Simpson et al. (2018) reviewed the available literature for mindfulness treatments and young offenders. They included 13 studies and concluded that the studies indicated that mindfulness improved mental health, self-regulation, problematic behaviour, substance use, quality of life and criminal propensity. Murray, Amann and Thom (2018) also reviewed the literature for mindfulness and young offenders, meta-synthesising 10 studies. They found that mindfulness could help reduce stress and anger and improve self-regulation and acceptance.

Yoon, Slade and Fazel (2017), conducted a systematic review and meta-analysis on therapy efficacy for prisoners with mental health problem, including 35 papers. They identified a medium effect size for most therapeutic interventions, with CBT and mindfulness being the most efficacious, although they too noted quality issues in the available literature.

Zgierska et al. (2009) reviewed 25 papers and found the mindful mediation had small effective in reducing substance misuse relapse. Subsequently, Moyes et al (2016) reviewed the literature on prisoners with dual diagnosis and found that mindfulness is an effective treatment for those with 'low-level' dual diagnosis.

The Mindfulness All-Party Parliamentary Group (MAPPG 2015) also report on the successfulness of mindfulness in prisons. They have highlighted that mindfulness can be beneficial for prisoners for improving self-regulation and decreasing negative affect.

The prison service and prison population face unique pressures and issues. It is valuable to review the nature and magnitude of the challenges.

Method

Mindfulness Project Thameside Prison

LSBU were given the opportunity to engage with the men as part of a prison reading group and to provide a professional therapeutic voice in the discussion on depression was the central theme the book the men were discussing.

The participants were curious to know our background and became especially interested in mindfulness. They were curious to know how it might help them and wanted to try out a group. Mindfulness is not a therapy: there was no stigma attached to their curiosity and emphasis was placed on this being something that could improve their experience of prison. The men initiated interest in the mindfulness project and pressed for the chance to have a group within the prison

The LSBU mindfulness research group (LMRG) approached Thameside prison with an offer of a full week 8 week course of MBCT (mindfulness based cognitive therapy).

These sessions were usually 2.5 hours in length, but also included a 6-hour silent day in week 6.

The decision was made to run an MBCT programme rather than the MBSR (mindfulness based stress reduction) as MBCT is more structured in the skills that are taught. These skills can help participants with lowering rates of anxiety, depression & suicidality. They would also learn to recognise when their mood was lowering and to be able to do something about this before it became too difficult.

Twelve participants initially attended. However, one subsequently left, voluntarily and four more were moved to other prisons. The remaining seven completed the programme.

The initial programme involved a number of stages:

STAGE 1

LMRG met with a range of different agencies and service providers within Thameside to ensure that the MBCT programme was explained and placed in context with the other rehabilitative and therapeutic activities running at present

STAGE 2

LMRG began a screening and assessment process by which to identify prisoners that were appropriate for the MBCT course. Whilst the selection was designed to be as open as possible, there needed to be some exclusion criteria. These were applied to any prisoners who posed a major management risk of violence to others, any prisoners who were actively psychotic, and any prisoners who were actively struggling with issues of ongoing drug use or intoxication. These criteria were agreed between LMRG and Thameside itself, as otherwise there was a risk

of breaching prison protocols. An initial 12 prisoners were selected. Whilst the ideal MBSR group does not always have a ceiling in terms of numbers, it is generally recognized that any more than 20 is potentially problematic in the amount of time and attention that can be given to any single participant. LMRG negotiated 12 places with the prison in order to provide a compromise between the high demand and ensuring proper facilitation and risk (especially with the needs of this particular group of participants). All participants were interviewed for an hour and a half for a comprehensive assessment. The interview focussed on current concerns or stressors, and how these might be linked to current and past behaviour. Health considerations were taken into account and background and family history were noted. Employment history and forensic history were discussed and participants were encouraged to talk about what had drawn them to the mindfulness course

STAGE 3

LMRG and Thameside organized the materials required for the MBCT group, including stools, blankets, CDs and the printing of the MBCT manual.

STAGE 4

This was the intervention stage in which the 8-week MBCT programme was run (see figure 1, below).

Figure 1: MBCT 8 week programme

Week	Topic
Session 1	Awareness and automatic pilot and extending new learning
Session 2	Living in our heads

Session 3	Gathering the scattered mind
Session 4	Recognizing aversion
Session 5	Allowing/letting be
Session 6	Thoughts are not facts
	ALL DAY SILENT RETREAT
Session 7	"How can I best take care of myself?"
Session 8	Maintaining & extending new learning

STAGE 5-

This stage was concerned with endings and reviewing the programme, including rating scales and interviews. We also decided to have a discussion panel with participants to talk about what might be useful changes to make to the programme.

The feedback was overwhelmingly positive, with all of the participants remarking on how the programme had improved their quality of life. They also spoke of how the practice had helped them adapt to their lives in new and more helpful ways, with a marked reduction in anxiety, low mood, suicidality and despair. The positive feedback was very encouraging. It was noticed

by staff that the participants were far more settled than before, and participants agreed with this. They also felt that their practice was acting as a role model to other prisoners. LMRG was encouraged to repeat the programme and think about how the MBCT could be used to help prisoners across the spectrum of needs that they present.

STAGE 6

Three-month after the programme was run a follow up & discussion with group was held to ascertain the participants reflections on the programme. In particular, what worked and what part of the programme needed adjustments.

Results

Participants expressed the view that the programme needed to be longer as their circumstances were different from a more traditional depression group, with added difficulties in the type and range of emotion felt and issues around safety in the group.

They all considered that they benefitted from the yoga and that this was a major breakthrough for them, in terms of noticing a reduction in hyper arousal states and generally helping with extreme aches and pains in the body. It was noted that this group had a very different relation with the body than other non-clinical groups, this relation being typified by chronic pain. This was the sort of body response typified in a depression group but even more intense.

The guided practice tapes used standard language as heard in any MBCT group and the men had real issues with this. They believed that the language should be far more “down to earth”. However, this concern did not extend to the poems chosen. The participants really enjoyed the poetry chosen, even if it was difficult to understand at times or used a language style they were not familiar with.

Participants found access to the guided practice was difficult as the promised CD players, to facilitate this exercise, did not all arrive.

Participants need to commit to practice in order to benefit from the programme. Participants were required, as standard to carry out between session homework and create dedicated time to ensure that these took place. An unexpected side effect of the environmental constraints of the prison meant that they were able to commit to the practice (by being so restricted), whilst also quickly noticing its value in helping them manage the ennui of the prison's "lock down" regime.

One of the adaptations we had to make to the course as we were doing it was to increase the length of the course from 2 to nearly three hours, in line with the original Mindfulness Based Stress Reduction programme (John Kabatt Zinn 1990). Prison life is very regimented and the time we had to do the MBCT programme had to fit in with prisoners' "movements", allocated times when the population are given to move around the prison. Prisoners are not allowed to move freely and are given "blocks of time" before they are allowed to move from one part of the prison to the other. Extending the sessions maximised use of the block of time available and provided participants with more time to build trust.

Their feedback was that the eight week course really helped them in the management of the stress and chaos of the prison regime, and also gave the long periods of "lock down" a structure and purpose. They also reported that other prisoners observing their practice had become interested and they had shared their knowledge and learning with them to promote practice on a wider scale on their prison wings. Written feedback of the group: one group member had written an article in the prison journal of his experience, which stated that

"…we were feeling common experiences such as anger, stress, loneliness and depression. Once identified, we discussed how we could teach ourselves to cope with these feelings"

And

“Accepting that you have no control over what comes into your head but knowing how to refocus was the “breakthrough” moment for me and has helped reduce my negative thoughts and emotions.”

Discussion

Mindfulness research in prisons has focussed mainly on looking at differences in clinical states: reductions in depression, reduction in anxiety or at positive change, so changes in recidivism, changes in impulse, control changes in suicide and self-harm, with similar results for yoga practice (Auty, Cope and Liebling 2017).

The decision to offer a MBCT rather than a MBSR programme worked well as participants enjoyed a structured approach which taught them to look at how thoughts could influence their emotions. They learnt to recognise at an earlier stage the importance of noticing warning signs that their mood was changing. This meant that they had the skills not to respond habitually but to create new patterns of being, and therefor new neural pathways (Williams, 2007). At the follow-up three months later, participants reported still feeling improvements in the overall health & wellbeing.

Once the group was established the participants attended regularly. Consequently, the transfer of four participants was frustrating for them and unsettling for the group.

In prisons, there is a much greater issue of trust. We found that eight weeks, which works for the general population, is too short for the prison population: more time needs to be spent on making the group feel safe. Statistics show this is a cohort that is going to have a stronger

prevalence for severe forms of anxiety, depression & trauma responses the National Audit Office 2017, The Prison Reform Trust

We struggled with some of the exclusion criteria that we had intended to apply. Normally in most MBCT groups, patients are seen in remission from depression and not actively suicidal. However, Barnhofer et al (2018) has suggested that a mindful programme is beneficial to those participants who felt suicidal. Following interviewing potential participants, we considered that it would make sense to include those with high levels of distress and suicidality

The studies we reviewed didn't seem to address the impact of trauma on the prison population and its effects on individuals. Observations were made that noted these were symptoms displayed by group members and testimonials written by the men refer to a reduction in their feelings around suicide. The group members showed typical trauma responses such as hyper arousal, which translated into difficult body sensations and reduced thought processing (Van der Kolk 2015).

The process of trauma and the impact of early childhood attachment on the brain is slowly becoming more apparent, and this is beginning to inform practice.

When we looked at research conducted by Travers and Mann (2018) we discovered key traits of trauma: at the top of the list was poor problem solving, closely followed by impulsivity and followed by adverse childhood experiences. Poor temper control and binge drinking and drug misuse were also high. The strongest dynamic predictors of violent reoffending for women included temper control, problem drinking, and binge drinking, alongside lack of closeness with family: all strong correlators for chronic trauma. The most prevalent criminogenic factors for women and men were poor problem solving, impulsivity, and unemployment (Travers & Mann 2018). Within our group, we found poor problem solving, impulsivity and adverse

childhood experiences were key to understanding our cohort's experience, closely followed by poor temper control and drug use.

Mindfulness teaches us to start being aware of what we are experiencing: it focusses on what is happening right now and encourages curiosity of the felt senses. However because trauma response is grounded in the body, additional work involving sensory motor responses have been proven to be effective (Van der Kolk, Ogden et al 2016), as trauma is often "the speechless terror" (Ogden 2016, p Wilde & Gur 2008, Scott et al 2018 , Etkin 2015). This is where the traumatised person is reduced to silence and terror due to their body sensations being so overwhelming. Survivors of extreme traumatic exposure commonly exhibit difficulty recounting the terrible events they have suffered or witnessed. In our experience of the eight week course for this population, yoga and yoga based movement were very successful and this may have been in part due to the cessation or reduction in body sensations as hyper arousal systems were processed.

The voice recordings proved to be a source of difficulty, with group members having difficulty accessing CD players. The inventive use of playing the recordings over the radio partly solved the problem but further difficulties ensued when the wrong recordings were played: there was also an element of "Big Brother", that is mantras being chanted over a loudspeaker system to pacify a captive audience about this arrangement (Orwell 2008)

In line with the central tenets of mindfulness, often the strongest impact on the group came from what arises through the inquiry. Challenges that are met and worked with proved to have the strongest impact on the group and topics for inquiry including gender and sexuality were particularly nuanced and rich. The challenges of working with this population are not to be diminished, they were at times argumentative and would try and push barriers. However working with the edges of this in a mindful manner meant that challenges which were supposed

to push boundaries became subjects of deep connection. In particular, men who would try and use sexuality to provoke or "get a laugh" were instead allowed to become the subject of the guided practice. So questions around what constituted masculinity connected deeply with their experience.

Mindfulness is not an easy choice, it entails hard work. It is a behaviour driven way of being that can require someone to be at 'rock bottom' before they are able to fully immerse themselves in it. This makes it highly appropriate for the prison population. We found that homework, so often a source of difficulty in practice, became a source of comfort for participants and the difficulty was finding a ***safe space*** rather than time to practice. This was a group where participants would learn new life skills and we felt it was extremely important that it would be a group that members would be able to help co- run, and eventually run, maybe setting up a prison mindfulness programme. With this is mind, it became important to think about length of sentence and so, as part of our inclusion and exclusion criteria it was important to have a sentence of no less than 1 year. This would enable participants to engage in at least one group as an active participant and then receive a week's training (similar to mindfulness students receiving their first level teacher training qualification) and begin to co-teach other groups.

Limitations

This is an audit of a single program in one establishment, consequently, generalisations need to be treated with extreme caution.

Recommendations

The following points would enable similar programmes to be run more effectively in the future:

- All attendance should continue to be voluntary.

- Where possible participants should be allowed to complete the course and not moved to other prisons.
- Participants should be accepted who were actively feeling traumatised, anxious, depressed and suicidal.
- Pre and post ratings assessing mood be taken weekly and that the group facilitators work closely with prison staff with regard to risk.
- Care should be taken to use language that is accessible to all group participants.
- Access to a CD player has to be a priority for participants.
- The course needs to be 12 weeks to allow for longer orientation, trust building and exploration of trauma, impulse control, building resilience and social awareness.
- Group members, if they wish, should undergo a period of training so that they can become facilitators.
- Sessions be increased from two to three hours.

In addition to the MBCT eight week programme, we then considered that such was the presentation of the prison population (Travers & Mann 2018), that as well as the mindfulness programme, additional weeks which incorporated elements of self compassion therapy (Gilbert 2010) & dialectic behaviour therapy should be included, as well as an extended sensory motor approach to the group.

Conclusion

There is a real need to further refine the teaching of mindfulness for particular populations (Jamie Bristow, Chris Cullen, Mark Øvland 2010). The available evidence suggests that mindfulness based interventions can be effective for adult males and females and male young offenders for a variety of socials and psychological difficulties. There is a lack of research

available for understanding the role of mindfulness in female young offenders. The social and psychological difficulties treated include depression, anxiety, poor social skills etc, but the literature can perhaps be best summarised as there being a link between mindfulness and improvement in prisoner's quality of life.

However, this conclusion should be tempered by the poor quality and heterogeneous nature of the available research. This reduces the generalisability of the available studies and makes drawing firm conclusions on the effectiveness of mindfulness in the prison population difficult. Research around trauma and how this links in with perpetuating behaviours linked with criminal activity are particularly poor and robust research in this area would be of great interest.

This audit has demonstrated proof of concept for this initial project and we recommend a sustainable continuous programme of mindfulness is established in prisons. It can help people find their place, accept responsibility, stop feeling fear and fulfil their rightful potential.

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Research on prison population can be found at the National Audit office and useful research on factors inhibiting recidivism at the MoJ site.

Work on trauma and psycho motor responses and neurology can be found in the works of Pat Ogden, Bessel Van der Kolk and Babette Rothschild.

Clinicians interested in working with trauma body response should contact

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