# A Qualitative Review and Thematic Synthesis of Resident Experiences in Prison-based Democratic Therapeutic Communities

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The authors report there are no competing interests to declare.

This research received no external funding.

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## Abstract

A qualitative systematic review and thematic synthesis was conducted to explore residents’ perspectives of prison-based democratic therapeutic communities (DTCs). This is important to inform effective treatment for residents of these communities. Five databases were searched for studies published between January 1962 and November 2023. Following screening, eleven qualitative studies were included in the review. Collectively, the review sample were 153 male residents of prison-based DTCs. Three themes were generated by thematic synthesis: (1) The Importance of Safety in the Therapeutic Environment, (2) Opening Up to Vulnerability and (3) Life Within and Beyond the DTC. Experiences were highlighted within the papers reviewed where progress in each of these areas was comprised for some residents, due to inequalities, stigma, and disconnection. Further training and awareness to support residents who experience such difficulties is needed. Interventions within prison-based DTCs to help reduce toxic masculinity and promote emotional vulnerability are also recommended. In addition, there is a need for culturally informed and adapted practices to help those from minoritized background integrate into prison-based DTC communities. Further qualitative research across UK prison-based DTC settings incorporating the voices of those participating in therapeutic communities would be beneficial to expand the generalisability and diversity of findings.

Keywords: Prison, Therapeutic Communities, Experiences, Residents

## Introduction

Approximately 95,526 prisoners reside in prisons across the United Kingdom (UK) (Sturge, 2023). Prisoners with complex mental health needs and severe risk-presentations to self and others can be referred for specialist support within the Offender Personality Disorder (OPD) Pathway (National Health Service (NHS) England, 2023). The OPD pathway replaced the National Personality Disorder Programme (NPDP) and was developed in 2011 jointly between His Majesty's Prison and Probation Service (HMPPS) and NHS England. The pathway was designed to provide evidence-based rehabilitation to better suit the growing complex needs of high-risk offenders across prison sectors using a range of therapeutic approaches(Haigh & Benefield, 2019; HMPPS, 2018; Skett & Lewis, 2019). The pathway is designed to support residents to access formulation-driven interventions, across their journey through prison and beyond, if applicable (Joseph & Benefield, 2012).

Prison-Based Democratic Therapeutic Community (DTC) treatment is one of many interventions offered within the OPD pathway (Ross & Page, 2023). Prison-based DTCs differ to hierarchical substance-misuse prison TC programmes, which focus towards addressing substance-use cessation, with external drug and alcohol services informing the intervention (Kennard, 2004). Prison-based DTCs adopt a greater holistic approach, enabling eligible residents with complex mental health needs to live together in a structured prison wing (Rawlings & Haigh, 2017). This is crucial, as an individual’s environment plays a key role in the development or dysfunctionality of core life areas, including their sense of identity, their meaning or purpose in life, their sense of agency and belongingness within a community (Ashforth, 2001, as cited in, Needs & Adair-Stantiall, 2018). Underdevelopment in these areas, coupled with adverse life events across the lifespan and experiences of societal disorganisation are associated with poorer mental health outcomes and increased chances of individuals engaging in criminal behaviours (Haigh & Benefield, 2019; Sahni & Krishnakumar, 2021).

DTCs serve to meet the psychosocial needs of residents, encouraging the development of routine, individual expression and alternative ways of thinking (Bennett & Shuker, 2017). DTCs are additionally shown to effectively reduce repeat reoffending in residents with therapy promoting the development of relational skills and exploration of new narratives (Stevens, 2012). Reductions in reoffending appear more robust when DTC treatment is followed by appropriate community intervention (Beaudry et al., 2021). The programme incorporates pre-group and community meetings to discuss current affairs , allocate roles to residents and explore group dynamics. Small therapy groups enable residents to talk openly about life experiences. The collaborative reflective feedback spaces ensure all residents are briefed about small therapy group topics. Residents also participate in other structured activities and events with others, to further develop relationships outside of therapy (Akerman, 2021).

Prison-based DTCs are heterogenous interventions which can evolve, within reason, to fit around residents’ needs, making for an effective intervention (Bennett & Shuker, 2017). Moreover, residents can experience the DTC in different ways. As residents enter the community, they can bring in a wealth of diversity, which can be impactful on their own and others’ experiences. This may be relative to their individual backgrounds and life experiences to what criminal offences they committed. Although essential, quantitative outcomes research can be difficult due to the individualised approach of the DTC (Capone et al., 2016; Pearce & Haigh, 2017; Richardson & Zini, 2021). Therefore, it remains important to understand experiences from residents directly engaging in interventions to ensure they are receiving effective treatment and to inform service development accordingly (Seers, 2015).

The aim of this review was to systematically synthesise qualitative research articles pertaining to understanding experiences of residents participating in UK prison-based DTCs. This may help towards conceptualising the impact of DTC therapy and capture a broader understanding of how they work from residents’ perspectives. This can support the development and adaptation of DTCs and further expand to inform the recovery and rehabilitation aims of the OPD pathway.

## Method

### *Pre-registration*

Prior to starting, the review was registered on the International Prospective Register of Systematic Reviews (PROSPERO) (ID: CRD42023583085). This served to ensure the review was novel, increase the transparency of the process the review was conducted by and minimise bias (Pieper & Rombey, 2022).

### *Search Strategy*

The conduct and reporting of this review was based on systematic reviews guidance recommended by the Centre for Reviews and Dissemination (CRD, 2009) and Boland et al. (2017). Following scoping searches, five bibliographic databases (APA PsycINFO, MEDLINE, CINAHL Plus, Scopus and ProQuest) were searched to determine any published or unpublished research, relevant to the topic area. These searches either covered the period from 1962-to November 2023 (as the first prison-based democratic therapeutic community was established in 1962 (Rawlings & Haigh, 2017) or the date the database commenced. Each bibliographic database housed on the EBSCO interface was searched individually. A hand search of the International Journal of Therapeutic Communities (IJTC, 2023) was also conducted from available journal issues from its online start date of 2012-2023. Experts known to the field of prison-based therapeutic communities were contacted to obtain any potential unpublished literature that could be included.

The search strategy was devised based on the results of the scoping searches, including terms that appeared frequently in relation to descriptions of the population "(MH "Incarcerated" OR MH "Incarceration" OR MH "Prisons" OR (prison\* OR forensic\* OR incarcerat\* OR offender\* OR perpetrat\* OR imprison\* OR convict\* OR inmate\* OR detain\* OR resident\*) and type of qualitative research or phenomena investigated (experienc\* OR perception\* OR view\* OR understanding\* OR opinion\* OR response\* OR qualitative\* OR theme\* OR attitude\* OR perspective\* OR interview\* OR “focus group\*” OR observation\* OR explorat\* OR investigat\* OR analys\*. The term “therapeutic communi\*” was used to define the type of intervention. Boolean operators of AND or OR were used to search accordingly. Where possible, MeSH and subject terms were included. Librarians were additionally consulted during the development of the search strategies. A table of the full search strategy is included in supplementary materials.

### *Inclusion and Exclusion Criteria*

Table 1 highlights the inclusion and exclusion criteria for the review.

**Table 1**

*Inclusion and Exclusion Criteria*

|  |  |
| --- | --- |
| **Inclusion Criteria** | **Exclusion Criteria** |
| Adult (18+) prisoners who are engaging or had engaged in UK prison-based democratic TCs or specialist learning disability (LD) TC+ communities | Experiences of residents in substance-misuse prison TCs  |
| Mixed method reviews, where qualitative data findings could be extracted | Studies of Prison-Based DTCs outside the UK due to differences in legal systems/prison management policies |
| Qualitative research studies | Studies that explored additional therapies or psychotherapeutic groups (e.g., psychodrama, art therapy) offered within prison-based TCs as they are not offered to every resident/not compulsory |
| Mixed method reviews where qualitative data could be extracted | Research related to participant experiences of pre-engagement strategies or aftercare of prison-based democratic therapeutic communities |
| Studies written in English | Alternative treatment interventions pertaining to the Offender Personality Disorder (OPD) Pathway or other prison therapy programmes (e.g. Sex Offender, Self-Change, Healthy Relationships Programmes) |
|  | Children/adolescents in therapeutic communities/Young Offenders Institutions |
|  | Research focused on staff experiences |
|  | Quantitative research studies |
|  | Books, book chapters, ethnographies, editorials, conference abstracts, short articles with incomplete data |
|  | Studies not written in English |

### *Data Screening*

A total of 4174 papers were found across all databases, as shown in Figure 1. Once databases were searched, the results were transferred to Rayyan (Ouzzani et al., 2016), a free systematic review software package. Articles that were not published in English (n=49) were excluded using an automated feature within Rayyan. Articles were de-duplicated leaving 2007 articles. An independent reviewer second screened 10% of abstracts (n=207) with excellent agreement (100%) (Polanin et al., 2019). These were first screened for their relevance to the review via title and abstract, retaining 49 articles. Upon searching for full texts, (n=1) report could not be sourced. The remaining 48 articles were full text screened with application of the inclusion criteria by the primary researcher and the independent reviewer with four discrepancies. These were discussed and decided upon inclusion or exclusion with the research supervisory team. Eleven articles were included in the review.

### *Data Extraction*

Data was extracted using a premade data extraction form using the following parameters: Author, Setting, Aims, Main Themes, Participant Sample Characteristics, Data Collection Method, and Research Design (see Table 2).

### *Quality Assessment*

The quality of the papers was assessed using the Critical Appraisal Skills Programme Qualitative Studies Checklist (CASP, 2023). The CASP checklist has 10 questions in total; each question was marked Yes (Y), No (N) or Cannot Tell (C/T). No scores were ascertained, as CASP (2023) does not recommend this. The primary researcher and independent reviewer used the tool separately, with high inter-rater agreement (92%). Discrepancies resolved through discussion with a second independent reviewer (trainee clinical psychologist).

### *Data Synthesis*

Data synthesis was undertaken qualitatively using thematic synthesis, as outlined by Thomas & Harden (2008). The results section of each paper was extracted and read several times, with the author making any initial notes of their thoughts in the margins. Line-by-line’ coding was completed using NVivo Version 14 (Lumivero, 2023), with at least one or more codes assigned to each line. This was to ensure meaning was captured effectively and was data driven, aligning with the researcher’s critical realist epistemological stance (Fryer, 2022). Critical realism considers the experiences elaborated upon within participants’ accounts, including their thoughts, emotions and behaviours, are shaped by context and the environment. The author further developed codes, moving from descriptive coding of individual experiences to consolidation coding, using theoretical concepts that group experiences together (Fryer, 2022). The initial codes were shared with the supervisory team. The primary author and the supervisory team were acknowledged to bring their own ideas and views into the interpretation of participants’ realities (Pilgrim & Bentall, 1999). Descriptive themes were developed by grouping codes that related to similar experiences of residents. Thematic mapping on paper was used to group concepts visually which was then transferred accordingly into the NVivo datafile. The descriptive themes were then developed further and grouped into analytical themes in line with the research question. The final codebook is included in supplementary materials.



**Figure 1**

### *Reflexivity*

The research team was made up of the primary researcher (trainee Clinical Psychologist), with previous experience of working in a community-based TC, a voluntary undergraduate psychology student, a research psychologist, a clinical psychologist, and counselling psychologist who led a community-based TC. The primary researcher used a reflexive journal to document thoughts, experiences and discussion with their supervisory team. This served to identify influences the researcher may have incorporated into both the design and analysis to minimise bias in the research process. Therefore this kept the decision-making process transparent (Jasper, 2005; Ortlipp, 2008). Versions of codebooks and thematic maps were created at each stage of analysis and explored with supervisors to ensure analytical themes were true to the data.

## Results

### *Study Characteristics*

Collectively, the review sample were 153 male residents (this was excluding nine residents from two studies (Sullivan, 2007; Sullivan, 2006) who were sent back to mainstream prison from the assessment wing, thus did not enter DTC treatment). From studies that reported age, residents ranged from 22-70 years old. The time residents spent in the DTC varied from one week to five years. Forty-six residents were those leaving the DTC; these were either planned having completed treatment or unplanned (been made to leave) or self-deselected from treatment (Duncan et al., 2022; Sullivan, 2007; Sullivan, 2006). The rest of the sample were active residents. Most studies were conducted within HMP Grendon (Akerman & Geraghty, 2016; Brookes et al., 2012; Dolan, 2017; Jacobs & Shuker, 2019; Jones et al., 2013; Kontosthenous, 2020; Sullivan, 2007; Sullivan, 2006), one in HMP Dovegate (Miller et al., 2006), one in HMP Gartree (Ross & Auty, 2018), and one in an unidentified Category B prison (Duncan et al., 2022). Only one study included residents from a TC+ wing, an adapted TC for individuals with learning disabilities (Duncan et al., 2022). As seven studies did not present ethnicities of participants, it was not possible to aggregate; however, from those that did residents were described as White British (Kontosthenous, 2020), Black (Brookes et al., 2012), Black Caribbean, Black British, Mixed/White/Black Caribbean, White Other, White Irish and Asian Other (Jones et al., 2013).

Ten out of the eleven qualitative studies were published papers, one was an unpublished thesis (Kontosthenous, 2020). Seven studies were authored by directors, clinical psychologists, forensic psychologists, or research officers who were employed by HMP Grendon (Ackerman & Geraghty, 2016; Brookes et al., 2012; Jacobs & Shuker, 2019; Jones et al., 2013; Sullivan, 2006; Sullivan 2007) and HMP Gartree (Ross & Auty, 2012). Four studies were authored by trainees (Kontostenous, 2020) and university research fellows and lecturers (Dolan, 2017; Duncan et al., 2022; Miller et al., 2006). Two studies utilised focus groups to collect data, and the rest used semi-structured interviews. Two studies did not use formal qualitative methodology, the rest either utilised Interpretative Phenomenological Analysis (n=4), Thematic Analysis (n=2), a Mechanical and Interpretive Approach (n=1), Grounded Theory (n=1) or Framework Analysis (n=1). One study used a mixed methods study design (Dolan, 2017), whereby questionnaire data informed the production of the interview schedules. As such, only the qualitative findings were included in the analysis for this review. Table 2 shows the full table of Study Characteristics and Main Themes of Included Studies.

### *Quality Assessment*

Overall, the quality of evidence was mixed; the table of ratings following conduction of the CASP qualitative assessments are illustrated in supplementary materials. Two studies met the full criteria of the CASP, thus were regarded as high-quality research (Jacobs & Shuker, 2019; Kontosthenous, 2020). Three studies used input from residents to help inform the construction of interview schedules and build up trust with residents (Brookes et al., 2012; Dolan, 2017; Sullivan, 2006). Six studies did not fully state how participants were identified and recruited to take part in the studies, thus were subject to selection bias. Seven studies did not comment on reflexivity of the research; thus it was not clear how authors’ subjectivity and experiences (as some worked within prison-based DTC settings) influenced the research process (Olmos-Vega et al., 2023). Five studies did not mention obtaining the relevant ethical approvals to conduct the research. Some studies lacked details of methodological processes they undertook when conducting interviews., For example, there were no descriptions of the topic guide used to guide interviews, no details about where the research took place and how interview data was collected and analysed.

**Table 2**

*Study Characteristics and Main Themes of Included Studies*

| **Authors** | **Setting**  | **Aims** | **Main Themes**  | **Sample Size and Demographics** | **Data Collection Method** |  | **Research Design** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ackerman & Geraghty (2016) | HMP Grendon | To explore how residents hold discussions in a prison DTC  | 1. Type of material that affects residents during therapy2. Impact of the material on group members3. How residents manage the material | N= 10 male. Committed violent/sexual offencesUnknown: ages, ethnicity, time spent in TC | Focus Group, Thematic Analysis |  | Thematic Analysis |
| Brookes et al. (2012) | HMP Grendon | To investigate experiences of ‘black’ prisoners who participate in DTCs | 1. Grendon2. Father Deficit3. Self-Concept4. Desistance – “knifing off” | N= 11 male, blackUnknown: Age, offence or time spent in TC | Semi-structured interviews, Grounded Theory |  | Grounded Theory |
| Dolan (2017) | HMP Grendon | To explore which factors which are most effective in changing behaviour within DTC | 1. Small Group Therapy2. Background and Family3. Discussing Offence Details/Impact4. Resolving Problems5. Feeling Responsible for Self and Actions6. Open Communication7. Feeling Safe, Trust and Empathy | ‡ N= 36 male, aged 22-70Time spent in TC: 1-60 monthsUnknown: Ethnicity, Offence | Semi-structured Interviews  |  | Framework Analysis |
| Duncan et al. (2022) | Category B UK Prison(unidentified) | To explore residents’ reasons for dropping out of the DTC, prior to completing therapy | 1: (Un)therapeutic Climate.2: Disillusionment with the Illusion | N=7 male Committed sexual offencesTime spent in TC = 4 months-5 yearsUnknown: Age, Ethnicity | Semi-structured Interviews |  | Interpretative Phenomenological Analysis |
| Jacobs & Shuker (2019) | HMP Grendon | To explore treatment experiences of residents within a prison DTC | 1. Therapeutic Process2. Acceptance3. Insight4. Relationships5. Barriers | N= 4 male, aged 28-49 (M=40), committed filicideTime spent in TC: 14-97 months (M= 56 months)Unknown: Ethnicity | Semi-structured Interviews |  | Interpretative Phenomenological Analysis |
| Jones et al. (2013) | HMP Grendon | To explore experiences of DTC therapy and determine how sensitive therapy was to their cultural backgrounds | 1. Therapy and Cultural Values2. Relating to Others3. Cultural Competency4. Cultural Understanding/Awareness5. Responses to Experiences | N= 8 male Ethnicities: Black Caribbean, Black British, Mixed/White/Black Caribbean, White Other, White Irish and Asian Other (N of each = unknown)Time spent in TC: Minimum of 12 monthsUnknown: Age, Offences | Semi-Structured Interviews |  | Thematic analysis |
| Kontosthenous (2020) | HMP Grendon | To explore experiences of residents engaging in DTCs | 1. Relating to others2. Community living3. Motivation to engage | N= 6, male, aged 26-64 years old (M=39), White British Committed violent or sexual offencesTime spent in TC:1 week - 5 years | Semi-structured Interviews |  | Interpretative Phenomenological Analysis |
| Miller et al. (2006) | HMP Dovegate | To understand resident’s experiences of change within DTCs compared to Grendon and if this type of research be done within focus groups. | 1. Change is a Process2. Self-Properties and Self-Agency3. Inter-personal Facets4. Change is Challenging | N= 27, male, aged 22-57 years (M=34)Offences were robbery, violence or sexual related.Time Spent in TC: 1-18 months.Unknown: Ethnicity | Exploratory Focus Groups  |  | Two Stage Analysis:Mechanical StageInterpretative Stage |
| Ross & Auty (2018) | HMP Gartree | To explore experiences of residents making change within DTCs | 1. Motivation to change2. Environment3. Removal of Masks4. Relationships | N=5 males, aged 38-58, Committed MurderTime spent in TC: 34-41 monthsUnknown: Ethnicity | Semi-Structured Interviews  |  | Interpretative Phenomenological Analysis |
| Sullivan (2006)\*Sullivan (2007)\* | HMP Grendon | To explore residents’ perspectives on leaving the prison-based DTC. To explore residents’ perspectives of the DTC | 1. Therapy Wing Dropouts1. New Arrivals2. Staff3. Visits4. Food5. Bullying6. What men say they gain from Grendon | † N= 48 malesUnknown: Age, ethnicity, offences, time spent in TC | Semi-structured interviews |  | No formal analysis method identified |

\* Sullivan (2006) and Sullivan (2007) used the same sample of participants for both papers

† Return to Unit participants (n=9) were excluded from the analysis as they did not participate in the TC intervention.

‡ N=2 are from the TC+ wing (specialist DTC wing for residents with Learning Disabilities)

### *Study Findings*

Thematic synthesis revealed three main themes: The Importance of Safety in the Therapeutic Environment, Opening Up to Vulnerability and Life Within and Beyond the DTC. Main themes and corresponding subthemes are depicted in Figure 2.

**Figure 2**

*Thematic map of themes and subthemes of Prison-based DTC Experiences*



### *Theme 1: The Importance of Safety in the Therapeutic Environment*

The importance of safety was highlighted in studies as foundational towards engaging in DTC therapy. The DTC is characteristically illustrated as a contained safe space created by both the TC set-up and the members of the community. Whilst this was achieved for some residents, other residents reported opposing experiences. Factors for the diversity of experiences appeared to be due to changes in structure and the coming together of a range of individuals with different offending backgrounds and ethnic origins. The following subthemes explore resident’s experiences of the physical environment and those encompassing relational safety with peers and staff.

#### *Subtheme 1:* *Establishing Safety in the Physical Environment*

The DTC invites a range of serious offenders to live together. Given the level of risk involved, the environment appears paramount to ensuring residents feel comfortable and secure enough to live as part of the community:

‘individuals convicted of sexual offences were more likely to engage in treatment if they perceived the prison environment to be safe.’(Author, Duncan et al., 2022)

Some residents expressed concern regarding access to amenities, impacting on their ability to sustain through therapy. This was compared to mainstream facilities, which residents in one study appeared to have found more accommodating than those of the DTC:

‘Conditions we live in: sanitation facilities, lack of amenities or upkeep…Other prisons stay on top of all infrastructure faults… here they aren’t so complaints get in the way of therapy’ (Resident, Sullivan, 2006)

The authors in another study reflected on the importance of residents’ nutrition and the impact a poor diet could have on resident’s mood and subsequent behaviours (Sullivan, 2007).

Whilst some residents were dissatisfied with provisions, others appeared surprised at what the DTC offered. The creation of normality, in providing living spaces like bedrooms and gardens, were beneficial in increasing a sense of comfort and homeliness:

‘I felt a bit on edge… I've come down here and I’ve unpacked straight away, put all my stuff in my cell, made it a bit like a bedroom as much as I can. (Resident, Kontosthenous, 2020).

Alongside facilities, the structure of DTC therapy appeared pertinent in creating a predictable routine for residents. Residents felt contained by DTC boundaries. Boundaries served to enable residents to engage freely and feel safe that the community would manage challenging, volatile behaviour if displayed. The possibility of exclusion from the DTC, for violent behaviour provided peace of mind.

‘everyone knows like the constitution up there […] the boundaries up there helped me be comfortable and take on board what other people were saying (Resident, Ross & Auty, 2018)

There’s bullying in every prison, but a lot less here because of the structure and challenging’(Resident, Sullivan, 2007).

Alongside boundaries implemented by the DTC, one study commented on the skills residents learnt through DTC programme, which enabled them to manage their emotions and aggression. This had potential in maintaining the safe environment for all residents, whilst equipping residents with the skills needed to manage long term:

‘Linked to this was developing new skills to manage the material …this included developing their perspective taking skills and alternative viewpoints, which can be difficult to those prone to black and white thinking’ (Author, Akerman & Geraghty, 2016).

Whilst residents noted positives in safety management, two studies highlighted residents who had doubts about the competence of staff, in adhering to boundaries pertaining to bad behaviour of other residents. They also questioned staff’s commitment in keeping the community secure. Being unaware of how to contain small-therapy groups were similarly commented on. This may have led residents to feel uncontained and uncared for, given their concerns were perceived to not be taken seriously:

‘I will say to [staff] I will be sat in the office…someone will be doing something, and I’ll go well why is that happening… they won’t do what they’re supposed to.’ (Resident, Duncan et al., 2022)

‘Well sometimes the facilitators don’t deal with the structure as they are supposed to’ (Resident, Dolan, 2017)

One study discussed the impact of high turnover of staff. This may have been disruptive to the consistency of resident’s therapy, given the frequent changes experienced. Taken with the above, this highlights how much staff are integral to the facilitation of safety and the overall therapeutic process:

‘There has been changes in the uniformed staff as well which makes a big change because you have got to discuss your personal issues your private issues…with one personal officer and (then another) again’ (Resident, Dolan, 2017)

#### *Subtheme 2: Navigating Relational Safety and Unsafety*

Alongside a safe physical environment was the importance of a safe relational network, to promote residents’ sense of connection, belongingness, and inclusivity with peers and staff.

All studies commented on residents’ experiences of connection with peers within the DTC. Three studies alluded to small groups being more conducive in developing connection and trust (Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020), whereas one study acknowledged the whole group’s role in this process:

 ‘It’s like thinking that you’re in a big family and somebody’s caring for you, somebody’s watching out for you. It is a nice warm feeling you get’ (Resident, Ross & Auty, 2018).

Increasing connection included exercising acceptance of others and for who they are. This involved conveying respect for their situations (Miller et al., 2006). The impact on residents’ positivity when seen as a person, rather than a prisoner, was detailed across three studies (Dolan, 2017; Jacobs & Shuker, 2019; Jones et al., 2013). The reciprocal nature of respect was further portrayed (Sullivan, 2007):

‘It’s having that human contact that makes you more human…You treat people like animals then they are going to become animals. You treat them like people, they are gonna become people.’ (Resident, Jacobs & Shuker, 2019)

‘Men with long histories of prolific and serious offending… may find themselves being consistently treated with respect and positive guard for the first time…after their initial wariness has subsided, [they] may repay that treatment.’ (Author, Sullivan, 2007)

Group cohesion was highlighted to build slowly but once achieved, residents benefited from these interactions (Miller et al., 2006). Spending time with each other appeared to grow closeness and create solidarity. One study highlighted how residents celebrated others’ achievements:

‘There’s a camaraderie between you and your group members when you are with them for a long time…you get a big buzz when you see someone complete’ (Resident, Ross & Auty, 2018).

Relationships with staff were accounted for in developing relational safety. Six studies recognised residents’ appreciation of staff for their consistent kindness and humane treatment (e.g. shaking hands, first-name introductions, welcomed into staff offices etc). This appeared significantly different from some interactions encountered in mainstream prison environments (Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020; Miller et al., 2006; Ross & Auty, 2018; Sullivan, 2007):

‘how (staff) interact with inmates, their honesty, care, not taking sides, respect they show. They’re the crucial components of success’. (Resident, Sullivan, 2007)

‘If I’m having a spill out and I’m swearing…I was just put in segregation…whereas here staff tend to say look come and sit down and talk’ (Resident, Dolan, 2017)

In two studies, residents reported minimal conflict, with violence not being present at all:

‘I done 33 months up there and I never saw one fist connect to anyone… So it is safe. (Resident, Ross and Auty, 2018)

However, not all residents could relate to experiencing positive interactions in the DTC, with some experiencing minimal relational safety. Five studies illustrated experiences of residents who found peer relationships difficult. Some residents felt isolated in only being able to achieve a sense of connection with those from the same background. Other residents experienced racism from peers and felt the need to accept the situation as it was, to continue with therapy in the DTC:

‘[There] was one, one black person… it was only me and him .. . it was a bit hard…with regard to the cultural background, I couldn’t really link in with anyone else’ (Resident, Jones et al., 2013)

‘Well it made me angry [receiving racist comments] but I came here for a reason so I had to swallow that’ (Resident, Jones et al., 2013)

Residents convicted of sex offending experienced stigma and bullying from others and retreated from connecting. Indeed, views from one resident detailed how much they struggled to be in the presence of an offender and wanted to physically harm them. Those who received abuse from peers felt deserving of it and experienced increased shame and isolation:

You know we’re still sex offenders, and the people still hate us…it’s not equal at all… it’s just still that mainstream mentality. I hear it most days, you know, f\*\*\*\*\*\*\* rapist’(Resident, Duncan et al., 2022)

. ‘lad in my group who was a sex offender and I didn't know before that … when he said it… the blood had drained up on my face… I was shaking…. I was really struggling’(Resident, Kontosthenous, 2020).

Two studies reported strained resident-staff relationships. Residents felt staff lacked the understanding of their cultural norms, behaviours and issues and unfairly challenged their use of language dialects in the DTC. Some residents felt they had to change parts of themselves or lie to fit in:

‘You know [staff] would pull you about using slang… but this isn’t slang this is Caribbean banter…. Meanwhile people using cockney they were fine…’ (Resident, Jones et al., 2013).

‘You’ll get a group of black guys walking on the yard and they’re automatically labelled as, ‘‘ah look at them they’re back into their gang culture behaviour, loud, walking with a bit of a swagger…”. You get a number of white people walking in their group but it’s not an issue, when they do it.’ (Brookes et al.,2012)

I was the only West Indian… I felt lonely and lost. I use Jamaican patois and I’ve had to change the way I talk. (Resident, Brookes et al., 2012)

I could tell straight away… they want you to ﬁt in with their middle-class white people.’ (Resident, Brookes et al., 2012)

However, Jones and colleague’s (2013) study highlight an experience of residents having members of the same religion around in the DTC, indicating a sense of connection, if not with the whole community, a small group:

‘Nearly all the participants expressed that they had increased relatedness with other BME prisoners… One of the staff is Muslim ... a practicing Muslim ... oh it, it makes the atmosphere here a lot different.’ (Author/Resident, Jones et al., 2013)

### *Theme 2: Opening Up to Vulnerability*

The act of vulnerability within the group setting required members to trust other residents and share triggering stories that could potentially result in rejection or shame. By doing this, residents could take away reflections that arose from other members’ ideas and perspectives. Authentically opening up to vulnerability appeared easier for some residents than others in the DTC. Experiences of unsafety alongside societal, familial, and cultural narratives carried by residents may have fed into the barriers to expression and reflection. The following subthemes depict residents’ experiences of sharing with others and the process of learning and reflecting in therapy.

#### *Subtheme 1: Sharing with Others in Therapy*

The process of sharing appeared a vulnerable experience for many residents. Seven studies conveyed the need for residents to authentically share and have confidence to explore experiences and feelings with others, to benefit fully from DTC treatment (Akerman & Geraghty, 2016; Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020; Miller et al., 2006; Ross & Auty, 2018; Sullivan, 2007):

‘Participants talked of being out of their comfort zone and allowing their “masks” to come off, exposing themselves to potential ridicule by others’ (Author, Akerman & Geraghty, 2016)

‘I’ve talked to about stuff that I never discussed with my own family’ (Resident, Jacobs & Shuker, 2019)

 Four studies highlighted residents’ need to trust their peers when sharing, due to the sensitive nature of experiences (Akerman & Geraghty, 2016; Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020):

‘Trust is huge…when you’ve got to sit with these people and talk about your own trauma and trust that they’re not going to use that against you (Resident, Kontosthenous, 2020)

Two studies showed that residents found it helpful to learn how to share by following peers’ examples:

‘I was thinking well he speaks… so let me speak. We’re all in the same boat… So I wasn’t alone’ (Resident, Ross & Auty, 2018)

‘By seeing other people expressing emotion, and being supported for it…, then that only encourages you to do the same.’ (Resident, Jacobs & Shuker, 2019)

Once residents did share, some experienced relief and comfort in having a non-judgemental, understanding platform to voice their thoughts and feelings. This meant that residents could continue to live in the community without fear that they would act out on anguishing thoughts (Dolan, 2017; Miller et al., 2006; G. E. Ross & Auty, 2018):

‘It was important for me to speak about things that I wasn’t able to…Because of the nature of my offence… in the system it was eating me up in a way’ (Resident, Dolan, 2017)

‘To be able to go to vulnerable places to speak about something from the past is one thing… [it] gets you into a good habit of doing it in the [present]…So instead of brushing stuff under the carpet… you’re… more willing to deal with it as it happens.’ (Resident, Ross & Auty, 2018)

Two studies recognised residents’ desire to help others benefit from therapy and reflected on how this could help themselves too (Jacobs & Shuker, 2019; Miller et al., 2006):

‘I’ve helped people in therapy and they’ve helped me, it’s a 50/50 thing, you take on board some of theirs and you off load some of yours.’ (Resident, Jacobs & Shuker, 2019)

Group therapy exposed members to situations they may not have encountered in other settings. For example, a prisoner who experienced childhood sexual abuse was suggested by the group, to talk about his experience with a sex offender, which they hoped was beneficial:

‘he would have the opportunity to communicate the ways in which victims can suffer and potentially gain an understanding of the reasons behind some sex offending.’(Author, Miller et al., 2006)

For some residents, the experiences of sharing were too difficult. Some residents struggled to grasp the concept of therapy or did not see how the processes were relevant:

‘I couldn’t understand the TC concept at all to begin with’ (Resident, Miller et al., 2006)

Some residents struggled to trust others from childhood (Duncan et al., 2022) and within prison (Dolan, 2017). Some acknowledged that residents were ‘criminals’ who stereotypically could not be trusted (Dolan, 2017; Jacobs & Shuker, 2019):

‘I’m a criminal myself… I know than better to trust the buggers. Like you want me to walk into a room and start trusting them? nah they have had a life of being devious and everything’. (Resident, Dolan, 2017)

Five studies illustrated residents’ fears of how they would be perceived by others. One study highlighted residents feeling ‘childlike’ in exposing vulnerability (Miller et al., 2006). The breakdown of the male masculine norms in not showing emotions was also difficult for residents to adjust to. Residents experienced fears of losing control if they opened up (Duncan et al., 2022; Kontosthenous, 2020; Ross & Auty, 2018):

‘I should have gained a bit of strength seeing these fellas, who I would call strong characters, talking…I was thinking “they’re in bits here”. You know I didn’t really wanna be like that (Resident, Ross & Auty, 2018)

Three studies described how residents felt others ‘faked’ their way through therapy, thereby being disingenuous. This led them to feel duped and question their need to be genuine (Duncan et al., 2022; Kontosthenous, 2020; Miller et al., 2006):

‘(residents) pull out because they think that it’s all s\*\*\*…they can’t quite get to the point where it means something to them…everyone else is being fake…you think why the f\*\*\* am I doing this? No one else is f\*\*\*\*\*\* doing it’ (Resident, Duncan et al., 2022)

In one study, residents expressed cultural barriers in sharing with other residents, which misaligned with familial norms of keeping stories within family boundaries:

 *'it was hard for me because my culture played too much part, I keep things in the family…express[ing] your feelings, what’s going on in your family…it’s like you have broken the code of the family’ (Resident, Jones et al., 2013)*

The perceived inability for residents to bring their authentic selves to the DTC, for fear they would not be understood (Jacobs & Shuker, 2019) or shut down when expressing thoughts about sensitive topics (e.g. racism) was also evident (Brookes et al., 2012; Jones et al., 2013):

‘You are judged straight away…I feel that they don’t really understand where I’m coming from…they’re not letting me still be black, they’re not letting me still have my culture, and they’re trying to take that away from me.’ (Resident, Brookes et al., 2012)

Four studies highlighted residents’ opinions of staff not being fully involved or invested in therapeutic processes, as staff are generally expected to be, in a ‘flattened hierarchy’ DTC. This left residents reluctant to engage given the perceived unfairness of the process (Brookes et al., 2012; Duncan et al., 2022; Miller et al., 2006; Sullivan, 2006):

‘(Staff) don’t like you challenging them. It’s about you, not about them…you’re (staff) part of the community, so you should be up for challenging as much as we are, so I challenged them and they didn’t like it.’ (Resident, Duncan et al., 2022)

#### *Subtheme 2: Learning and Reflecting Through Therapy*

Sharing with peers in therapy appeared to enable residents to acknowledge their past and understand why they offend, increasing their levels of self-awareness. This was again, an exposing and vulnerable process for many residents. Four studies highlighted how residents felt therapy was slow and time-consuming, but beneficial for progress and growth (Jacobs & Shuker, 2019; Jones et al., 2013; Miller et al., 2006; Ross & Auty, 2018):

‘you have to take it step-by-step . . . there’s a lot to take in . . .’ and: ‘I expected more at the start, but I soon realised that things took time’. (Resident, Miller et al., 2006)

Five studies highlighted that gaining feedback from others on things they brought to therapy, was an enlightening process for some residents. It appeared to help them understand themselves and situations clearly (Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020; Miller et al., 2006; Ross & Auty, 2018). Feedback also helped to inform and reflect on decisions made in the DTC:

‘other residents and TC therapy staff helped him ﬁnd the ‘pieces’, but that it was up to himself to put the pieces together and see the ‘full picture’’ (Author, Miller et al., 2006)

‘It took me quite a while…over a year of twenty-one people telling me “what!?!” “that’s not ok”…it took quite a while to think “could it be me – could I be in the wrong here’ (Resident, Ross & Auty, 2018)

‘they’ve said listen, you’re hanging around with the wrong person here, you need to look at why he’s hanging around with you…this fella is going to drag you down (Resident, Kontosthenous, 2020)

Six studies highlighted how residents were able to reflect on how aspects of their childhood had shaped their behaviours in adulthood. Some residents acknowledged similarities to their peer’s experiences, which appeared uncomfortable and revealing, but allowed for viewing themselves from different perspectives (Akerman & Geraghty, 2016; Brookes et al., 2012; Dolan, 2017; Jacobs & Shuker, 2019; Miller et al., 2006; Ross & Auty, 2018):

‘Another man talked about the signiﬁcance of ﬁnding out that his childhood [influenced] the way he lived…as an adult. He referred to this as ‘making a link’… about how it helped him understand… a ‘part of myself that has been hidden for a long time’.(Author and Resident, Miller et al., 2006)

‘And hearing people talk, how they follow the pattern…well 90% of their lifestyle their upbringings have been so parallel with mine’ (Resident, Dolan, 2017)

They were also exposed to how past relationships were being played out within the DTC, which sometimes were impactful on staff (Ross & Auty, 2018):

‘...their relationships with staff and community members would mirror difficult relationships in their life, helping them reflect on repeating patterns…staff were “quite happy to suffer through transference” (Author, Ross and Auty, 2018)

Three studies illustrated how residents used therapy to reflect upon the impacts their offences they committed had on their victims and families and the need to make a conscious decision to not reoffend (Brookes et al., 2012; Dolan, 2017; Sullivan, 2007).

‘You’ve got to think about other people – if you don’t think about other people you’re not going to care about yourself and then you’re going to create more victims’ (Resident, Brookes et al., 2012)

‘Equally important is the ability to understand the consequences of one’s actions, to develop victim empathy, to take responsibility for one’s actions and not to justify one’s criminal behaviours’ (Author, Sullivan, 2007)

These experiences are difficult and three studies highlighted residents, who found the process overwhelming and shaming (Akerman & Geraghty, 2016; Jacobs & Shuker, 2019; Sullivan, 2006). Some residents drew upon strategies to manage difficult feelings, including overeating, humour and making inferior comparisons to other residents (Akerman & Geraghty, 2016).

‘…therapy can encourage group members to face reality which evokes feelings of shame, guilt and self-loathing (Author, Akerman & Geraghty, 2016)

Residents acknowledged how helpful it was reflecting upon how their mind works and

learning more about themselves in the present:

Another reason for being at Grendon is so I can learn a bit about myself, why I do these things, to try and change my thought process and my behaviour to a better way. To stop doing things that make me end up in trouble (Brookes et al., 2012).

For some residents, reflecting on self-development and change appeared difficult. This may highlight difficulties or unwillingness in exercising introspection (Miller et al., 2006; Ross & Auty, 2018):

‘Sometimes, in your own situation you can’t see the wood for the trees but you can see the same stuff for other people – it’s easier. I don’t think you want to see if in yourself.’ (Resident, Ross & Auty, 2018)

### *Theme 3: Life Within and Beyond the DTC*

The DTC ultimately allowed residents to explore other perspectives, including a chance to experience what life could be like, if they engaged in personal development and change. Alongside residents sharing and expressing themselves in the group, DTC therapy promoted opportunities to safely engage with external organisations and learn new skills. For some residents, learning life skills appeared integral to fostering growth, agency and independence whilst they completed their time in the DTC.

Three studies acknowledged the opportunities of roles (e.g. TC jobs) on giving residents a sense of purpose and responsibility that evolved over time. (Dolan, 2017; Jacobs & Shuker, 2019; Kontosthenous, 2020).

‘…I was amazed at the sort of inclusion that the prisoners have and there's certain jobs that you can get that in a way helps that process along with the individual’ (Resident, Kontosthenous, 2020)

‘Being trusted with responsibility was… hugely important in terms of changing behaviour…many had never previously had any type of job, or responsibility…this led to increased feelings of self-worth’ (Author, Dolan, 2017)

One study acknowledged the potential for residents to assist staff in recruitment for DTC employees, which was a novel experience. They reflected on opportunities to engage with external institutions and charities:

‘We do a lot here [in Grendon]…It's not about just being locked up 23 hours a day…and attending [mainstream prison] work. …there's a lot more social engagement here with the outside’ (Kontosthenous, 2020).

Whilst some residents perceived work opportunities as beneficial, other residents commented on how jobs detracted from engagement in ‘real’ therapy:

‘Why can’t it just be the work? . . . Why does there have to be stuff like rep jobs and jobs thrown into the mix to test you, I don’t see that as therapeutic, it kind of is challenging my thought process of therapy.’ (Resident, Duncan et al., 2022)

The ability to engage with family members on family days at the DTC, which they found positive and necessary (Sullivan, 2007):

‘Visits occupy a place of great importance to men in prison and to long-serving prisoners in particular’ (Author, Sullivan, 2007)

Family appeared to be a motivating factor for residents in three studies, offering opportunities of hope in the future (Akerman & Geraghty, 2016; Miller et al., 2006; Ross & Auty, 2018):

‘My family spurs me on and motivates me. [This is]…part of my transition of who I want to become’ (Resident, Akerman & Geraghty, 2016).

 When asked about the future, one study illustrated residents’ acknowledgement that life in the ‘real world’ would be difficult:

I have to understand and acknowledge, the first two years…when I'm released.. I will be a vulnerable human being… …I just have to acknowledge that actually…, I've got lots of faults… [there’s still more] I’ve got to learn. (Resident, Kontosthenous, 2020).

However, four studies reflected upon residents’ concerns about reintegration with life outside of the DTC. Systemic pressures (e.g., mainstream prison culture, location, street culture, familial values) conflicting with progress made in therapy. Residents highlighted potential to inevitably revert back to ‘old’ ways of behaving to fit into their environment (Brookes et al., 2012; Jones et al., 2013; Kontosthenous, 2020).

‘If I was to adapt to the way therapy expect me to adapt…do my therapy and address my offending behaviour, if I was to go back within my culture that would be a problem.’ (Resident, Jones et al; 2013)

‘returning to mainstream is a problem because people will think you are over-analysing everything, that you’ve gone soft… so, do you try and tell them you’ve changed or hide it?’ (Resident, Miller et al., 2006).

## Discussion

The qualitative review aimed to explore residents’ experiences of prison-based DTC treatment. The results of the synthesis highlighted how safety can evolve and be borne from the DTC environment, if the structure and boundaries are adhered to by residents and staff. The safety of the community’s relational network enhanced belongingness, respect and acceptance between residents and staff. However, residents from ethnic minority backgrounds or sex offenders struggled to integrate, with some experiencing disconnection, isolation, and racism from the community. In therapy, residents were exposed to vulnerability, in sharing experiences with others. This became easier over time for some as they learnt to trust. For other residents, the fear of being judged or misunderstood hindered this process. Residents used therapy with their peers to reflect on their life, their relationships, and offences. This was often a revealing process, but residents recognised the necessity for personal growth. Finally, residents engaged with roles both internally and externally within society as part of treatment. This appeared to develop agency, life-skills, and a sense of purpose, crucial for growth and the move away from the criminal identity to a law-abiding citizen identity (Needs & Adair-Stantiall, 2018). Opportunities to connect with relatives appeared to increase hope and optimism for some residents. Some residents held a more pessimistic outlook on reintegration into life outside of the DTC. Some felt their new ways of living learnt in therapy, failed to be accepted in mainstream prison or their home community, due to perceived systemic, familial, and cultural values.

The results of our review crucially highlighted experiences of residents from minority backgrounds who endured marginalisation and racism within the DTC. Our findings showed that sex offenders experienced similar treatment, which has been shown across prisons in general (Ievins & Crewe, 2015). Bennett (2013) identifies how such narratives and power imbalances are imported into prison systems and acted upon by other residents and staff. Such experiences hindered and halted progress in therapy. A review by Sullivan (2007) exemplifies black men’s experiences of negative stereotyping by peers and staff and lack of belonging. However, other named reasons for disengagement were language barriers, being unable to name their criminal behaviours as crimes (e.g. honour killings) and not wanting to ‘grass’ others up by naming their crimes. These named experiences question the current generalisability of the DTC’s model ‘the quintessence of a therapeutic environment’ (Haigh, 2013, p.6). The model stipulates that all DTCs encompass five main qualities: belongingness, safety, openness, participation, and empowerment, of which some residents did not experience.

The cultural dissonance hypothesis outlined by De Leon and colleagues (1993) emphasise how individuals of an ethnic minority background may struggle to integrate into a TC constructed by and for those from a majority background. Given our findings of feeling marginalised applied to sex offenders, the dissonance hypothesis can be extended to this population. Bunt and colleagues (2008) reviewed how substance-misuse TCs worldwide have adapted their practices to better fit cultural backgrounds. Suggestions for adaptations ranged from TCs incorporating religious practices in treatment, to cultural training for staff. Our findings illustrated how prison services are more diversified, (i.e., one resident appreciating the presence of a Muslim officer in the TC). A culturally informed workforce could support residents with ethnic minority backgrounds integrate successfully into the DTC (Newberry, 2010). Further adaptations recognising faith, cultural practice could be beneficial for prison-based DTCs in improving interventions for residents, reducing cultural dissonance and increasing a positive social climate (Williams & Winship, 2018). The DTC helped residents to reflect on the past and present, which appeared important in instigating behavioural change (Bennett, 2013). Stevens (2012) illustrated how residents practiced creating and connecting to a different version of themselves which required vulnerability and openness to do so effectively. Residents appeared to learn that looking back at the past provided a pathway forward towards developing a ‘new’ self that fits coherently with their ideas of a valued life. Again, our findings showed there were some residents who found engagement with this process difficult. Residents may not have experienced what being vulnerable was like, inadvertently make therapy feel threatening (Ayonrinde, 2003). Residents also expressed a loss of masculinity, making them appear ‘weaker’. Crewe et al., (2014, p.67) illustrates how prisons have ‘emotion zones’ to allow residents to temporarily halt the bravado and express vulnerability where needed. Group counselling programmes like ‘The Inside Circle Programme’ in a mainstream prison in Massachusetts work similarly to small group therapy in the DTC (Karp, 2010). More opportunities to practice elements of these ideas within DTCs may be beneficial. Mainstream prisons could further work to embed some of these principles, for example with staff encouraging residents to speak about their difficulties confidentially on a 1-1 or voluntary small peer-group basis (Ramesh, 2023). This can help enable systemic change, enabling men to break barriers of toxic masculinity.

The opportunity to hold responsibility and engage in wider societal events appeared key to the growth of residents. Shuker (2022) acknowledges that this is one of the many parts towards encouraging togetherness and empowerment. Residents were additionally able connect with family members through family events. This has been shown to strengthen family bonds and help with successful community integration (Folk et al., 2019). Bridging the gap between prison and society means residents are better placed to move forward and build better lives (Whiteford, 2000). However, our findings indicated ethnic minority residents worried about difficulties reintegrating back into community life. These were similarly documented in research, with uncontrollable systemic factors (e.g. social stigma, access to services etc) being key barriers (Buck et al., 2022). Healy’s (2014) research on desistence in offenders demonstrated an offender’s motivation to change depended on how valued and attainable the ‘new’ identity would be to them. A lack of support from their community or their environment to keep up their learning, likely placing them in a vulnerable position. The DTC could implement joint-working with community interventions within the OPD pathway, to promote seamless care for residents. This could ensure they are well equipped and able to continue working on self-development and minimise the risk of repeat reoffending once completed DTC therapy (Chouhy et al., 2020; Logan & Ramsden, 2015).

Taken together, the results of this synthesis suggest prison-based DTC employees may benefit from further training to inform practice. Training, and reflective practice could enhance connection and engagement with residents. The Boundary Seesaw Model, developed by Hamilton (2010) within forensic settings, exemplifies the idea that staff can hold specific roles. These may include: a ‘controller’ (who is more controlled, less flexible towards residents), a ‘pacifier’ (who is over-involved and too flexible) or a ‘negotiator’ (who holds consistent boundaries but exercises appropriate and necessary flexibility). From our findings, it appeared that most staff in a DTC fit the ‘negotiator’ role, as staff treated some residents with respect and equality. However, our findings also showed some residents may have felt staff fit into more ‘controller’ roles, when perceived as unwilling to participate in therapeutic processes (Duncan et al., 2022). An opportunity to reflect on how this model fits within DTC communities and could potentially filter down to inform residents as they become more autonomous within the DTC, may build an informed therapeutic environment. This could serve to increase shared learning between residents and staff; a principle that is pivotal to the values of the OPD Pathway (Skett & Lewis, 2019).

### *Strengths and Limitations*

The current review included studies that captured a range of residents’ voices, providing a broader picture into their experiences. The review also searched and included grey literature, which helped reduce publication bias (Mahood et al., 2014). Most studies were conducted by employees of prison DTCs, which may have influenced the validity of answers given by residents and how results were interpretated and written up by authors. The results of the quality assessment highlight how future qualitative research could benefit from more reflexivity from authors and more thorough reporting of methods and analysis plans, to increase transparency.

The sample of this review was limited to male residents across all eleven papers. As such, there remains an inherent lack of research pertaining to DTC treatment experiences of women (Richardson & Zini, 2021). Similarly, most studies included in our review were conducted within HMP Grendon, thus lacks generalisability across other prison-based DTC settings. Ethnographic research conducted by Stevens (2013) captured experiences of female residents within a female prison-based DTC, inclusion of which may have surfaced further insight into gender specific experiences. Our review did not include ethnographic research as the authors voice may be too integrated into findings, limiting its representativeness of the studied sample. However, future reviews may wish to consider inclusion of such studies to broaden understandings of prison-based DTC experiences. Further research and reviews into exploring resident’s experiences post-release may provide vital insights into the sustainability and longevity of prison-based DTC treatment in such populations (Stevens, 2012).

As prison-based DTCs sit within the OPD pathway, it would helpful to consider how well it integrates within the whole pathway. Evaluations on this have commenced, exploring resident and staff data quantitatively and qualitatively, over the first five years of the pathway, with initial findings looking positive (Moran et al., 2022). Future longitudinal studies and reviews, exploring experiences of the whole pathway from start to finish will be beneficial.

### *Conclusion*

Residents’ experiences of the DTC are integral towards understanding how therapy works towards recovery and rehabilitation. The following review has captured both the highlights and the challenges residents’ experience. It remains important to recognise the intricacies within resident populations, which may result in some feeling unsafe and disconnected from the community. The review further shows there is a need for culturally informed and adapted practices to help those from minoritized background integrate into the community. Furthermore, inherent systemic barriers may prevent some residents from accessing opportunities and support in the future once they have completed DTC treatment. Further training, awareness, and joint working within the Offenders Personality Disorder Pathway (Skett & Lewis, 2019) may help support such residents in future.

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