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**PRACTISING 'PREVENT' IN PRISONS: PRISON  
CLINICIANS' PERCEPTIONS OF  
RADICALISATION AND THE PREVENT STRATEGY**

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A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Master of Science by Research in Criminology and Criminal Justice

The University of Huddersfield

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## **Abstract**

This qualitative study aims to start building an evidence base regarding prison healthcare staff perceptions, experiences and use of the UK Government's counter-terrorism Prevent Duty when caring for inmates not convicted of terrorism-related offences who are deemed vulnerable to radicalisation. There is substantial debate about the role of radicalisation in UK prisons and the extent of the risk of prisoners being recruited into Islamist extremist groups. The question of how best to respond to this issue is also highly debated with the UK Government's counter-terrorism policy – CONTEST – and particularly, the Prevent Duty arm of this, being scrutinised. The healthcare sector has been mandated to detect and report any suspicions of radicalisation and this has been regarded as highly contentious.

Qualitative interviews were conducted with 12 prison clinicians from two high security prisons in England. Thematic findings pertain to: a high engagement with and acceptance of Prevent Duty use in prisons; a good staff understanding of prison radicalisation; perceptions that caring for convicted terrorists is complex and a view that operationalising Prevent in prisons is feasible. The research findings present a largely positive attitude towards the Prevent Duty with it being regarded as a 'safeguarding' measure to protect patients. Prevent Duty training was largely well received by staff and enthusiasm was shown in regards to improving the package and increasing the frequency of its delivery. Staff did present unique challenges that they are faced with when contributing towards the prevention of prison radicalisation, because of the prison environment, therefore suggesting that perhaps bespoke training should be offered to prison clinicians rather than the 'one size fits all' training that is currently offered to all healthcare staff.

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## Introduction

"Raising awareness of the health sector contribution to the Prevent strategy amongst healthcare workers is crucial. We are one of the best placed sectors to identify individuals who may be groomed in to terrorist activity, with 1.3 million people employed by the NHS and a further 700,000 private and charitable staff delivering services to NHS patients, we have 315,000 patient contacts per day in England alone. Staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space." (NHS England, 2015: p5).

Of concern to the UK Government is the risk of radicalisation in prison establishments with many commentators proposing that prisons act as 'incubators' for (Pantucci, 2009) and 'universities' of (Clarke & Soria, 2010) terrorism. In particular, Islamist radicalisation within high security UK prisons is of growing concern (Brandon, 2009). Where some commentators state that radicalisation into Islamist extremism in prisons is rare (Hamm, 2009) others point out that terrorist attacks have been plotted by extremists that were radicalised whilst incarcerated (BBC News, 2005) and that this should be of grave concern to everyone. Indeed, there are cases in the UK of ex-prisoners that were radicalised in prison attempting to carry out terrorist attacks upon release, such as Muktar Ibrahim's thwarted attempt to bomb the London underground as a follow up to the '7/7' Islamist inspired terrorist attack. Richard Reid, also known as the Qaeda 'shoe bomber' attempted to blow up an American Airlines plane flying from Paris to Miami in 2001. Both individuals were converted to Islam within a British young offenders' institution (BBC News, 2005).

In an attempt to respond to the problem of terrorism, the UK Government introduced their counter-extremism strategy, 'CONTEST', in 2011. Four components make up the strategy:

'Pursue' (to stop terrorist attacks)

'Prevent' (to stop people becoming terrorists or supporting terrorism)

'Protect' (to strengthen our protection against a terrorist attack)

'Prepare' (to mitigate the impact of a terrorist attack)

Of particular focus here, is the Prevent strand of the strategy. 'Prevent' is aimed at those who are being drawn into terrorism by providing advice and help through the use of a multi-organisational approach, referring the individual of concern to the 'Channel' panel which reviews each case (HM Government, 2011). The Prevent arm (or Prevent duty) of the

strategy is of particular focus here, as healthcare professionals have been implicated in the UK government's efforts to stop people from being radicalised. That is, the government has placed a responsibility onto the health system to prevent patients and even fellow staff, from being influenced to participate in violent extremism.

The last few years has seen a spate of Islamist inspired terrorist attacks committed in Britain and Europe (Global Terrorism Database, 2016) which could warrant increased scrutiny of the UK Government's counter-terror strategy 'CONTEST'. The government has brought health and education sectors into their agenda for minimising terrorism through the prevention of radicalisation, by requiring them to incorporate the Prevent duty into their safeguarding measures (Open Society Justice, 2016). The government sees the co-operation of these sectors as being crucial to successfully preventing radicalisation and reducing the potential for violent extremism further down the line (HM Government, 2011). This requires, the UK's National Health Service (NHS) to practice vigilance in observing, detecting and reporting concerns of potential radicalisation in patients and other staff (HM Government, 2015).

The NHS provides healthcare for many prisoners across the UK and therefore these efforts also have to be carried out by prison clinicians. It could be argued that the co-operation of healthcare departments and staff within prisons is even more important as there are some prisoners that are incarcerated for terrorism-related offences who could try to radicalise other prisoners they come into contact with. However, it could also be argued that the involvement of healthcare in the issue of radicalisation is questionable due to potential conflicting effects on patient clinician therapeutic relationships through possible breaches of confidentiality and diminished patient trust in clinicians (Open Society Justice Initiative, 2016). It could also be argued that the duty places an additional responsibility on public sectors that are already overworked and understaffed (HM Government, 2015).

The House of Commons (2017) published statistics pertaining to the number of prisoners convicted of terrorism; as of 31st March 2017 there are 183 prisoners being held for terrorism-related charges. The majority of UK terrorism prison sentences come as a result of 'international terrorism' which the House of Commons defines as 'activity linked to or motivated by a terrorist organisation based outside the UK (this does not relate to the nationality of the suspect)' (House of Commons, 2017: 11). Islamist extremism is included in this category of terrorism.

As the UK has been subjected in the last two years to more terrorist attacks at the hands of Islamist extremists (Global Terrorism Database, 2016), than from any other extremist groups, this study will focus on Islamist extremism. The terms and associated descriptions used throughout this study can be found in Appendix 4. However, it is not within the scope of this project to explain or critique the concept or process of radicalisation or to suggest a solution for the problem of radicalisation in prisons. Rather, it seeks to investigate the perceptions of clinicians who are on the 'front line', dealing with terrorist prisoners in their daily jobs (for details of what constitutes a 'terrorist prisoner' see the glossary in Appendix 4). Additionally, staff awareness of and attitude towards counter-terrorism strategies and training are explored. Staff will be asked about their views of the potential risk factors of radicalisation in prisons and their perceptions of any warning signs that might indicate this process is taking place (for details of which prisoners are deemed as potentially vulnerable to radicalisation see the glossary in Appendix 4).

This research study comes at a time when terrorism is a topical issue and effective responses to the problem are highly sought after. It has been argued that Counter-extremism responses have so far, however, been based on a lack of empirical evidence and informed by a confusing and conflicting theoretical body of information (Schmid, 2013). Effective responses to a public health risk should be informed by rigorous research methods and empirical research studies (Stares and Yacoubian, 2007) but this is difficult to achieve due to certain barriers. Barriers to conducting credible research in this area include the challenge of recruiting terrorists (current and ex) and even the staff who deal with such individuals due to the criminally and politically sensitive nature of the subject. However, before even considering this, there exists the challenge of a weak consensus among theorists about what actually constitutes terrorism as well as the potential explanations behind terrorism. One challenge of gaining more agreement among theorists pertains to the terminology used within terrorism studies; there is no one standardised set of terms or accompanying definitions relating to how one adopts extreme ideologies and then progresses on to violent behaviours in support of these.

This paper presents the background, rationale, methodology and findings from an enquiry into the influences of the UK government's counter-terrorism strategy on the delivery of health care within two high security prisons. This dissertation is made up of 6 chapters beginning with a literature scoping review of key concepts and terms in the area. This includes, theoretical and empirical literature pertaining to the potential causes of and responses to prison radicalisation, literature regarding the evaluation of prison radicalisation responses and research conducted on clinicians' perceptions of such responses. The next

chapter covers the research methodology employed for data collection activities and the methods of data analysis used. The third chapter is a combined findings and discussion section revealing the themes and sub-themes found upon conducting a qualitative thematic analysis, and how these relate to existing evidence. Chapter 4 is a discussion of the study's strengths and weaknesses, followed by implications of the study findings pertaining to future policy, practice and research. Lastly, conclusions and recommendations have been made based on the research findings and analysis.

### **Justification/rationale**

Currently, the UK Government's (2011) requirement of healthcare staff to adhere to the Prevent duty element of the Contest Strategy, receives a 'bad press' from a substantial proportion of health care staff with many professionals feeling infuriated that they are being asked to do this in addition to their regular roles (Dean, 2011). Many clinicians have voiced concerns that such protocols will lead to patient confidentiality breaches and the compromising of their ethical stance when faced with the obligation to report particular service users to the authorities (PULSE Today, 2015). As explored in chapter Two, (literature review) views of clinicians have yet to be sought in an empirical and rigorous manner, in particular, pertaining to healthcare employees working within the prison setting.

### **Aims**

This is a study first and foremost, of prison-based clinicians' experiences of and attitudes towards working with the Prevent duty in their daily roles caring for prisoners. More specifically, a discussion was held with prison clinicians about the UK Government's Prevent Strategy and the mandatory use of this when providing extremist prisoners with healthcare services (in particular, prisoners who have been incarcerated for Islamist inspired violent extremism). Secondly, it seeks to explore prison clinicians' understanding of prison radicalisation in terms of what warning signs might indicate it is going on and how it can affect the health of prisoners who have been 'targeted'. The clinicians are employed by Spectrum Community Healthcare CIC; a social enterprise that provides healthcare services across the north of England). Although Spectrum is considered as a non-NHS organisation, its employees are responsible for providing healthcare to NHS patients and it is subject to requirements of NHS regulatory bodies.

Due to the recent increase in Islamist-related terrorism, Islamist violent extremism was focused on. Prison-based clinicians' perceptions of the use of Prevent duty's training and protocols when caring for prisoners convicted of offences relating to Islamist violent terrorism will be explored in order to understand how they can effectively engage with

them, for the benefit of the prisoners' health and that of the wider public. The research begins to build up an evidence base pertaining to the healthcare sector's use of and experiences with the UK Government's Prevent duty. This has been under-researched and is important as it considers perceptions and experiences of prison healthcare staff within high security English prisons, which house some of the most dangerous convicted terrorists in the country.

### **Objectives**

To meet the above aims, the following objectives were set;

1. Explore prison clinicians' perceptions of the possible risk factors for and health consequences of prison radicalisation.
2. Explore prison clinicians' current engagement with and acceptance of counter-radicalisation protocols, procedures and training when caring for prisoners convicted of offences relating to Islamist violent extremism.
3. Explore prison clinicians' perceptions of the efficacy of existing counter-radicalisation protocols, procedures and training for prison clinicians caring for prisoners convicted of offences relating to Islamist violent extremism.

## 1. Literature Review

This is the first study, to the researcher's knowledge, that investigates UK high security prison clinicians' perceptions of the UK counter-terrorism strategy's use in prisons and their experiences of adhering to the strategy when providing health care to prisoners convicted of Islamist related terrorism.

The literature outlined at this stage serves to provide a broader understanding of the context, whilst highlighting contemporary and topical issues and exploring national and international perspectives. Firstly, this literature review will explore some of the key concepts and terms pertaining to prison radicalisation as well as some of the contentious debates surrounding these. The review will then go on to shed some light on some of the literature pertaining to the possible process of prison radicalisation. Some of the research conducted and theories developed in the United States of America (USA), Australia and Denmark will be discussed briefly followed by a more in-depth discussion of UK-based research literature. This literature review will have an emphasis on radicalisation into Islamist extremism in line with one of the research aims, which focuses on prison clinicians' engagement with prisoners convicted of Islamist inspired terrorism. The key responses to prison radicalisation used in the UK will then be highlighted and some interventions used further afield will be touched upon. Some reflections will be made pertaining to some of the differences and similarities across responses to prison radicalisation in the following countries: USA, Australia and Denmark. Of particular interest here, is any potential opportunity for the more successful responses to prison radicalisation to be transferable to the UK. This literature review will then move on to a more in-depth discussion of UK responses to prison radicalisation with a specific focus on the health service's role within such responses.

### *1.1. Key concepts and terms*

Terminology use is a 'hot topic' in the field of terrorism studies (Silke, 2007). Silke (2007) discusses in his paper, 'Terrorism and the blind men's elephant', the difficulties faced by academics when developing a widely agreed upon definition of 'terrorism'. He describes this as a 'conceptual deadlock' (p. 12) and explains that the main issue with defining the term terrorism, comes from disagreements of whether it should be classified as a particular type of warfare or a completely separate phenomenon. Silke (2007) explains that whilst some researchers view terrorism in its fuller form and try to engage with this issue in terms of the

'bigger picture', other commentators perceive the individual and smaller details and aspects of the problem. Thus, explanations of terrorism are far too vague, or they are simply too specific. James Poland (2011) goes as far as arguing that not being able to agree on the definition of terrorism is perhaps the most significant problem in this field of study.

Silke (2007) goes on to discuss the lack of consensus in terms of whether terrorism should be seen as warfare or not, and how this evolves from many scholars classing terrorism as so abhorrent that they are unable to objectively interpret the problem and subsequently develop a 'fair' definition of it. Whilst terrorism is seen as such a uniquely objectionable phenomenon, separate from other 'legitimate' forms of waging war, scholars are making their own minds up on which forms of conflict are regarded more morally sound than others, adding further confusion and contention to the area.

There is more confusion in the field of terrorism studies when trying to understand the difference between the terms 'violent' and 'non-violent radicalisation'. As Bartlett and Miller (2011) point out, radicalisation is a process that descriptively means to change one's ideologies to a more radical, less socially acceptable state. This, on its own, does not necessarily cause any harm to others as simply having an extremist ideology that goes against the status quo is not necessarily destructive. A better understanding of exactly what radicalisation means is clearly needed.

A report which highlights problems with the concept of radicalisation, comes from CAGE (2016), a small organisation that investigates cases of human rights abuses. Their report reveals that the UK government have based their Contest Strategy and Prevent duty on flawed research which was conducted in secret and not peer reviewed or formally scrutinised. The CAGE report provides a critical analysis of research conducted by psychologists Dean and Lloyd for the National Offenders Management Service (NOMS) which was completed in 2010, informed the Contest Strategy and Prevent duty in 2011 and then went on to be published in 2015. They argue that the theories that feed into existing training and tools pertaining to detecting radicalisation have been developed as a result of flawed research findings, with the use of questionable methodologies and a failure to make raw data publicly accessible. Rather than using empirical face-to-face interviews with convicted terrorists, Dean and Lloyd recorded case observations made during contact with 20 extremist offenders who had some kind of association with Islam. However, as the CAGE report highlights, Dean and Lloyd have still not released any of the raw data that they collected but simply published a paper explaining the methodology they employed and how it led to their conclusions. The CAGE report questions whether indicators of extremism can



simply be labelled and grouped into standardised categories as is suggested by Dean and Lloyd (2015). The CAGE report calls for more involvement from the wider psychological community when the government develop policy and legislation based on psychological underpinnings.

The term 'Islamic extremism' is contested for suggesting that terrorism is ever committed in the name of true Islam (Stares & Yacoubian, 2007), a religion that many adherents regard as one of peace (Fakhraei, 2016). Although it is important to acknowledge that even this is highly debated with, for example, new atheists arguing that the Islam is not one of peace (Harris & Nawaz, 2015). Nevertheless, it is argued by some commentators (Stares & Yacoubian, 2007) that by using the term, 'Islamic extremism', the peaceful (and most widely practiced) form of Islam is blamed for terrorist activity. As such, some researchers have decided to opt for the term 'Islamist extremism' instead, to highlight that any terrorism that is apparently Islam-inspired actually comes from a place of insincere, unauthentic 'following' of the religion (Stares & Yacoubian, 2007).

Clearly, the definitions of concepts and terms within this area of study need to be refined and clarified as they are the very definitions that drive the government's counter-terrorism policy agenda. This is difficult to achieve as the concepts are deeply contentious but important to strive for as without standardised and agreed upon terms for a problem it is difficult to actually address it (Neumann, 2013). It is important to acknowledge that the arguably ill-defined, Government developed terms, can encroach on the professionals who are required to follow the attached policies and put these into practice when the problem itself is unclear.

In the UK Government's (2011) counter-terror strategy, 'Contest', 'extremism' is defined as,

"Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas."

The Home Affairs Committee (2012, p. 4) define 'radicalisation' as, "*the process by which a person comes to support terrorism and forms of extremism leading to terrorism*". According to the Terrorism Act (2000) 'terrorism' is,

“the use or threat of action... designed to influence the government or to intimidate the public or a section of the public... for the purpose of advancing a political, religious or ideological cause.”

These definitions have been argued as being problematic due to their ambiguity and vagueness i.e. it is unclear whether they relate to cognitive or behavioural processes (Richards, 2011; Neumann, 2013). Such contested terms and definitions influence real world applications of responses to them. For instance, ambiguity and vagueness can lead to net widening effects in that the number of crimes that are considered as terrorism-related are increased due to the broad sweeping definitions behind the so-called acts of terrorism that individuals can be imprisoned for (Bigo, Bonelli, Guittet, & Ragazzi, 2014). These definitions will nonetheless be used throughout this paper as they inform the UK government's Prevent duty; a main focus of this project. Please see the glossary in Appendix 4 for a full list of terms and definitions used throughout this dissertation. The exact terms that are favoured by other commentators will be used when discussing their work.

### *1.2. Causes of prison radicalisation*

Some commentators (Rushchenko, 2017) have argued that the risk of prison radicalisation across the UK secure estate is a significant and pressing issue that needs to be better understood. It is argued that the risk of prison radicalisation in the UK needs to be better understood so that it can be minimised in order to diminish the potential for ex-prisoners that are radicalised whilst in prison, to go out into the community and spread extremist ideologies and/or commit terrorist attacks. In the prison environment there is opportunity for recruiters to groom and manipulate vulnerable peers for their own personal gains (Sinai, 2014). There are many individual variables that, when brought together, can determine whether a prisoner targeted for recruitment is more likely to become 'successfully' radicalised. The risk of prison radicalisation is not confined to one country or part of the world (Neumann, 2010). Researchers across the globe seek to understand the issue so that the risk can be minimised, if not eliminated. It is hoped that by preventing prison radicalisation, there will be fewer terrorist attacks orchestrated by ex-prisoners that were radicalised whilst they were incarcerated (Neumann, 2010).

In terms of prison radicalisation into Islamist extremism, research has shown that certain prisoners with specific personal vulnerabilities and unique circumstances are most at risk of

becoming radicalised. For instance, prison radicalisation is a particular concern when considering new prisoners who have not experienced incarceration before as entering the prison system for the first time can be daunting and stressful, exposing the new prisoner to bullying and manipulation from other, more experienced prisoners (Brandon, 2009).

Liebling, Arnold and Straub (2011) confirmed in their study exploring staff and prisoner relationships within HMP Whitemoor in England, that radicalisation in prisons is indeed a problem. They found that the majority of prisoners were followers of Islam, making the largest group within the secure estate, Muslims. This also means that every gang within this particular prison structure is inferior in terms of size. Liebling et al. (2011) found that the leading Muslims within HMP Whitemoor used this as leverage to gain power within the establishment and as a tool to influence others. This example illustrates how following a religion in prison can be 'used' as a tool for personal gain. Findings showed that staff were anxious about the dominant role of Islam within the prison and associated this with fears of potential radicalisation within the establishment. Liebling et al. (2011) found that within the high security UK prison, relationships between prisoners as well as prisoners and prison staff were becoming increasingly negative due to growing anxiety pertaining to terrorism and fear of radicalisation, with low levels of trust acting as a strain on already volatile social structures of the establishment. These findings were based on rigorous and extensive research methodology that were employed on a substantial and diverse number of prisoners and prison staff. Methods used included observations, the building of a regular dialogue with prisoners as well as lengthy interviews, surveys, and focus groups with a substantial number of prisoners and prison staff. However, the study does appear to have focused solely on prison officers and neglected the exploration of relationships between prisoners and other prison staff such as health care professionals, chaplaincy staff and probation workers.

Supportive of Liebling et al. (2011) and their assertion that Islamist radicalisation is indeed happening in UK prisons, are Brandon's (2009) research findings. His study found that al Qaeda was actively recruiting in UK prisons as confirmed in secret prisoner accounts, which were smuggled out of the secure estate by well-known extremists. The accounts presented concerning information about how prison radicalisation is possible through their 'befriending' of vulnerable prisoners by offering them protection, in addition to an increase in Muslim gang formation. Perhaps more worryingly, the prison system itself was revealed as 'helping' radicalisation within prisons as apparently, known extremists are allowed to lead Friday prayers and complete training in spiritual teaching. Other concerning information revealed pertains to the apparent failing of prison authorities to prevent the dissemination of

extremist literature and propaganda within the secure estate. Perhaps most relevant to this project on staff perceptions of prison radicalisation, is Brandon's finding that a low level of staff understanding of the issue leads to failures in detecting radicalisation and subsequently stopping it. However, it is important to consider that few accounts suggested overt radicalisation and all accounts may not be trustworthy as false claims are often made by recruiters and the radicalised in order to exaggerate the importance of the jihadist movements. Research such as this is extremely difficult to arrange to begin with but if it *is* conducted, it must then be acknowledged that the data gathered is likely to be discredited due to dishonesty and the possibility of false reporting from extremists simply to get their cause and message across. Terrorist prisoners may also be weary of sharing information that might incriminate them any further.

Brandon's (2009) finding of an increase in Muslim gang culture in prisons, is reinforced by other researchers who have highlighted parallels between prison gang recruitment methods and the radicalisation process. Hamm (2009) explains in his discussion paper pertaining to the role of Islam in prisons, that there have been UK cases of Islamic prisoners using gang recruitment techniques to force other prisoners to adopt the Muslim faith, in preparation for moulding them into al-Qaeda recruits. Hamm refers to the 'Muslim boys'; a group of violent Islamic extremists who began attempting to radicalize other inmates in the high security prison, Belmarsh. If other prisoners refused to convert to Islam, then they would be violently attacked and slashed with razors or scalded with boiling water. These real world examples substantiate the prison staff and prisoners' fears reported to Liebling et al. (2011) about prison radicalisation into Islamist extremism.

In the USA, Joshua Sinai (2014) developed a model of prison radicalisation in which he posited that seven phases are progressed through in the move from adopting radicalised ideologies whilst incarcerated through to committing actual terrorism upon release (violent radicalisation). The stages are outlined below:

#### Phase 1: Pre-radicalisation personal vulnerabilities

The first phase pertains to 'pre-radicalisation personal vulnerabilities' which, specific to being a prisoner, include a strong discontent with being incarcerated coupled with pre-existing violent tendencies. Personal and environmental factors interact with one another to lead the prisoner to embark on a journey of spiritual discovery. The prisoner will start to seek out empowering religions and/or ideologies in the hope that they will help with their atonement for past mistakes. More specifically, personal factors such as a previous criminal history, a history of violent behaviours, and the presence of anti-social attitudes are said to

make a prisoner more vulnerable to violent radicalisation. When these personal factors are combined with a sense of crisis, low self-esteem and a compromised identity, as a result of going through the shock of being arrested and incarcerated and having to face a new lifestyle, they can make a prisoner even more susceptible. The daunting and challenging environment of the prison combined with loneliness associated with the experience and a fear of harm from other prisoners may well lead to a search for protection from a gang-like extremist group.

#### Phase 2: Situational enabling factors

This phase pertains to 'situational enabling factors' and represents a combination of conditions that can work together to radicalise prisoners. In particular, a prisoner is more at risk of violent radicalisation if they are looking for the following: human connections to combat inmate loneliness; a sense of meaning to empower themselves; and physical protection and social support for survival. If these prisoner goals are combined with particular external influences such as exposure to charismatic extremists and access to extremist literature, this can make the process of violent radicalisation even more likely. Charismatic extremists can convince such prisoners that membership in their extremist group will suspend loneliness; following their religion or ideology will give them meaning and empower them; and protection provided by their group members will ensure their survival. If, practically speaking, this can be executed easily (e.g. privacy gained from poor access to cell blocks, leaving influential extremists to their own devices) then the opportunity for radicalising other prisoners becomes a real possibility.

#### Phase 3: Self-identification

Phase 3 of the model is of particular importance because it is argued as being the pivotal moment at which the process of violent radicalisation really starts to take hold of the prisoner. The prisoner will start to 'self-identify' with the extremist messages, groups and other extremist like-minded people. Extremist narratives that resonate with them personally will encourage them to gravitate further away from their past identity. A more active role in the exploration of extremist materials and association with other extremist individuals will reinforce this. For the prisoner, the improvement of their awareness of ongoing unresolved global conflicts that affect like-minded followers of the same cause, can harbour anger and a sense of grievance, paving the way for the next phase.

#### Phase 4: Indoctrination

Phase 4 refers to 'indoctrination' and pertains to the actual indoctrination into the extremist group. Extremist beliefs and ideologies intensify with ongoing influence from charismatic extremists and gang leaders.

#### Phase 5: Militancy

This phase represents the prisoner having fully adopted the extremist religion or ideology and as a result, they fully accept their perceived responsibility to be a 'soldier' fighting for their cause.

#### Phase 6: Post-prison release terrorism

Phase 6 refers to 'post-prison release terrorism' in which the individual who was radicalised in prison, starts to plot terrorist attacks and even commits crime to fund terrorist activity.

#### Phase 7: Post-attack re-incarceration

Phase 7 relates to 'post-attack re-incarceration' in which former prisoners who carry out terrorist acts but survive them, are imprisoned again. Once they are back in prison, the process of prison radicalisation could potentially happen all over again.

This proposed trajectory from radicalised thoughts through to extremist action (whether in the form of committing violent attacks or simply attempting to orchestrate them) highlights prison as a crucial setting for focusing counter-radicalisation efforts. The model is comprehensive in that it considers the complexities of prison-specific contributory factors to violent radicalisation of inmates, such as the prisoners' need for protection; the coercive nature of the prison environment; the criminal history of the prisoners; and their diminished trust in and increased anger towards authority (just to name a few). The model also considers the role of 'self-radicalisation' in the violent radicalisation process that is usually largely influenced by external factors. For instance, it highlights the prisoner's own move towards extremist ideologies with a progression onto joining an extremist group and then plotting and committing terrorist activity upon release; it places a lot of emphasis on the role of the individual's own desire to meet personal goals in the radicalisation process. It appears that the prison dimension of the radicalisation process emphasises the importance of potential 'gains' of the radicalised prisoners more so than the recruiters' motivations. Perhaps prisoners have more to gain from joining extremist groups in their specific situation of being incarcerated than civilians out in the community.

In Australia, Jones (2014) puts forward a completely different perspective in which he argues *against* the general consensus that prisons are 'hot spots' for radicalization and

instead posits that radicalization within prisons is unlikely when certain prison conditions are at play. In an attempt to contest the general consensus that prisons act as 'breeding grounds', Jones (2014) developed case studies based on the prison systems of the United States, the United Kingdom, Australia, the Philippines, Indonesia and Pakistan with a focus on the prevalence of prison radicalisation in each area. This comparative debate argues that not all prisons are faced with the problem of radicalisation and recruitment into Islamist extremism. In fact, it was concluded that the nature of some prisons can actually *hinder* recruiters' efforts to radicalise other prisoners into Islamist extremism. One example of this is the way in which some prisoners are outwardly discriminative of the religion of Islam, such as the extremists that belong to neo-Nazi gangs and far right white supremacy groups. Subsequently, logic would suggest that they are less likely to be recruited into Islamist extremism gangs/groups. Although his paper raises some interesting arguments against the possibility of prisons as 'hot spots' for radicalisation, it is not an empirical research study in which case studies were developed from actual observations of and investigations into the different countries' prisons. As it is simply an opinion piece, it cannot be scientifically and rigorously analysed and conclusions drawn from this debate must therefore be considered with caution. Moreover, not all prisons are the same and even if Islamist radicalisation is not a major problem in one prison this is not necessarily the case for the entire secure estate. Nevertheless, the debate raises some interesting points that could influence future research into the risk of radicalisation within prisons. The debate also highlights the possibility of creating prison conditions that are much more preventative in nature as opposed to simply countering prison radicalisation once it has already happened.

To conclude, there is a sparsity of empirical research pertaining to the potential causes of prison radicalisation with much of the literature being theoretical in nature. More specifically, there is a lack of high quality research methodologies being employed in a formalised way to investigate the narratives of radicalised individuals (or those at risk of radicalisation) and individuals who have disengaged with extremist ideologies (Reding, Clutterbuch, Hellgren & Warnes, 2013). The existing evidence base is predominantly anecdotal and includes a great deal of subjective opinion (Borum, 2011). Additionally, the little research that *has* been conducted has been criticised for its lack of methodological quality (Schmid, 2013).

### 1.3. Responses to prison radicalisation

**Table 1. Interventions and responses to prison radicalisation in the UK, Denmark, North America and Australia**

| <b>Country</b> | <b>Current interventions and responses to prison radicalisation</b>   |
|----------------|---|
| United Kingdom | <ul style="list-style-type: none"> <li>- Staff training and awareness building of risk factors for and warning signs of radicalisation</li> <li>- House terrorist prisoners within specialist terrorist prison wings away from general population prisoners</li> <li>- Channel programme: government’s counter-terrorism policy</li> <li>- Healthy Identities programme: extremists seen individually by psychologist to look at possible root causes of having been radicalised. This is voluntary and many prisoners who are referred to this do not participate (Silke, 2014).</li> </ul>  |
| Denmark        | <ul style="list-style-type: none"> <li>- Terrorist prisoners segregated away from general population prisoners</li> <li>- Effective intelligence sharing through more systematic data collection methods</li> <li>- Staff training and improving skills in detecting potential prison radicalisation in addition to teaching staff about cultural norms and different languages</li> <li>- Convicted terrorists must participate in an exit/disengagement project before they can be considered for parole</li> <li>- Investment in research into potential causes of and responses to prison radicalisation</li> <li>- Better and stricter monitoring of religious leaders in Danish prisons with more intense screening and other rules e.g. they can only speak in Danish when delivering sermons</li> </ul> |
| North America  | <ul style="list-style-type: none"> <li>- Correctional Intelligence Program (CIP) extremists’ attempts</li> </ul>  |



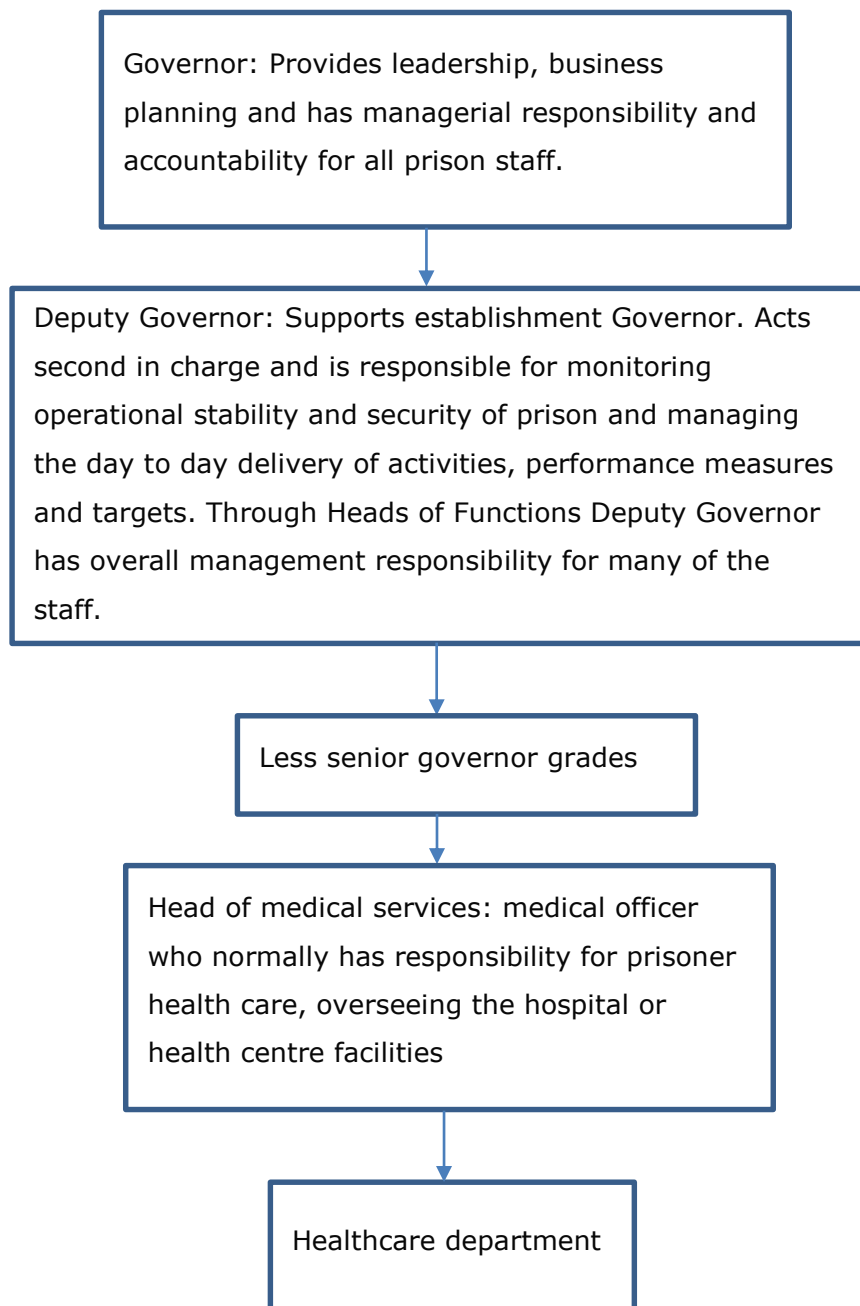
|           |  |
|-----------|--|
|           | to radicalise other prisoners must be detected and disrupted through intelligence gathering, focus is on professionals to be watching and listening, emphasis placed on using information sharing as a tool to try and stay one step ahead of potential radicalisation   |
| Australia | <ul style="list-style-type: none"> <li>- Isolating terrorist prisoners from one another</li> <li>- New bill passed recently allowing prisons to extend the incarceration period of any radicalised inmates who they still classify as a terror threat to the public</li> <li>- Teaching their prison staff about how to detect and report warning signs of potential radicalisation</li> </ul> |

The term 'responses to prison radicalisation' can refer to many things and therefore, considering it from a crime prevention design could be useful. Brantingham and Faust (1976) developed a three pronged conceptual model; primary, secondary and tertiary crime prevention measures. Primary prevention refers to preventative measures taken to reduce opportunities for crime as well as helping the public to avoid becoming victims of crime. In the context of addressing the risk of prison radicalisation, it could pertain to the logistical methods of how best to house and manage terrorist prisoners in order to reduce their opportunities for radicalising other prisoners. Secondary crime prevention refers to early interventions for those at risk of embarking on a life of crime, such as substance misuse interventions and troubled families programmes. In this context, secondary crime prevention could relate to the prevention of radicalisation of inmates whether violent or non-violent radicalisation, Islamist inspired or motivated by far right extremism, through referring prisoners identified as having been potentially radicalised (or possibly in the process of being radicalised) to for example, a disengagement programme. Tertiary crime prevention refers to working with those who pose the most risk to the public through, for example, restorative justice. This strand of the crime prevention model seeks to help perpetrators as well as potential victims. When considering responses to prison radicalisation, tertiary crime prevention could be used to refer to the prison's attempt to help convicted terrorists disengage from their extremist ideologies. Therefore, depending on each prisoner's individual circumstances and where they are in their journey towards radicalisation or beyond it, 'responses to prison radicalisation' can refer to very different things. Nevertheless, each prison has a duty to respond to the threat of prison radicalisation whilst also housing and managing prisoners convicted of terrorism (Silke, 2014). This is not an easy feat as they are simultaneously responsible for all of the following: preventing the

risk of prison radicalisation, countering radicalisation when it has already happened as well as managing convicted terrorist prisoners.

Maintaining a good standard of care for terrorist prisoners is just as important as it is for other prisoners and can be challenging due to the conflict of interests between the prison and the healthcare departments within the secure estate (Pont, Stover & Wolff, 2012). When considering the care of convicted terrorists, the potential for conflict is even greater due to the government's requirement of clinicians to monitor for potential radicalisation. As figure 1 below shows, healthcare is not the prison's priority and they have much less influence in the prison, where security is paramount.

**Figure 1. Partnership working between healthcare and prisons – typical organisational structure of UK prisons (Health & Safety Executive, Public Services Sector, 2013).**



Prison clinicians in the UK are required to complete training on how to detect and report potential cases of radicalisation, although they are not instructed on exactly how best to engage with terrorist prisoners (or any prisoner who has been or is in the process of being radicalised). The UK Government requests that all healthcare workers,

"ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of and can locate available support, including the Channel programme where necessary." Within this strategy, the government requests that healthcare workers treat potential radicalisation as a safeguarding issue comparable to child abuse or domestic violence. As per NHS England's (2015) requirements, healthcare professionals are required to complete the UK Government's (2011) Workshop to Raise Awareness of Prevent (WRAP) training at least once every three years. Within HMP Eastside and HMP Westside, WRAP training is delivered through Spectrum Community Health CIC, by the organisation's Safeguarding Lead. The one-hour session consists of trainees being taught potential explanations of radicalisation and shown real-world examples of individuals who have been radicalised in the past, and referred to the Government's Channel panel. Scenario based clips presenting different forms of extremism (from Islamist extremism to far right white supremacy) are shown and trainees are asked some questions about the clips pertaining to their perceptions of any potential warning signs of radicalisation. All staff are required to complete the same training regardless of their typical work setting, if they have any contact with patients whatsoever; whether they usually work in prisons, the community or at head office.

The UK Government's response to this ever-increasing issue is to impose the same counter-extremism protocols, within prisons as is enforced outside in the wider, general population. Whilst prison staff are usually given awareness training in grooming, coercion and bullying among prisoners; this is separate from WRAP training and provided by the prison establishment itself. The government's WRAP training provided in prisons however, does not appear to differ from the WRAP training offered to professionals outside in the community; there appears to be no differences in content or mode of delivery regardless of experts in the field voicing concerns that prisons are potentially 'breeding grounds' and 'hot spots' for radicalisation.

Since the above requirements were set out they have sparked contention among healthcare professionals questioning whether they should exist in the first place. For instance, in 2016, the Open Society Justice Initiative conducted a large scale research study assessing the impact that the incorporation of the Prevent strategy within the health and education sectors has on human rights. The study investigated the suitability of the UK Government's (2011) Contest Strategy's Prevent duty being used within UK health and education sectors as these particular services are heavily based on trust between clinicians/teachers and patients/students. The research questioned whether the strategy should indeed be conscripted within these sectors in the first place. Over 87 interviews were conducted across England with parents, school teachers, university officials, college and university students, members of parliament, current and former government officials, health professionals, religious leaders, community advocates, academics and journalists. Findings showed that Prevent was indeed violating the human rights of individuals. There is evidence that many primary care practitioners and wider professionals feel both uncomfortable and unconfident in practising the principles outlined in the Prevent strategy (Open Society Justice Initiative, 2016). There is of course a real risk that such a safeguarding referral could lead to permanent irreversible breakdown in the clinician-patient relationship. Various case studies were reported regarding the implementation of the Prevent strategy across education and health sectors. One such case study highlighted the real risk of patients feeling wrongly targeted and alienated by GPs and thus losing trust in them. This specific case involved a patient of Muslim faith who allegedly underwent an inquiry regarding his political views. Such an inquiry had lasting negative effects on the patient with him being subjected to further questioning from the police on numerous occasions up to a year and a half later. It later became apparent that he was being monitored by the police because they had learned of his father's trips to Syria. However, these trips were made in order to help with humanitarian relief work. Subsequently, the patient has been left feeling harassed and criminalised and has not felt able to confide in any of his friends in fear of being ostracised by them. His trust in GPs has been tarnished and he now feels like he has been 'silenced' by the strategy.

These findings highlight that the health system is a potentially sensitive area to incorporate the Prevent duty into. There appears to be potential long-lasting effects on clinician-patient relationships, in particular, the risk of patients feeling discriminated against and losing trust in healthcare professionals. Healthcare is an area where trust matters, with patients less likely to share their health concerns when trust is diminished (Open Society Justice Initiative, 2016). When considering healthcare within a secure estate, there are even more implications as prisoners cannot choose who they go to for health-related advice or care.

Incorporation of the Prevent duty into the NHS should therefore be regularly reviewed and research should be conducted to explore exactly how staff are incorporating the duty into their daily roles.

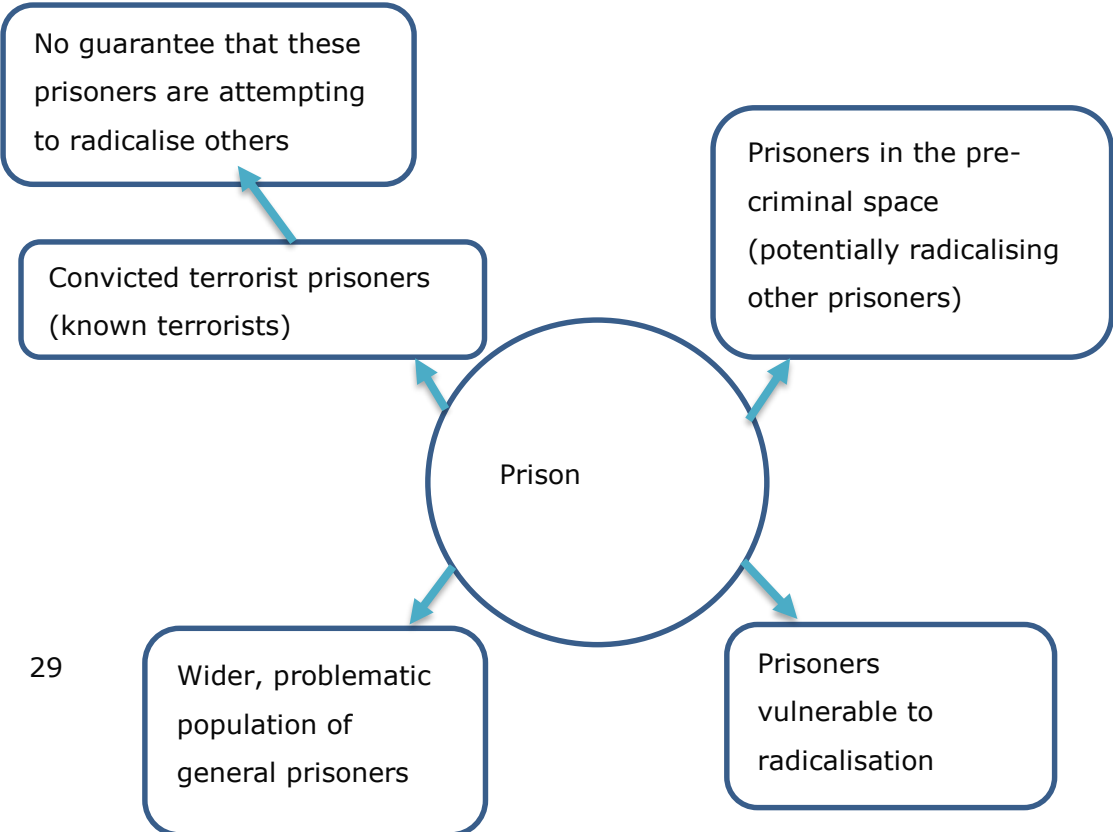
In addition to concerns about patients losing trust in clinicians, healthcare services have also shown anxieties about the duty placing an additional burden on their clinical roles (HM Government, 2015). The British Medical Association (BMA) published guidance last year that states however, that no 'new responsibilities' have been placed on healthcare authorities or staff. Their guidance explains that the above requirements ask no more of healthcare staff than to simply adhere to their usual legal and professional duties to disclose, at their own discretion, any confidential information in the interest of the public. As the specific Prevent strand of the Contest strategy focuses on stopping individuals from being drawn into terrorism and embarking on engagement in terrorism-related criminal activities, in the first place, the BMA (2017) argue that this aspect of the strategy should be regarded as any other adult-and-child-safeguarding. As this strand was intended to work in a 'pre-criminal space', when considering this within prisons, healthcare staff need to help in the efforts to prevent convicted terrorists from recruiting / radicalising any 'typical' prisoners within the establishment.

However, according to Goldberg, Jadhav and Younis (2017), the concept of 'pre-criminal space' is not clear throughout health sector protocol documents and therefore it is difficult for health professionals to understand what it actually means. The concept was developed for inclusion in the NHS England's 'Prevent Training and Competencies Framework' (2015) and is used to refer to cases when an individual is referred to the Channel panel (Goldberg et al., 2017). It could also be argued that the concept of the 'pre-criminal space' is not particularly helpful for prison clinicians where they are already treating patients that have often moved beyond this. Prison clinicians are still expected to adhere to the same principles of the Prevent strand as any other clinicians out in the community or working within a hospital, yet this could be argued as inappropriate and irrelevant to them as the 'pre-criminal' objective is not easily achievable here. Although it could be argued as still being applicable to preventing 'typical' prisoners from committing new crimes that are related to terrorism.

In the UK, prisons offer new staff induction training in how to manage security risks, how to detect and report suspicious behaviour, how to avoid being manipulated (groomed) by prisoners and ultimately how to keep themselves and others safe. Within some prisons (each prison has its own set of protocols and systems for the delivery and content of

training) new staff are taught what to do if a prisoner convicted of terrorism takes them hostage. Usually the advice given is to escape as soon as they physically can. Prison employees are taught that convicted terrorists do not usually take staff hostage for leverage to gain materialistic things like 'typical' prisoners (such as a television) but instead their objective is to promote their cause and voice their radical ideologies. Therefore, employees are taught that these prisoners feel they have nothing to gain by freeing the hostage and hence staff are advised not to try and negotiate with them. This example illustrates that the presence of terrorist prisoners introduces a whole new dynamic to prisoner-staff relationships and this has implications pertaining to exactly how such prisoners should be managed, cared for and communicated with. The idea that terrorist prisoners should perhaps be managed differently to other prisoners is reinforced within the literature, for instance, it has been suggested that the behaviours of terrorist prisoners are unlike conventional criminal prisoners (Neumann, 2014). This differentiation between certain types of prisoners and how they are housed is, however, not new. For instance, in the UK, prisoners classified as 'vulnerable' (i.e. more likely to self-harm or be assaulted by other prisoners) such as sex offenders are usually kept separate from general population prisoners and usually occupy one wing which is exclusively for them (Travis, 2016). With terrorist prisoners, prison management have to consider extra risks they pose to other prisoners in the general prison population. Convicted terrorists have to be monitored for their potential to radicalise other prisoners and also have to be blocked from continuing terrorism-related activities whilst incarcerated. As such, arguments have been made for and against housing terrorist prisoners in specialised ways, based on the problematic setting of the prison estate.

**Figure 2: A problematic setting**



Within category A (high security) prisons HMP 'Eastside' and HMP 'Westside', new specialised wings have recently been introduced to the institutions in which prisoners incarcerated for terrorism are held. This method of segregating and containing terrorist prisoners from the general prison population has received scrutiny throughout the literature. Neumann (2010) highlights that whilst separating terrorist prisoners from other prisoners might be useful in that it prevents convicted terrorists from radicalising the general prison population, it might also hinder counter-terrorism efforts in the long term by attracting unhelpful public attention that could give out a message of discrimination and thus encouraging feelings of grievance.

Clearly, preventing prison radicalisation whilst also trying to treat terrorist prisoners with fair treatment is a complex issue. Nevertheless, in category A prisons, prisoners tend to serve longer or life sentences (Allen & Watson, 2017). This characteristic of the high security prison estate could be viewed as an opportunity for prison healthcare professionals to address health and social problems and when appropriate, contribute to continued support for and potentially successful rehabilitation of prisoners after release. This becomes particularly relevant when considering prisoners who have been incarcerated for terrorism related offences or prisoners who have been incarcerated for other offences but radicalised whilst institutionalised because the standard of care provided is likely to have an impact on whether an individual will or will not disengage from extreme and radicalised thinking (Neumann, 2012). This is important when considering how the released prisoner might affect the general public when re-entering the wider community; it is hoped that an ex-prisoner who has disengaged from radical thinking due to rehabilitative help they received in prison, would be less likely to go on to radicalise others and/or commit a terrorist attack upon release.

Over in the USA, law enforcement has prioritised the prevention of prison radicalisation through the 'Correctional Intelligence Program' (CIP). This nationwide counter-terrorism project was developed collaboratively by the United States Federal Bureau of Prisons (BOP) and the Federal Bureau of Investigation (FBI). Their aim is to prevent prison radicalisation through practicing vigilance and detecting terrorist activity as well as potential cases of radicalisation. The project is run according to the premise that in order to prevent terrorist

activity, extremists' attempts to radicalise others in prison must be detected and disrupted through intelligence gathering. Much like the UK's Prevent duty, its focus is on professionals to be watching and listening out for any warning signs that radicalisation could be taking place. The emphasis here, is on using information sharing as a tool to try and stay one step ahead of potential radicalisation and/or terrorism.

Prison radicalisation responses in Australia take a slightly different stance to the USA and UK. For instance, where the UK use specialist terrorist units to separate terrorist prisoners from general population prisoners, Australia isolate their terrorist prisoners from one another (Community Justice Coalition, 2016). Australia, like the USA, UK and Denmark, do teach their prison staff about how to detect and report warning signs that potential radicalisation is taking place. Unlike the USA and UK, Australia authorities now have the ability for prisons to extend the incarceration period of any radicalised inmates who they still classify as a terror threat to the public should they be released (see the 'Terrorism (High Risk Offenders) Bill 2017' for further information). It is hoped that within the extended time frame, rehabilitative work can be done with the said prisoners to help them move towards no longer posing as a risk to the general public. In a parliamentary debate pertaining to the bill, Piper highlights a need for caution when detaining someone beyond their original sentence, based on crimes prison administrators suspect they *might* go on to commit, as this could potentially violate prisoners' human rights (Parliament of New South Wales, Legislative Assembly, November 21, 2017).

In Denmark, much like in the UK, prison management of terrorist prisoners sees them being segregated and isolated in specialist units within the institutions. Efforts to combat radicalisation in Danish prisons appear to be something that is taken very seriously by the country's government. Their recently updated strategy to prevent radicalisation in prisons is comprehensive in that it appears to acknowledge how complex the phenomenon really is. Their approach is multi-pronged and informed by a review of Danish prison radicalisation responses which took place in 2015. The review led to the following recommendations for the improvement of prison radicalisation responses:

Better intelligence sharing through more systematic data collection methods. In order to achieve this, Information Technology systems will be improved to allow for easier data collection for staff when logging concerns about particular prisoners.

Investing in staff training and improving their skills in detecting potential prison radicalisation. Denmark's proposed training looks to go one step further than the



UK's training in detecting radicalisation, teaching staff about cultural norms and even about different languages.

The requirement of convicted terrorists' participation in an exit/disengagement project before they can be considered for parole.

An emphasis on the need for religious representatives to speak up and report concerns of radicalisation.

Investing in research to improve policy and procedural development pertaining to the prevention of prison radicalisation. In particular, research will be conducted regarding how best to house terrorist prisoners. Research pertaining to the increasing overlap in and interaction between criminal gangs and extremist groups.

Lessons will be learned from gang exit interventions for future disengagement strategies.

Better and stricter monitoring of religious leaders in Danish prisons with more intense screening and other rules such as only allowing religious representatives to speak in Danish when delivering sermons.

Magnus Ranstorp of the Radicalisation Awareness Network, praises Denmark for their counter-terrorism efforts (cited in Grouch & Henley, 2015). As shown above, their response to preventing prison radicalisation is a comprehensive one, their response considers the importance of targeted interventions for prisoners, as well as better training for staff, tighter monitoring of religious leaders, and even go so far as improving their IT systems. Refreshingly, they emphasise the need for empirical research into the issue of prison radicalisation. Danish authorities have clearly considered the problem in great detail, attempting to tackle it from intervention, training, security and rehabilitation perspectives.

In summary, the evidence base pertaining to responses to prison radicalisation highlights the continued contention and confusion regarding how best to manage the risk of prison radicalisation as well as how already-convicted terrorists might be most effectively managed. The evidence suggests that different countries are still grappling with the trial and error process whilst attempting to find solutions to such questions. Whilst for the UK, some lessons can be learned from other countries, their 'success stories' are not always transferable due to the contrasting political landscapes and cultural make-up of these different parts of the world. It is advisable then, that any so-called success stories for

managing prison radicalisation are scrutinised and evaluated in the hope that even some helpful information can be shared and then implemented.

#### *1.4. Reviewing responses to prison radicalisation*

In recent years, the UK government has reviewed its counter-extremism protocols and policies in light of the increased frequency and severity of terrorist attacks. However, there is yet to be a credible and reliable method of evaluating such responses to radicalisation (Davies, Warnes & Hofman, 2017). The challenging nature of reliably evaluating counter-radicalisation and counter-extremism programmes drives a need for further research in order to avoid developing interventions based on trial and error (Veldhuis, Gordijn, Lindenberg, & Veenstra, 2014); a method that is both time consuming and expensive.

A literature scoping exercise revealed that there is a scarcity of empirically robust evidence pertaining to the evaluation of responses to prison radicalisation, perhaps due to challenges that come with this specific issue. For example, Neumann (2010) highlights the limitation that examiners of prison radicalisation disengagement programmes face as released prisoners are difficult to follow up once they are out in the community. He argues that it is difficult for such disengagement interventions to be evaluated because it is hard to know whether released prisoners have remained disengaged or not.

Some commentators argue that this difficulty in evaluating existing countering violent extremism (CVE) interventions can act as a barrier to developing effective responses to begin with (Davies et al., 2017). For instance, Davies et al. (2017) conducted a literature review exploring the current evaluative methods used for measuring the efficacy of interventions that seek to counter violent extremism. When they discovered that there is sparse credible evidence that high quality evaluation tool kits of this kind exist, it was decided upon to refer to evaluative toolkits used in other areas of criminology. It was found that reviewing the evaluative methods used to measure the effectiveness of gang-related interventions could be useful due to the parallels made between gang grooming and radicalisation into extremist groups. One parallel that has been made pertains to the demographic profile of those most likely to be recruited to gangs or radicalised; young males that feel ostracised by society (Decker & Pyrooz, 2015). Another parallel relates to the individuals that are often targeted for recruitment into gangs as well as into violent extremist groups; those that are deemed as being psychologically predisposed to participating in criminal activities and potentially violence (David, Warnes & Hofman, 2017). Individuals that are selected are usually then vetted for reliability and then initiated into the gang or extremist group. David, Warnes and Hofman's (2017) literature review concluded

that methods used to evaluate gang interventions were of higher quality than those used to evaluate CVE interventions. Although they found that there was a lack of specific gang interventions in Europe, they did conclude that the US's specific interventions can be transferable to Europe.

There is a gap in evidence pertaining to the use of the Prevent duty by professionals that are obligated to follow its protocols. The only literature that could be retrieved pertaining to professionals' views of Prevent comes from government consultation processes with the last one being held in March 2015. The government sought feedback about the Prevent duty through an open process of consultation. Over 1,700 written responses were received and around 316 attendees were present at the various consultation events. Feedback about the strategy was received from academic and key public sector institutions (including education, health and criminal justice systems) (HM Government, 2015). A number of themes were found from the government consultation:

Support for Prevent: Prevent was seen as a safeguarding issue; for adults as well as children.

Concerns regarding the Prevent duty: Anxieties were expressed that using the duty might inhibit people's ability to freely express their religiosity. It was also suggested that following the duty protocol might put a strain on organisations due to additional responsibilities.

Suggestions for improvements to the Prevent duty: Responses called for information sharing systems to be improved.

Although literature pertaining to concerns of how to effectively evaluate responses to prison radicalisation was uncovered, there appears to be no literature pertaining to prison clinicians' views on the government's counter-extremism methods. Given that the UK Government implicate the health sector in its counter-terror efforts, this was quite surprising. This literature review finding prompted the development of this study's aims and objectives and informed the research questions outlined in the Introduction chapter. It felt timely and necessary, due to the ongoing debate pertaining to the Prevent duty's applicability to education and health sectors, to seek views from some of the professionals who actually have to apply the duty to their everyday work settings. The views of health professionals working within the prison setting were considered as particularly relevant to the issue due to the debate that prison is a problem area for radicalisation. Gathering such

views in an empirical manner is something that appears not to have been accomplished before.

## **2. 0. Research Methodology**

This is an empirical qualitative study of prison-based clinicians' perceptions and views of, and experiences with prison radicalisation, the UK Government's Prevent counter-terrorism policy and the mandatory use of this when providing prisoners with an index offence pertaining to Islamist related terrorism, with healthcare services. This is the first reported study that could be found which explores prison clinicians' perceptions of the duties that they are required to carry out in line with the UK Government's counter-terrorism policy. Using qualitative semi-structured interview techniques, firstly an enquiry is done pertaining to the prison clinicians' general awareness and understanding of the concept of prison radicalisation and the associated counter-extremism protocols that they are expected to incorporate into their daily jobs when providing healthcare to prisoners. The enquiry moves on to examine whether participants have completed the Prevent training and if so, what their views and experiences are of having undertaken it. Prison clinicians are then given the chance to voice their own ideas of what Prevent training should look like and how they might improve existing practices. Prison clinicians' acceptance of and engagement with the Prevent duty and how it is operationalised in prison healthcare is then explored. In particular, the interview schedule investigates the potential role conflict of and tensions between staff balancing the different demands of their clinical work with the counter-terrorism policy.

### *2.1. Research setting*

The research was undertaken across two 'category A' (high security) prison sites (anonymised as Eastside and Westside prisons) in England of which details can be found below, in figure 3. The prisons that this project focused on house inmates who have committed offences connected or sympathetic to terrorist aims (HM Chief Inspector of Prisons, 2016).

**Figure 3: The research setting**

| HMP Eastside   | HMP Westside   |
|--|--|
| <ul style="list-style-type: none"><li>• Category A (high security) prison</li><li>• Population of approximately 850 males</li><li>• Holds category A, Category A High Risk and Category B prisoners</li><li>• Prisoners typically serve 10 years and over</li><li>• Offers primary care services and in-patient care to prisoners</li><li>• Long-standing issue of recruitment and retention of healthcare staff</li><li>• There are 4 Spectrum Community Health CIC staff (1 pharmacist, 2 pharmacy technicians and 1 GP)</li><li>• 13 healthcare wing spaces</li></ul> | <ul style="list-style-type: none"><li>• Category A (high security) prison</li><li>• Population of approximately 600 males</li><li>• Holds category A and B prisoners</li><li>• Prisoners typically serve 4 years and over</li><li>• Offers primary care services and in-patient care to prisoners</li><li>• Long-standing issue of recruitment and retention of healthcare staff</li><li>• There are 28 Spectrum Community Health CIC staff (made up of doctors, nurses, pharmacists, pharmacy technicians, mental health workers, recovery workers)</li></ul> |

Around 600 adult men are held within HMP Westside and there are around 800 incarcerated in HMP Eastside. Both establishments accept prisoners from all over England and Wales. Both primary care services and in-patient care are delivered at the secure sites. Spectrum Community Healthcare employ pharmacists and trained nursing staff within HMP Eastside whilst HMP Westside enjoys a wider range of Spectrum staff ranging from General Practitioners through to addiction Recovery workers. Throughout this study, prisoners will also be referred to as 'patients'.

## 2.2. Participants

Spectrum employed healthcare workers were approached via email through the head of health care for each site who were asked to circulate the email. Interviews were conducted just outside of the prison site, in neighbouring staff training buildings, to minimise the need

for security related administration and use of prison resources. This also meant avoiding the added layer of approvals that would need to be sought from the security departments in order to take an audio recorder into the actual prisons. It was decided that this would be too time-consuming and an unnecessary inconvenience to prison staff.

The qualitative research approach deals with how people make sense of and attach meaning to components of their lives with an emphasis on their own interpretation of personal experiences (Taylor, Bogdan & DeVault, 2015). Qualitative research methods can be used for the more intense study of smaller samples in which participants are selected based on their knowledge of and experience with the topic that informs the interview schedule (Miles, Huberman & Saldana, 2014). Emphasis is placed on the participants' ability to describe and explain their experiences and therefore, random sampling is not appropriate. Purposive sampling was employed in the attempt to recruit participants from each of the following health care staff types:

- Head of healthcare
- General practitioner
- Nurse
- Healthcare assistant
- Mental health worker

### ***2.3. Response rate***

Initially, 25 Spectrum CIC staff members were invited to be interviewed, which then increased to 33 when difficulty was experienced with finding participants who had adequate time to take part in the study. This increased number of invitees originated from colleagues' recommendations of other staff I did not know of at the initial invitation stage. Due to the staff being so busy, it was challenging to schedule interviews with all of the invitees that agreed to be interviewed and many had to decline the invitation altogether.

### ***2.4. Sampling issues***

Due to a shortage of staff and resources, no healthcare assistants were able to take part in this study. This would have been of great value to the study as this particular group of staff spend more time face-to-face with prisoners than any other prison clinician. As they spend most of their time on the 'shop floor', tending to prisoners' healthcare needs and get involved in a vast amount of practical work, it is likely they would have provided insightful accounts of their own experiences of treating extremist prisoners. By interviewing health care staff from a diverse range of specialties/professional backgrounds, different

perspectives from across the healthcare field were harvested. Due to problems of understaffing, the following types of clinicians were interviewed (please see table 2, below).

**Table 2. Participant characteristics**

| Participant number | Gender | Clinical Role                                      |
|--------------------|--------|--|
| 1                  | Male   | GP   |
| 2                  | Male   | Pharmacy Technician                                |
| 3                  | Female | GP   |
| 4                  | Female | Pharmacist   |
| 5                  | Female | Pharmacist   |
| 6                  | Male   | GP   |
| 7                  | Male   | Substance misuse recovery and mental health worker |
| 8                  | Male   | Substance misuse recovery and mental health worker |
| 9                  | Male   | Substance misuse recovery and mental health worker |
| 10                 | Female | Nurse  |
| 11                 | Female | Nurse  |
| 12                 | Female | Nurse  |

Role diversity of the participants was important in order to explore whether different types of clinicians engage with the government’s counter-terrorism policy differently and possible reasons for any discrepancies. It was hoped that recommendations could be made pertaining to improvements of the policy training and protocols, appropriate to the various clinical roles. Unfortunately, no healthcare assistants were able to give up their time to be interviewed and so instead, substance misuse recovery workers and pharmacists were interviewed as these are clinicians that, like healthcare assistants, spend a lot of time working on the ‘shop floor’, out on the prison wings and face-to-face with prisoners.

Participants were recruited to the study by an introductory email telling them about the study and requesting about of an hour of their time to be interviewed about their views and perceptions of and experiences with the government’s counter-terrorism policy and the



requirement of them to incorporate this into their daily clinical roles. Those responding positively were followed up and offered an interview date, time and location.

### *2.5. Data collection procedure*

A semi-structured qualitative interview schedule was used with 12 health care staff from 2 Category A (high security) English prisons in which they were asked about their;

1. Perceptions of the possible risk factors for and health consequences of prison radicalisation
2. Current engagement with and acceptance of counter-radicalisation protocols, procedures and training when caring for prisoners convicted of offences relating to Islamist violent extremism
3. Perceptions of the efficacy of existing counter-radicalisation protocols, procedures and training for prison clinicians caring for prisoners convicted of offences relating to Islamist violent extremism.

The initial interview schedule which can be found in Appendix xx, was reviewed by my project supervisors for comments and minor amendments were made in light of their feedback. This included comments from a very experienced prison healthcare researcher; also a General Practitioner and the Clinical Research Director for Spectrum Community Health CIC in order to gain a healthcare perspective.

The semi-structured face-to-face interview approach was selected for its ability to encourage participants to 'open up' and generate new ideas and insights (Gomm, 2004). This approach also allows the interviewer to prompt the participant for elaboration on their initial answers so that richer data can be obtained (Coolican, 2013). This kind of data collection also equips the researcher with the opportunity to cross-examine participants' answers in order to delve deeper and get clarification on any answers that are not clear (Miles et al., 2014). By using this more flexible method, a rapport can be built between the researcher and the participant and encourage a more honest and open discussion (Gubrium, Holstein, Marvasti & McKinney, 2012). Other methods were considered and ruled out for various reasons. For instance, a survey based methodology could have been employed and this would have resulted in data from a much larger sample size as it would have been a much less time consuming data collection process. However, the data gained would most likely have been superficial as unlike in face-to-face interviews; there is no opportunity for interaction with the participants and therefore no chance for probing for further information. Also, a face-to-face interaction with participants allows for a natural flowing conversation to

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occur and therefore can harbour richer data. As the study topic is so sensitive and controversial, it felt more appropriate and potentially more useful to ask about peoples' experiences and perceptions, face-to-face. The open ended questions used within the semi-structured interview style also discourage participants from giving short answers, void of detail; more meaningful answers can be obtained. Even if open-ended questions were used with a survey to allow participants to answer in a free text manner, there would still be a possibility of participants not answering the questions in full - or if they do not understand the questions - at all. Interacting directly with participants gives them the opportunity to ask for clarification on any questions they do not understand.

The interviews lasted between approximately 40 minutes and 2 hours each and were digitally audio-recorded and transcribed verbatim by an experienced assistant. The transcripts were then listened to in order to check for accuracy.

#### *2.6. Ethical approvals procedure*

Ethics approval processes for this study were sought and granted from both the university of Huddersfield and Spectrum Community Health CIC. As only staff (and no prisoners) were interviewed and they were conducted outside of the prison, prison security approvals were not needed. Because it was clinical staff and not officers that were interviewed, National Offender Management Service (NOMS) ethical approvals were not necessary.

Other ethical considerations were made with regards to the collection and handling of personal data; all participants were assured that all data would be kept confidential by saving it on a password encrypted folder on a Spectrum work computer that only the Research Team could access and that their personal information would be protected by anonymising names with pseudonyms. To further protect interviewees, the prison sites were also anonymised.

#### *2.7. Data analysis*

The data was analysed using thematic analysis. Thematic analysis is a way of finding patterns (themes) within a body of data, analysing these and then presenting any conclusions that have been made as a result of the analysis (Braun & Clarke, 2006). This method of analysis is used to explore what things mean to participants, to allow for flexibility and to find any emerging themes and patterns across and within participants' accounts (Braun & Clarke, 2006). Some commentators have criticised the flexibility of the approach for its lack of strict guidelines, arguing that this lack of direction leaves it open to

being used incorrectly (Miles et al., 2014). However, as this research is the first study of its kind, and it looks to explore people's perceptions and experiences, this flexibility seemed relevant and appropriate here.

The study's interview schedule was informed by a topic guide that was very closely linked to the research questions, which resulted in a more top-down thematic analysis approach to searching for themes. The data analysis also used an element of bottom-up analysing, also known as data-driven thematic analysis (Coolican, 2013), in order to look for novel themes that had not been considered previously. This was enabled by the variety of clinicians that were interviewed as they were able to offer different perspectives on the issue, from their own specific roles. It is this flexibility that thematic analysis offers that led to selecting this particular approach.

Firstly, the audio recordings were listened to whilst the corresponding transcripts were read to familiarise myself with the data. Secondly, the transcripts were read again but this time any ideas and/or potential initial codes were noted on the hard copies. Coding is a way of identifying a feature of the data that appears interesting to the analyst and a way of organising data into meaningful groups (Braun & Clarke, 2006). For this study, I had specific research questions and an interview schedule that I could then code around. I printed paper copies of the transcripts and used highlighters to indicate potential patterns.

Thirdly, the transcripts were re-read again but this time the data and the initial ideas and/or codes were reviewed to discover themes across them. I then moved on to reviewing all of the themes across the entire data set, in which the initial themes were reconsidered; whether they were indeed themes in and of themselves, whether they needed to be moved and/or changed to subthemes or separated from one theme into two for example. Once the final placing and organisation of the initial themes was complete, I was able to properly define and name each in the final iteration.

### **3.0. Findings and Discussion**

In this chapter the results of the data analysis are presented. The responses were analysed in response to the research questions, aims and objectives outlined in chapter 1: to explore the perceptions of the possible risk factors for and health consequences of radicalisation; to investigate the current engagement with and acceptance of counter-radicalisation protocols, procedures and training when caring for prisoners convicted of offences relating to Islamist violent extremism; and to gauge perceptions of the efficacy of existing counter-radicalisation protocols, procedures and training for prison clinicians caring for prisoners convicted of offences relating to Islamist violent extremism. The findings in this chapter demonstrate that participants are largely supportive of the Prevent strand of the UK Government's counter-extremism Contest strategy and enthusiastic about taking responsibility to play a role in what respondent's view as the 'fight against terrorism'. Almost all participants agreed that they should practice vigilance by observing and reporting any concerns about radicalisation, whether to do with patients or colleagues. Although, there was some negativity towards the duty with some views that it focuses unfairly on Muslims as more at risk of becoming radicalised. There was also an argument made that the strategy's WRAP training should be improved both in terms of content and mode of delivery in order to help staff to learn as effectively as possible and to develop the skills needed to detect and report potential radicalisation and prevent any potential escalation to terrorist offending upon release. This study demonstrates that Prevent protocols should be continually reviewed for improvements and that it could be particularly helpful for the government to seek the views of how this might be achieved from the professionals who are required to follow them. Likewise, the Prevent WRAP training should be regularly reviewed for potential improvements in staff ability to detect, report and potentially prevent possible cases of radicalisation.

#### ***3.1. Thematic analysis of findings***

A qualitative thematic analysis was carried out on data generated from semi-structured, face-to-face interviews. A summary of the main themes and sub-themes are shown in table 3 below, followed by a discussion of these in relation to existing research and theoretical models.

**Table 3: Table of thematic findings**

| <b>Theme</b>   | <b>Sub-theme</b>   |
|--|--|
| 1. High staff engagement with and acceptance of Prevent in prisons | 1.1. Most clinicians see Prevent duty as safeguarding<br><br>1.2. Some negativity towards Prevent duty use for healthcare<br><br>1.3. Room for improvement in staff ability to prevent prison radicalisation |
| 2. Good staff understanding of prison radicalisation               | 2.1. Staff perceptions of prison radicalisation risk factors<br><br>2.2. Staff perceptions of prison radicalisation warning signs<br><br>2.3. Staff perceptions of effects of radicalisation on prisoners    |
| 3. Caring for convicted terrorists is complex                      | 3.1. Caring for 'typical' versus terrorist prisoners<br><br>3.2. Role-specific experiences   |
| 4. Operationalising Prevent in prisons is feasible                 | 4.1. Staff well-being and the importance of teamwork<br><br>4.2. Staff ideas for improving Prevent WRAP training in prisons<br><br>4.3. Staff suggestions for treating those at risk of radicalisation       |

## 1. High staff engagement with and acceptance of Prevent use in prison healthcare

### 1.1. Most clinicians see Prevent duty as safeguarding

What really struck a chord was the observed high enthusiasm for and acceptance of the government's counter-terrorism policy and the obligation to incorporate the associated Prevent duty into participants' daily roles, refuting other findings that the mandatory use of Prevent within healthcare is stigmatised (CAGE, 2016). Participants were open to the use of Prevent when caring for their patients and did not show concern for its use impinging on patients' human rights. Therefore, the research findings did not reinforce other recorded reactions to the duty's use across health and education sectors i.e. they did not share the same views of 300 academics, activists and health professionals that have questioned the ethical grounding of the Prevent duty and argued that its use contravenes the human right of free speech (CAGE, 2015). There was wide agreement that observing for potential warning signs of radicalisation and reporting any concerns is something that should be seen as mandatory by staff and incorporated into their daily jobs. There was a very strong theme pertaining to safeguarding repeated across and within the interviews, with staff stating that Prevent should be a professional obligation in order to provide a duty of care to colleagues and patients. This can be seen in the language used by participants with phrases such as 'duty of care' and 'code of conduct' being repeated throughout and across interviews.

*"You've got a **code of conduct** there and you've got a **duty of care** and candour... We've all got a **duty of care**, haven't we? It's like some people go, "Do you know if saw an accident outside and you were in your car and you knew somebody was hurt but you weren't at work, would you stop?" Hell yes... you've got a **duty of care** because you're not supposed to walk away from it because you're supposed to be a nurse all the time"*  
*Participant 11 [my emphasis]*

Unexpectedly, as there was no mention from any of the participants about feeling like a 'spy' by having to observe for potential cases of radicalisation in their patients, it appears that they did not interpret the duty in this way.

*"I've never once known anybody personally that's ever asked to be a spy or to tell tales or... All that people are ever asked is to raise concern over anything that they notice – what they think could be a threat, if it could put them at risk or put a colleague at risk. I think as part and parcel of what they do – whether they're in a prison or not – if it puts somebody else at*

*risk; whether it's a prisoner, a member of staff, somebody in the community – then they need to report it as part and parcel of their job role.” Participant 10*

This was somewhat expected because of reactions from some clinicians challenging the duty's use in healthcare. For instance, writing for the British Journal of Psychiatrists Bulletin, Dr Derek Summerfield (2016) argued that referring patients for potential radicalisation is 'unethical' and a 'form of spying and scapegoating, and essentially about Muslim patients' (Summerfield, 2016: p1); he goes so far as stating that clinicians should refuse to attend WRAP training or participate in the agenda.

Such a high acceptance of 'I'm doing safeguarding' among staff was unexpected. It was expected that prison clinicians would grapple more with tensions between their roles within healthcare and the added assigned role of counter-terrorism surveillance just as has been found with community clinicians (Open Society Justice Initiative, 2016). However, this finding may be due to prison clinicians' work environment and culture; the hostile nature of the prison and working with patients that are also criminals. The cultural norms begin with induction training when prison staff are taught about the importance of security and the risk of being groomed by prisoners. It could be argued that being suspicious organically develops among prison employees as they carry out their roles, working in such a hostile setting. For example, as Bosworth (2002) states, prison clinicians often have to figure out whether prisoners are being dishonest about their health; one example being when they claim to be ill to avoid work. In addition to detecting deception, staff have to remain alert to the risk of being manipulated by prisoners which could lead to being put in dangerous situations. Perhaps, therefore, counter-terrorism surveillance fits more naturally with the prison environment.

## 1.2. Some negativity towards Prevent duty use for healthcare

Surprisingly, there appeared to be minimal resistance towards the use of the Prevent strategy within prison healthcare, with only one person stating it should not be a role that prison clinicians have to adopt,

*"I don't think it should be, no. Because you're putting yourself at risk then. We're healthcare staff, we're not trained officers or security staff. And you shouldn't be putting yourself in that risk. Because if they took you hostage, they're not going to take you hostage because they want a couple of more codeine. They're going to take you hostage to chop your head off!" Participant 4*

The same participant showed disinterest in engaging with the subject of radicalisation,

*"I'm not interested in it, it doesn't really affect me", and argued that healthcare should not play a part in the government's counter-terrorism efforts, "It's not in my job description".*

Wright, Hankins, Allgar and Miller (2017) found much more resistance from staff in their study in which 80% of the 311 community GPs that completed their online survey, answered that they felt either 'uncomfortable' or 'extremely uncomfortable' that identifying suspicions of radicalisation is a role that they should take responsibility for. This study was, however, based on community based GPs and it could be argued that due to the criminal environment of prison clinicians' work setting, they are more at ease with detecting and reporting suspicious behaviours in their patients.

Surprisingly, there was no mention of participants about the duty's potential to alter the client clinician relationship. For instance, GP, Dr Clare Gerada (2016) expressed fear that the Prevent duty might lead to potential breaches in confidentiality obligations in the health sector and perhaps even promote the idea that doctors are abusing their positions. She also argued that the Duty could change the client clinician relationship with patients being too scared to be completely open with doctors in case they get referred for saying something that is apparently out of turn. She goes on to argue that doctors will also become reluctant to ask patients potentially helpful information gathering questions that might come across as suspicious and affect patients' trust in them. Other doctors have explained the duty will make it difficult to treat patients without all information about the patients which will not be obtained if patients are too scared to fully open up (Open Society Justice Initiative, 2016). Perhaps the research findings were dissimilar because prison clinicians have different priorities instilled in them in the prison setting, and where community clinicians are concerned with diminished trust from patients and potential breaches of confidentiality, prison clinicians are more concerned with the basic safety of everyone within the prison.

A finding that was synonymous with those outside of the secure estate, pertains to views that the duty focuses too much on Muslims as being particularly vulnerable to radicalisation (Summerfield, 2016). Participant 6 explained that he saw the duty as untrustworthy and even Islamophobic (see glossary in Appendix 4). Participant 6 discussed his suspicions of the WRAP training package content and challenged the UK Government's motivation behind the development of the duty.



*"...it was sold as being generically around radicalisation, but, in reality, it appeared very Islamic radicalisation-based. There was some lip service to the potential for nationalist or right wing radicalisation, but it was very obvious that that wasn't really what it was aimed at... I felt that that was inappropriate, and, for me, had a negative impact, in that it tried to portray itself as looking more deeply at radicalisation in general, which I could see the benefit of, and came over more that you had to be particularly aware when you are dealing with Muslim communities. It wasn't even that it was maybe happening, it was that it was likely to be happening in the background. It didn't give you much in the way of a balanced view, I didn't think. I thought it could play to people's prejudices. People that were already suspicious of Muslim communities would go away from that being even more suspicious, which I didn't think was greatly helpful if we are going to sort the problem out in the long term." Participant 6*

The concern that the Prevent duty is too focused on Muslims has also been voiced by representatives from academic, health, and education sectors to name just a few in the Prevent duty consultations held by the government in 2015. Professor Kundnani (2015) goes so far as arguing that this so-called over emphasis on Muslims could lead to feelings of discrimination and potentially lead to grievance fuelled radicalisation.

### 1.3. Room for improvement of staff ability to prevent prison radicalisation

When considering Channel referral activity, only 2 participants out of 12 confirmed that they had made a referral. This reflects the lack of channel referral activity reported in the study conducted by Wright et al. (2017) in which only 3 out of 311 GPs across Yorkshire and the Humber, reported having made a referral. The low CHANNEL referral activity could be as a result of a disconnect in professional identity (healthcare) and prison priorities (security). However, it could simply be a result of staff not having concerns of radicalisation within the prison. In this case, the low referral rate is most likely influenced by the participants' preferred methods of reporting any suspicious activity via the typical prison security incident reporting process. Staff seemed to prefer following existing internal prison reporting systems as opposed to the specific Prevent protocol reporting system.

*"Only security information risk, er... reports. So, I've never done a referral – I always followed prison protocol." Participant 10*

The majority of participants (eight out of twelve) confirmed that they had accessed and completed the Prevent strategy's WRAP training and five self-reported a 'basic' level of knowledge pertaining to radicalisation whilst two stated they had an 'average' level of knowledge and five reported an 'advanced' level. Three out of twelve participants confirmed that they had not completed the training and one participant could not remember whether they had completed or not. This in itself is a point of interest as it suggests that the WRAP training is not always perceived as very impactful by staff.

**Table 4. Training completion rates and self-reported levels of knowledge and confidence**

| <b>Participant number</b> | <b>Completed Prevent WRAP training? (Yes or No)</b> | <b>Self-reported level of knowledge regarding radicalisation</b> | <b>Self-reported level of confidence in making a Prevent referral</b> |
|---------------------------|---|--|---|
| 1                         | Yes   | Missing data   | Confident   |
| 3                         | Yes   | Basic  | Unconfident   |
| 6                         | Yes   | "Above basic"  | Missing data  |
| 7                         | Yes   | "I probably need more"   | Very confident  |
| 9                         | Yes   | Basic  | "Pretty confident"  |
| 10                        | Yes   | "Better than it was"   | Confident   |
| 11                        | yes   | "I've got a good awareness"                                      | Confident   |
| 12                        | Yes   | Average  | "Quite confident"   |
| 2                         | No  | "Not particularly high"  | Missing data  |
| 4                         | No  | Basic  | "Quite confident"   |
| 5                         | No  | "minimal knowledge"  | Missing data  |
| 8                         | Not sure  | Basic  | Missing data  |

Table 4 has been included to give an overview of participants' engagement with the WRAP training. In terms of staff confidence and competence in detecting and reporting potential signs of radicalisation, there were mixed responses. Although over half of participants self-reported being confident at detecting and reporting potential cases of radicalisation, there appeared to be anxiety pertaining to appropriate language use around prisoners convicted of Islamist terrorism-related offences. Some staff expressed a fear of saying the 'wrong' thing and being perceived as 'Islamophobic'. Some participants came across as anxious about what they should and should not say around colleagues and/or prisoners, in terms of an uncertainty about correct terminology use and a fear of incorrect terminology use being

perceived as prejudicial. One participant voiced such concerns and explained that she would like specific training about what is acceptable language when discussing the subject of radicalisation.

*"The concern I had was, is the plan is for next year to maybe an eight-bed wing open in [name of prison] which is going to house extremists – the worst extreme terrorists in the country. And obviously if most of the staff haven't had any training in that and obviously the pharmacy team would be over there, if they do try to convert you or suggest things, how would you react? What to say, what not to say? I'd feel a bit vulnerable...you will probably have to have some training in what not to say. What to say, what not to say." Participant 5*

Another participant felt the need to whisper during the interview when talking about Muslim prisoners and it was not until it was reiterated that the data would be anonymised and kept confidential, that the participant did not feel the need to whisper.

*"Certain groups, certain manner of look, say, prisoners with a certain [Whispers] –Muslim community. They do segregate themselves into different groups, talking together, and then trying to sort of convert anti, a British prisoner and have them in their group." Participant 4*

The anxiety displayed by this particular participant was of interest because it pointed to a real sense of unease from her regarding role legitimacy; that is, the participant seemed very uncomfortable with the incorporation of the duty into her clinical role.

## 2. Good staff understanding of prison radicalisation

### 2.1. Staff perceptions of prison radicalisation risk factors

An exploration of clinicians' understanding of prison radicalisation revealed that participants perceived the issue as a complex one, particularly pertaining to the potential risk factors of, warning signs for and health consequences of prison radicalisation. In particular, participants considered the radicalisation of prisoners who are incarcerated for offences unrelated to terrorism but deemed as potentially vulnerable to being radicalised by terrorist prisoners.

In terms of participants' perceptions of the potential risk factors of prison radicalisation, participants discussed external influences and personal/internal reasons that a prisoner might be more likely to become radicalised. Quite aptly, some risk factors that are included in the government's Prevent WRAP training were discussed. For instance, the experience of

social isolation, a sense of grievance and identity crises were all cited as potential risk factors. These examples are all included in the Prevent WRAP training. Understandably, risk factors that are specific to the secure estate were discussed, such as prisoners' needs for protection, survival, social connections and a desire to reduce boredom; all of which can be met through group affiliation. Interestingly, these are not examples that are used in the Prevent WRAP training, perhaps because it is a more general training package that is not specifically focused on radicalisation in prisons. This is an important finding because it suggests a need for the WRAP training to be refocused for staff working specifically in prisons.

### Transitions

Some of the participants' perceived risk factors of prison radicalisation could be argued as being particularly relevant to new prisoners. For instance, participants discussed prisoners having to adapt to being in prison and their need for protection particularly when they are experiencing a major life transition such as being new to the secure estate. There was a theme amongst participants pertaining to the experience of major life transitions making a person more susceptible to being radicalised. Major life changes are also described as risk factors for radicalisation by the Christmann (2012) who explain that people going through major transitions can be even more at risk of becoming radicalised. In particular, they posit that young people experiencing identity-based changes, the forming of new relationships with influential extremists and being exposed to new experiences, ideologies and world events, are the most vulnerable. In the context of prison radicalisation, such transitions might include individuals having to adapt to the major life event of entering the prison system or a maximum-security establishment for the first time. It was explained that people who are new to the prison are often seen as easy targets for bullying, coercion, grooming and radicalisation,

*"As soon as they come in you can tell who is going to be a vulnerable person as in just open to bullying or open to radicalisation or conditioning. You can tell the ones who have not been in a maximum security environment before." Participant 12*

Having to cope with the victimisation that often comes with being a first time prisoner can be linked to the literature pertaining to trauma and loss of identity explored by Goffman (1961) in his investigation of social identity changes of individuals held in asylums. Pertinent here is Goffman's concept of 'total institution' which relates to the immersive experience of being confined and separated (figuratively *and* literally) from the outside world. In addition to this, the disintegration of boundaries between the usual human

activities of rest, work and recreation. Adapting to these new ways of life therefore, is said to require a 'mortification of the self' in which the affected individual has to adapt his/her identity and sense of self to align with confined life of the institution. Their 'old' identity is switched for a different one which is used to cope with being institutionalised. It would not be naïve to conclude then, that being confined in prison (especially if for the first time) can potentially lead to an identity based crisis for the prisoner. Identity-weak individuals are said to be more prone to radicalisation as they lack self-esteem and direction and subsequently can often become depressed and de-motivated (McGregor, Hayes & Prentice, 2015). Identity-weak personality traits are said to cause a person anxiety and low self-esteem. People who are considered identity-weak tend to blame external factors for internal problems and struggle to navigate healthily, through uncertainty, frustration and adversity. McGregor et al (2015) describe the identity-weak as 'morally bewildered' in that they struggle to prioritise and assert personal values. With their lack of self-direction, they are supposedly prone to being attracted to the opportunity for immediate and concrete participation in aggression and membership in extremist groups as it can give them a sense of meaning, purpose, belonging and identity. Indeed, Al Raffie (2013) found in their study pertaining to the role of identity in the radicalisation process, that experiencing an identity crisis is a contributory factor to becoming vulnerable to radicalisation.

#### Social isolation

The prisoner's need for belonging was explored again with some participants expressing a belief that prisoners who tend to isolate themselves from others are more likely to be vulnerable to being radicalised.

*"Generally, with human behaviours, you are not necessarily dealing with reality, you are dealing with perceptions, and what they perceive. If they perceive that they are isolated, and that their horizons are limited, if they are not going to be able to progress in life, if they have been victims of bullying or racist abuse, or whatever it is, it all builds, for an individual, into a situation where they are vulnerable to being sold a message which gives them a feeling of worth and that they are part of something, and a future, if you like."*

*Participant 6*

*"He changed his behaviour, pulled away from people. He was isolated. He was vulnerable. He had family problems. He withdrew"* participant 11

*"I think anybody who becomes socially isolated is more vulnerable and is a greater risk"*  
*participant 3*

Social isolation is indeed linked with a higher risk of becoming radicalised by some recruiters (Bhui, Everitt and Jones, 2014). Social isolation occurs when an individual is lacking in meaningful connections with others (de Jong Gierveld, van Tilburg & Dykstra, 2016) and increases the likelihood of unpleasant experiences of loneliness. De Jong Gierveld et al. (2016) also state that in order to minimise loneliness and to feel socially embedded, one needs meaningful personal relationship networks in their life. Bhui et al. (2014) found in their quantitative survey of 608 Pakistani and Bangladeshi Muslims that the more social contacts a person has, the less likely they are to become radicalised. Participants were asked 16 questions to gauge the level of sympathy or condemnation they have towards protest related acts ranging from non-violent protesting on one end of the scale, right through to violent terrorist acts such as suicide bombing, on the other end. The study posits that the more sympathy participants have for violent protests and terrorist acts, the more likely they are to have or develop radicalised perspectives. For the men and women surveyed, results suggested that resistance to radicalisation was more likely if an individual had more social contacts. That is, participants who had had the most contact with friends and/or family over the preceding fortnight were less sympathetic towards violent protesting and terrorism. This could be due to less perceived social isolation; having no feelings of rejection or discrimination to fuel grievances that might 'justify' more extreme behaviours against another. A lack of positive and secure influences and relationships is also identified by McCauley and Moskaleiko (2011) as a risk factor for radicalisation, but was not an issue raised by participants in this study.

Prisoners are often ostracised by their loved ones as a result of their criminal activities, therefore they are more likely to crave and seek alternative social networks (Neumann, 2010). Prisoners who are socially isolated are more likely to be targeted for radicalisation as group conformity and cohesion is usually more achievable with group members who are experiencing isolation and loneliness (Moghaddam, 2004).

When exploring participants' perceptions of risk factors for prison radicalisation, a strong theme throughout the data relates to prisoners striving for a sense of belonging. For instance, the tribal like nature of prison was discussed and participants explained that often prisoners will submit to being radicalised for membership in a group and, in the case of Islamist radicalisation, to be part of the 'brotherhood'. Prison can be an extremely lonely experience and this can open prisoners up to being drawn to individuals and groups they might not usually associate with (Silke, 2014). As well as the comfort a sense of belonging can bring to a prisoner, being a part of a group within prison can offer its members

protection from other prisoners (Sinai, 2014). However, as participants discuss, this often comes at a cost (Liebling et al., 2011). Participants appeared to be able to identify these risk factors, and came across as knowledgeable of them as if they had taken a real interest in the subject. Interestingly, this seemed to be the case for the participants who self-reported a basic level of knowledge pertaining to radicalisation.

*"...perhaps it is even more possible in prison because of ... tribal is probably a bit of a strong word but a slight tribal nature of how prisons can be. That belonging to a group can offer protection, it can offer safety and that perhaps radicalisation becomes even more attractive for certain individuals who need that protection." Participant 3*

### Religious conversion

It was clear that among participants there was an understanding of the complexity of practicing a faith in prison whether voluntary or forced; highlighting that even when it is voluntary it is not always clear cut as to why a prisoner has chosen to participate.

*"within [prison site x] it is a lot to do with Muslims and Islamic faith and stuff like that. A lot of the white lads who come in who aren't Muslims originally do convert just to keep themselves safe." Participant 12*

Participant 12 refers to a prisoner's insincere adoption of Islamic faith, in that, conversion is carried out for survival in the often hostile environment of the prison, as opposed to being driven by a genuine belief in and desire to follow Allah's teachings.

*"I'm not saying that all people that convert do it for the wrong reason, the vast majority do it because they believe in the teachings of that religion, but you just have to be aware that one of the steps in radicalisation can be that conversion." Participant 6*

Participant 6 explains that conversion to a religion in prisoners is not always something that needs to cause alarm; 'sincere' conversion in which the prisoner is merely adopting a faith due to a genuine belief in its teachings, does not always lead to radicalised ideology or behaviours. However, they acknowledge that sometimes religious conversion in a prisoner can be a predictor for them becoming radicalised. This is synonymous with a report published in 2017 by think-tank 'The Henry Jackson Society' in which it is concluded: 'Though the process of conversion to Islam is not indicative of radicalisation, when taken together with other aggravating factors such as a criminal record, stigmatisation, paternal

absence, identity conflict, and exposure to the messages of radical preachers, it is an indicator of vulnerability to extremist ideology. Converts are often more malleable and vulnerable to radical rhetoric, often combining enthusiasm to change the world with a vacuum of knowledge about different interpretations of Islam...incarcerated people share a set of grievances and often exhibit other vulnerabilities mentioned in this report, and could be an easy target for Islamist recruitment and indoctrination. Therefore, more attention should be paid to conversions to Islam that take place in the context of prisons and probation services, with a particular focus on juvenile offenders.' (Rushchenko, 2017: p. 1)

Participant 4 discusses cases whereby prisoners convert to a religion simply to exploit the traditions that accompany them, giving them some control over their day-to-day lives in what is largely a restrictive environment for them.

*"...the Feast of Eden and all the little benefits that they do get. One of them, not being (unclear 0:04:38) suspected anything. But they don't have to take their medication at certain times, they can take it back, because they can't have anything to drink or eat or take it at certain times of the day within the prison regime. So they could be, some of them, I'm not saying all of them, could be using that excuse to stockpile medication." Participant 4*

This is reiterated by participant 10,

*"...there's other people what are pulled into that religion because of drawing up debts, because of fear, because of wanting to be protected." Participant 10*

Gang grooming

This discussed sense of belonging links to another theme throughout the data, which pertains to gangs in prisons. Participants explain that radicalisation is just another form of gang grooming and recruitment in prisons, suggesting that radicalisation to political/religious violence is not the issue, but gang culture is,

*"let's face it, it's a bunch of men calling themselves Muslims who are picking on other people and getting them to join their gang...That's basically what it is...Just gang culture in a different form...But then, we've the top end of the iceberg being individuals that want to kill the infidels. Within the prison system you've got, the Muslim is one big gang. And they're drug dealers and they're violent people. And at times, what we see is that we've seen very chaotic prisoners convert to the thing, and then get on really well. Because then they're protected from the worst strife and the stress, and looked after. But that means*



*they have to do things when they can cop up. So when you're part of a gang and they're collecting and people look after you, the biggest gangs of prison officers, that's the gang you should belong to because you'll be looked after." Participant 7*

## 2.2. Staff perceptions of prison radicalisation warning signs

The findings show that the Prevent narrative of prison radicalisation warning signs is generally accepted by respondents as they appear to adopt, quite naturally, the Prevent conceptual framework and language when discussing the issue. The findings also revealed that participants perceived the issue of prison radicalisation as a complex one. In particular, they pointed out that usually warning signs of radicalisation usually occur in conjunction with one another as opposed to exclusively. For instance, participants explained that multiple warning signs usually show and therefore something like religious conversion of a prisoner on its own would not immediately cause alarm to staff. With regards to participants' perceptions of potential warning signs that prison radicalisation is occurring, many examples were shared that are included within the Prevent WRAP training. For instance, changes in the prisoners' behaviours and appearance pertaining to extreme language use, withdrawing from socialising, keeping new and unusual company and religious conversion related appearance changes were cited as potential alarm bells that radicalisation may be occurring. Interestingly, there was a theme pertaining to the appearance of visible injuries as a result of the prisoner being bullied into joining an extremist group within the prison; one example that is not included in the Prevent WRAP training. This could be because this particular warning sign is more relevant to the secure estate in which gang culture, assaults and bullying are common. Most of the discussion pertaining to warning signs of potential radicalisation of prisoners, revolved around noticing a shift in their behaviour, appearance and social connections.

### Behaviour changes

Across the data, the main theme regarding potential early warning signs of radicalisation was linked to staff noticing a change in prisoners' behaviours including changes in the way a prisoner speaks,

*"For the people I see in the clinic, then early warning signs would probably be around language use, so if somebody was using terminology that seemed excessive about other people, or other religions... If there was a lot of use of religious language, or that kind of thing, then you would be thinking about it. That is not to say that everybody who refers everything to, whether it be the will of Allah, or whether it be Christian, or whatever, has*

*been radicalised. Or if you knew somebody and their use of language was changing over a period of time..." Participant 6*

A change in prisoners' behaviours in relation to conversion was discussed in the context of it being a warning sign of potential radicalisation. Specifically, how a prisoner suddenly changes the way they talk about Islam.

*"One day they are saying that they don't want anything to do with Muslims or that faith or whatever. And the next day, they are prettying it up. They say it in a different way or whatever. And then the next day, they have actually converted over. Because they have had a price put on their head." Participant 9*

Other forms of behaviour change were explored by participants when considering warning signs of possible radicalisation in prisons. One participant highlighted that if a usually non-Muslim prisoner starts to order new items from the canteen that perhaps relate to Islamic practices, this would cause concern.

*"Things that they order from the canteen can be quite obvious... Yes, like halal stuff, like different kinds of washing products, things like, say if they order sweets and then they don't order sweets anymore because it's got gelatine in, you know, all this, just little things. So, they might be little white caps in there, they might order religious caps so they go to Friday prayer on the Friday, they might order a rug... Different books that they order from the library, different videos, what they look at." Participant 10*

#### Changes in social connections

Participants also appeared to perceive new and unusual forming of social bonds in the prison as worrying, for instance, if a prisoner starts spending time with unlikely new 'friends' this might act as a warning sign of potential radicalisation.

*"If they begin to refer on to individuals within the environment who are known to be more radical, so, "So-and-so said this," or, "So-and-so said that," that kind of thing, or if they are witnessed to be mixing more with certain individuals or certain groups." Participant 6*

Aligning with other research conducted regarding healthcare staff engagement with Prevent (Wright et al., 2017), clinicians cited a sudden and unexpected change to the company that a patient keeps as a potential early warning sign of radicalisation. Wright et al. (2017) found that when General Practitioners were asked about what they considered to be possible early warning signs of radicalisation in a patient, 57 out of 311 discussed concerns sparked by any unusual interest shown in their patient by an unexpected individual. For instance, if a patient started speaking of a new, unlikely 'friend' that they had started spending time with and someone that might not generally show an interest in them, this might cause alarm.

To summarise, participants came across as confident and knowledgeable when discussing prison radicalisation warning signs and there was a real sense that they had taken on the role ascribed to them from the Prevent duty.

### 2.3. Staff perceptions of effects of radicalisation on prisoners

When discussing participants' perceptions of the potential effects of radicalisation on prisoners, some of the conversation was made up of an interwoven mix of effects of radicalisation and effects of religious conversion. It was difficult at times to unpick exactly which effects participants were assigning to each process. There appeared to be some confusion and conflation among participants when discussing their views of how radicalisation can affect prisoners. For instance, when participant 10 is asked about her views regarding health consequences of radicalisation on a prisoner, she discussed effects that could be associated solely with religious conversion,

*"when it's things like Ramadan and things like that and some people ... depending on what medication they're on, it might be life threatening medication, so if they don't take it, that they choose to fast within the hours" participant 10*

Also, when participant 12 is asked about the health consequences of radicalisation, she responds in a way that pertains to forced religious conversion as opposed to the more specific process of radicalisation,

*"We have had lads who have tried to commit suicide because someone has tried to make them become a Muslim and they really don't want to." Participant 12*

There was a similar issue with unpicking the potential benefits for prisoners going through the processes of religious conversion and/or radicalisation. For instance, participants discussed protection that a prisoner can get from co-members of an extremist group in prison but they also talked about the protection that can be gained from having 'brothers' from a Muslim group whilst incarcerated,

*"...health benefits, physical health benefits, especially if they're being protected and they are not going to be a subject to assault..." Participant 1*

Interestingly, the same participant discussed such benefits but focused more on such effects as a result of Islamist radicalisation as opposed to Islamic conversion, citing the prisoners' cessation of risky behaviours as a possible beneficial effect of having been radicalised. Less risky behaviours might include the cessation of substance misuse or not participating in risky sexual behaviours whilst imprisoned, due to Islam's condemnation of such behaviours.

*"...their physical health should improve because... they should reduce their expose to viruses, either through, you know, sexual practice or tattoos... I would suggest that someone who has been truly radicalised and adapts the full path would want to be off all drugs. So health benefits, physical health benefits, especially if they're being protected and they are not going to be a subject to assault, they will improve" Participant 1*

The same participant also suggested that for a prisoner who has joined a Muslim gang purely for protection purposes, they will endure less anxiety because they will not have to fear other prisoners anymore. He did, however, go on to explain that new anxieties would eventually surface due to new pressures put upon new members of the gang. This relates back to protection being used as a form of currency by prison gangs, meaning that the prisoner who is being protected has to repay in the way of 'favours' that can often involve risk taking. Participant 1 explained that recruiters can have a hidden agenda; for instance, they will often seek to radicalise vulnerable inmates in order to make them indebted to them so as to increase power and control over their peers.

*"...if you've had to do something you didn't want to do, you can end up with more anxiety because you're pressured to do something you didn't want to do... there's usually some help when they're originally brought into the fold in so far as they get support, you know with problems with other inmates and then usually they've got to do a favour, and their favour is usually either attacking another prisoner or attacking a guard... The way it happens in the prison, you've got to remember, a lot of it is gang culture, it's not really faith based, it's just*

*an excuse, so the vehicle, it's the vehicle that they use to get what they...to bring their own agenda, is faith, and they're using Islam" Participant 1*

The effects of radicalisation and/or religious conversion on prisoners, was further broken down into 'forced' and 'voluntary' experiences of the two processes. For instance, participant 10 explained that where radicalisation is forced, the effects on the target can be detrimental. In particular, the anxiety and stress of having been bullied into having extremist views and expressing extremist ideologies and behaviours. Participants suggested that sometimes prisoners will be forced into becoming radicalised through threats to their safety. This fear was also said to feed into further anxiety and stress,

"If it's a forced radicalisation then you'll notice mental health. Things like depression, not wanting to come out of their cell, not wanting to interact... withdrawn from things. So, I do honestly believe that it can impact on people's mental health if it's not a genuine case."

Participant 10

Where religious conversion is voluntary, participant 10 perceived more positive effects on the prisoner,

*"they want to find something, they'll want to put to bed what they've done, they want to get some understanding for them, show a bit of remorse for whatever it is they've done. And follow that channel and become a different person and become a genuinely different person" Participant 10*

It is interesting that some participants made a link between prison radicalisation and potential health benefits. If clinicians perceive that a prisoner's health is benefitting from radicalisation, then they might experience a dilemma; whether to report the prisoner and remove the benefit or to avoid reporting concerns and breach the Prevent duty protocol. Adhering to a religion has been shown to cause cognitive, behavioural and emotional reactions; where the practice of fundamentalist religion can damage one's mental health i.e. effects of "separateness" from secular culture (Speckhard, 2012), the healthy practice of religion can benefit one's mental wellbeing and strengthen a person's ability to thrive, through its provision of order, a sense of meaning and comfort (Green & Elliott, 2010). For instance, having spiritual beliefs and following a religion has been found to have positive effects on human beings, both physically and psychologically (Panzini & Bandeira, 2007; Deuchar, Morck, Matemba, Mclean & Riaz, 2016). There is evidence that there are

benefits to adopting a faith whilst incarcerated in terms of structure, looking forwards, repenting for past mistakes and rehabilitation (Deuchar et al., 2016).

Participant 10 echoes conclusions made by Deuchar et al. (2016) in their exploration of the role of religion in prisoners' lives. They conducted face-to-face semi-structured interviews with 15 Scottish and Danish male inmates and found that for the prisoners they interviewed, the incorporation of religion and faith in prison had a very positive impact on their overall experience of being incarcerated. It appeared that prisoners who found religion and faith whilst incarcerated benefitted from an alleviation of guilt and were able to positively address the deep-rooted issues that had led them to committing crime in the first place. Religion appeared to help prisoners choose a new, healthier way of living and motivated them to look forwards in a more positive way. Thus, they opted for beneficial life choices whilst incarcerated, and subsequently avoided becoming radicalised; they used religion for good and did not choose to practice the faith in destructive ways. This is an important empirical evidence that acknowledges the other side of the argument that religion is linked to prison radicalisation and challenges the assumption that converting to a religion or faith whilst incarcerated is a risky and dangerous process.

Other effects of radicalisation that were discussed pertain to the risk of physical injury to prisoners who try to resist being groomed into particular groups, reflecting Hamm's (2009) findings that often for prisoners who refuse to convert to Islam they are violently attacked and slashed with razors or scalded with boiling water.

*"...he was a non-radicalised Muslim who was attacked by radicalised Muslims for not agreeing to radicalise, I suppose and they attacked him as a consequence of it..." Participant 3*

To summarise, participants' views of the potential health consequences of radicalisation on general population prisoners reflect the complexity of the problem. Understandably, because of the interview schedule's focus on Islamist extremism in prisons, most participants discussed conversion to Islam and joining an Islamist extremist group as going hand in hand. Most participants did, however, acknowledge that they were doing this and went on to explain that religious conversion does not always lead to joining an Islamist extremist group.

### 3. Caring for convicted terrorists is complex

### 3.1. Caring for 'typical' versus terrorist prisoners

Participants discussed their perceptions of the make-up of terrorist prisoners, experiences of their own interactions with such prisoners and reflected on any role conflicts in which their clinical role has been affected by the government's counter-terrorism policy. There was a theme regarding the importance of building trust between prisoners and staff, improving prisoners' perceptions of healthcare, and creating positive relationships between prisoners and staff through treating them fairly and giving them equal access to high quality healthcare that considers a wide array of prisoner needs. All participants stated that they try to treat all prisoners the same, regardless of their index offence. Participants were in agreement that the most efficient way to deal with prisoners is to remain professional and maintain healthy and safe boundaries.

*"your duty, by your profession is to be professional with them and what you should do is not make judgements that will then influence you one way or another, other than just doing what they need...all you've got to do is be professional. Prisoners will say thank you for looking after me and you've been very fair to me, you've not made a judgement on what I might do in the future, you've just done what your obligations are" Participant 1*

Participants were in agreement that terrorist prisoners must be provided with equal and fair access to healthcare services.

*"Every prisoner, I don't care who, gets treated with dignity, respect, they've got healthcare on tap." Participant 10*

*"... you come and work in this environment and you've got your paedophiles, your murderers, your rapists, whatever they are. Then you've got people who have then got a religion attached to them. It doesn't make any difference to me whether you're Christian, Rastafarian, Jewish, whatever you are, Sheikh, whatever, I'll still treat you as I'll treat anybody because at the end of the day, if I didn't treat all patients equally then I shouldn't be working here because there's a lot of things, a lot of people's crimes in here that you have a really hard time trying to get to grips with. I just don't think about what they've done. I just see them as a person, treat them as a patient, go by the code of NNC, do everything that you're supposed to do, give them the best of the care." Participant 11*

Understandably, there was a great deal of uncertainty pertaining to how best to deal with terrorist prisoners with questions being raised about whether all prisoners could be treated equally regardless of index offence or whether terrorist prisoners should be approached with

more caution and suspicion. There was uncertainty around whether it would be better to know the index offence of each prisoner or not. For example, when one participant was asked whether it would affect the way she treated a patient were she to know what he was incarcerated for, she responded,

*"It doesn't me. Most of our regular ones, we know what their crime is. When they come in, we see on the charge sheet what they're in for and then obviously we'll want to find out a bit more because you're only human or if they've been in the press you want to know..."*  
Participant 11.

At first, the participant presented a relaxed attitude towards knowing the serious crimes behind the prisoners' incarceration and seemed quite decisive about the matter. She then went on to explain that knowing the index offence of a patient has indeed affected the way she interacted with him. She then finally came to the conclusion that it is perhaps better not to know what the index offence of the patient is,

*"I was treating this guy as an inpatient, he was a young lad and I thought to myself, "I wonder what he's in for," because he was quite quiet, I always had a laugh and a joke with him and a little bit of banter... Then I just said one day to one of the officers, I went, "What's he in for anyway?" and then they said, "He killed his girlfriend's baby." I went, "He did what?" I went, "No. Really?" and they went, "Oh yes, he was out of his face on drugs." I went, "Oh hell." ... Then the next time I spoke to him, I had a really hard time getting that out of my head. I thought, "I can't believe that he would be capable of something like that," ... then I just thought, "Do you know what? It's just not even worth thinking about, so I didn't change the way that I was with him. I still addressed him the same as I always did. I still had a banter with him but it just left me thinking... just because you see somebody, how they are every day with you, they've always got that hidden depth behind them, they've always got that story, they've always got that unknown side of them. There's always something that makes you look at them differently..."* Participant 11.

In terms of 'the terrorist prisoner', participants appeared to perceive them as more dangerous than other prisoners from the general prisoner population and caring for them means putting themselves at risk. For instance, one participant explained that they pose a very real hostage taking risk,

*"if you're ever taken hostage by someone who has been involved in terrorism or is radicalised or involved in that, basically, to get out straight away, because they don't want*



*anything, they're doing that to kind of basically be a martyr or to show, to basically be a hero for doing it, so actually they're not doing it for any particular reason, so I've always been a lot more weary around those sorts of characters" Participant 2*

Differences in how convicted terrorists interact with prison staff compared with how other, 'typical' prisoners interact, were discussed. Terrorist prisoners were described by some as being 'less human' and more 'stand offish', with little display of their personality traits. It was explained that there is usually no 'chit chat' with such prisoners as they withdraw themselves from prison staff.

*"Most of the prisoners you can banter with, have a laugh with, have a chatter and that, the vast majority or the radicalised go down, get their meds and go back, that's the limit of the conversation, until you know them and then you don't even ask their name and number, when you first meet them you go name and number and they'll say the bare minimum and take it off you and go, whereas the next lad will come up and you'll go name and he'll say oh I don't remember! And it's just little comments and things like that, whereas its almost kind of very stone faced, everything is almost a job for them so it is like, I'm here for my meds, I'll take them and I'll go. There's no small talk. It's almost the humanness has gone from them and you're not getting that human side." Participant 2*

The research attempted to explore any conflicts or tension between healthcare and criminal justice priorities. Indeed, frustration with counter-terror prison protocols delaying care to terrorist prisoners was discussed.

*"I was put in a situation last year where there was a hi-risk terrorist that needed outside hospital. But because he was high risk, because he was Cat A, we had to book arrangements with the hospital before. So, he needed to go out - he'd got a dislocation... a quite severe dislocation. So, we got an ambulance on site and he was dealt with. So, he was dealt with by us and then he was dealt with by the ambulance. But it took around about five and half hours to get him to hospital because of the protocol behind it - the prison protocol behind it. So, that's a frustration." Participant 10*

Such frustrations of balancing priorities for providing prisoners with a good standard of care and the security priorities of the penal system have been documented by prison healthcare staff (Taylor, 2017).

### 3.2. Role-specific experiences

Participants revealed that their different clinical roles led to them having different levels of exposure to and interactions with terrorist prisoners (please see table 5 below, for a summary of this information). The different roles also appeared to have contrasting implications on how participants interacted with terrorist prisoners in terms of their nature and frequency.

**Table 5. Summary of role-specific findings**

| Clinical role                      | Finding   |
|------------------------------------|---|
| Nurse                              | <p>Significant exposure to and interactions with terrorist prisoners and prisoners that are potentially at risk of radicalisation.</p> <p>Nurses tend to focus mostly on physical health care so not much scope for meaningful interactions where potential radicalisation is happening.</p>                        |
| GP                                 | <p>GPs have less exposure to terrorist prisoners and prisoners potentially at risk of radicalisation but more meaningful interactions and therefore there is the possibility of detecting cases of radicalisation.</p> <p>GPs seen required to set an example/be a good role model to all other clinical staff.</p> |
| Pharmacist and Pharmacy Technician | <p>As a pharmacy employee, having control over prisoners’ medications can either help or hinder interactions with terrorist prisoners and those at risk of radicalisation. Where prisoners do not get what they want they can subject the pharmacy team to abuse.</p>   |

|   |   |
|---|---|
|   | <p>Fleeting and superficial interactions so not much scope for detecting potential cases of radicalisation but pharmacists are exposed to prisoners every single day so contact is much more frequent than with other clinicians.</p>   |
| <p>Substance misuse recovery worker</p> | <p>Substance misuse employees have less exposure to terrorist prisoners as most Islamist extremists do not consume drugs or alcohol due to their religious traditions.</p>  |
| <p>Mental health worker</p>             | <p>Less frequent exposure to terrorist prisoners as mental health is said to be a taboo to Muslims and therefore Islamist extremists are reluctant to access mental health services.</p> <p>In the rare cases that terrorist prisoners access the mental health team, there is a great deal of scope to detect whether they are trying to radicalise others as they deal with prisoners in an in-depth and holistic way and their service requires them to open up and talk.</p> <p>In cases whereby the mental health team sees prisoners who are being bullied into becoming part of an extremist prison group/gang, they have the scope to discuss this with them in an in-depth manner and possibly more likely to detect potential radicalisation.</p> |

Pharmacy Technicians reported having daily, regimented interactions with prisoners in order to dispense medications via the 'hatch'. However, these interactions were very brief and therefore superficial with little opportunity for many meaningful communications between the staff and the prisoners. When asked whether she had had any experiences of dealing with radicalisation in prison, one Pharmacist claimed,

*"No, because we're not exposed to that. We only go for a certain time of the day, all of the pharmacy technicians, and you don't really see that happen because you're not on that wing all day."* Participant 4.

Pharmacy staff explained that on a daily basis they have to face abuse from prisoners if their medications are not available and this was apparently no different for the few convicted terrorists that were on controlled medicines.

*"with the pharmacy side of things, if you don't have medication with them and stuff like that then you're going to have a negative...we get quite a nice side of the prisoners compared with a lot of the prison staff because actually we're giving them drugs, which is what they want, actually they quite like us, they're like oh there's the drug guy! But the second that you say I haven't got it or; no you can't have that anymore, that's when something switches and they change their attitude towards you... I wouldn't say it is any different the extremist versus any other prisoner, I think they're all pretty alright if you've got their meds, pretty angry if you haven't basically, doesn't matter what they've done, they're all pretty much the same, you get the odd couple that are more aggressive and you get the odd couple who just say it's fine. "* Participant 2

Substance misuse recovery workers advised they have less exposure to and interactions with prisoners incarcerated for Islamist-inspired terrorism as most Muslims do not consume intoxicating substances due to their religious practices.

*"We do groups throughout the year – dozens and dozens of sessions. But there aren't that many extremists that are on those groups, because a lot of them haven't got substance misuse or alcohol problems"* Participant 9

A mental health nurse explained that mental health workers have less exposure to prisoners convicted of Islamist-inspired terrorism as talking about mental health is generally a taboo for Muslims. The participant explained that it is difficult for mental health workers to engage

with Muslim prisoners due to their apparent reluctance to discuss mental health issues; a taboo within their faith,

*"We did have a group of detainees who were suspected of being involved in radicalisation and it was like a prison within a prison. It was like a unit on its own. But I was involved with the mental health - predominately, they were Muslims. Mental health is a taboo in the Muslim fraternity. They don't openly admit to having mental health issues. So very few of our caseloads are Muslim prisoners." Participant 8*

However, it seems that when they *do* work with prisoners convicted of Islamist-inspired terrorism, mental health workers are faced with an opportunity, unlike other types of prison clinicians, to delve deeper into any mental health problems. Such mental health problems might make them more vulnerable to becoming targeted for radicalisation. For example, according to (Bhui, 2013), people who have developed abnormal personality disorders in formative years are more likely to be involved in violent radicalisation.

Other characteristics of staff appeared to affect their interactions with particular prisoners. For instance, it was explained that providing care can be challenging as a woman due to Islamic religious traditions practiced by some prisoners. Some participants mentioned the different interactions they had, based on their gender,

*"The Muslim lads, they're very, very disrespectful to the lasses in pharmacy because they see women as inferior" Participant 2*

Another participant talked about her experiences of trying to provide healthcare to particular patients – in this case, Muslim male prisoners – and having her gender act as a barrier to being able to do her job in the way she thinks is appropriate,

*"You do get a lot of that thrown back at you as well. As a white, British female in a male-dominated, high-secure establishment you do get a lot of legal threats. So, you can be doing your job, and it would be "You're not doing that because I'm a Muslim. If I were [s.I out 00:19:37] I'd be able to have that. I'm going to my solicitor."" Participant 10*

#### 4. Operationalising Prevent in prisons is feasible

##### 4.1. Staff well-being and the importance of teamwork

There was a strong theme throughout participant responses pertaining to the importance of staff looking out for one another to ensure each-others' safety. Understandably, due to the hostile nature of the high security prison environment, staff bonds were regarded highly. There was an emphasis placed on the importance of multi-disciplinary working and the employment of proper information/intelligence sharing. Internal and external team work was also cited as crucial to minimise the risk of prison radicalisation.

Across the data, there was a great deal of discussion about the value of communication with colleagues and staff from other sectors within the prison establishment so as to promote multidisciplinary and joined up working. It was evident that great value is placed on interacting with other staff when any concerns of radicalisation arise,

*"I think everything has to be discussed and you don't make decisions on your own, so collective decisions, multidisciplinary meetings you can involve anyone that you want, if there is a genuine safeguarding issue you ring one of the safeguarding officers don't you. If there was a counter terrorism problem that you think was going on you would involve them and consent is done sensitively." Participant 1*

This is not atypical for a prison work setting where sharing information and intelligence is recommended for the safety and protection of all staff and prisoners (National Offender Management Service, 2012). Within prisons, anyone who has a concern about any suspicious activity can report it to the Security department through a Security Incident Report.

The overall message sent out by participants painted a picture of staff having strong bonds due to this particular work setting. There was a strong theme across the data pertaining to the importance of staff safety and wellbeing. In particular, there was a sense of staff solidarity with participants discussing the need to protect colleagues by preventing them from harm and offering help in any difficult situations. Perhaps due to the dangerous working environment, participants appeared to show a genuine passion for looking after one another and a higher acceptance of incorporating the Prevent duty into their roles.

*"We are very aware of each other's backs if you like. We can obviously watch each other as well. That's what we often do. These people aren't in here for robbing a sweet shop so*

*obviously we are very aware of our own security and safety. Also, if we feel ourselves that somebody is not quite right with us for whatever reason then we will either take another member of staff in or we will ask someone else to see them because you do get the ones that form attachments to you." Participant 12*

*"You just deal with, you just have to – as long as you are safe and know who you are working with is safe, you just have to deal with it." Participant 10*

The way in which participants presented their beliefs that prison staff should work together and look out for one another was of particular interest as personal past observations of conflict between staff when working in prisons tend to refute this. As a researcher with experience of working within various lower level security prisons, the experience of witnessing staff resentment towards managers as they felt unsafe and overworked due to staff shortages within the prisons, does not reinforce the strong sense of teamwork that participants displayed. However, participants' strong sense of solidarity could be something to do with their working in HMP Westside and HMP Eastside as they are category A prisons, housing the most dangerous criminals in the country.

From March 2010 to June 2017, the number of prison officers has been cut from 45,079 to 31,493 (Ministry of Justice, 2017). In July 2017, the Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPS) published a 'safety in custody' report in which they presented statistics pertaining to the prevalence of physical assaults on staff by prisoners, from March 2008 to March 2017. Worryingly, the number of assaults increased between March 2014 and March 2017 from 3372 assaults (of which 373 were classified as 'serious') to 7159 assaults (of which 805 were regarded as 'serious'), respectively. This increase in prisoner on staff assaults symbolises a new record high of staff coming to harm at the hands of prisoners. Serious assaults consist of the victim suffering from one or more of the following: 'a sexual assault, requires detention in outside hospital as an in-patient; requires medical treatment for concussion or internal injuries; or incurs any of the following injuries: a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing, bites, temporary or permanent blindness' (MoJ & HMPS, 2017: p6.). The evidenced danger of working in a prison could be the reason for participants' high acceptance of Prevent use in prison healthcare and the value they place on it as a safeguarding measure.

#### 4.2. Staff ideas for improving Prevent WRAP training in prisons

Participants discussed their thoughts of the Prevent strategy's implementation within the prison establishment in terms of their own experiences of putting it into practice. They also shared their views of the counter-extremism strategy and made suggestions for how it might be improved. Most participants advised they would prefer interactive, face-to-face training in this area as opposed to computer or literature based learning.

*"It was clear enough but you need scenarios and you need to talk with people who have dealt with these things before so they know what they are talking about. When you are reading a leaflet you just think, "Does that really happen? Are you sure?""* Participant 12

*"...also maybe having some sort of interactive scenarios they could deal with...I like that. I'm a volunteer. That's how we do our sessions – we get interaction, we get people up and that, we do role-plays for things"* Participant 9

Participant 12 discussed the benefits of the WRAP training being delivered by Imams; WRAP trainees in the NHS are typically safeguarding leads as opposed to religious leaders. Participant 12 raises questions about who might be best to deliver WRAP training rather than simply focusing on the content and delivery mode of the training.

*"They need to definitely do more of a Prevent training in line with what NOMS used to do where we all have much more insight...we had the Imams there to give us scenarios and we had to sort them out...It was really useful because they actually gave us the side of what radicalisation is in the Muslim community and what happens and things like that. It was good the way the Imam did it."* Participant 12

There was a theme that the WRAP training content should be updated so that it is relevant to each particular prison and community by making the training package more localised, contextualised and applicable to their own work settings. It was suggested that training content be geared towards current and local issues so that staff could relate more easily to the agenda, echoing some of the government consultation responses obtained in 2015 (HM Government, 2015). It was agreed that this would be more useful than general content which might not be appropriate to them and perhaps more staff would then engage with the strategy more actively. Therefore, it appears current training the way it is, is too generic in the participants' eyes.



*"It is good though because when it tells you the local stuff it really sticks...Just make sure it is bespoke to the place that you're doing it...it's worthwhile to talk about your own community... you would want a proper brief about your gangs and the volume of what is going on. But security keep a lot of that quiet don't they and actually they should discuss what they think. How are you expected to know what to help if you don't know the problem?" Participant 1*

Surprisingly, clinicians called for more frequent training in detecting cases of radicalisation suggesting that they feel they do not receive enough training in the area.

*"I think it should be a least once a year. It should be half a day, face to face, once a year to keep yourself updated." Participant 12*

*"Well, obviously you need a refresher course. I think what they could do with is having a refresher course every year." Participant 9*

Another interesting finding pertains to the GP perceptions of the WRAP training content. The GP participants expressed views that the material was too simplistic for the professionals it was aimed at,

*"...it was pitched at too low a level... it almost felt as if it would be something you would play to anybody, anywhere, just as an awareness raising tool... it was just like a public service thing, I mean it was a bit more detailed and lengthy than that, but it was that same kind of just pitch it at anyone, just general information thing, I felt that particularly for prison work, but for healthcare workers in general who do have a privileged position in seeing people sort of one to one and getting insights into things that you wouldn't get ordinarily, then I just think it was a bit of a lower level, maybe. I think whether there are any practical sort of hints and tips, I don't know but that's what it felt like it was lacking, I think you listen to it, you came away feeling a little bit more reassured that you weren't missing any really obvious sort of warning signs or whatever it might be but I don't think you came away equally with any toolkit... of thinking this is what I can do, this is what I must be really aware of, this is what I could potentially ask, you didn't really come away with anything practical..." Participant 3*

#### 4.3. Staff suggestions for treating those at risk of radicalisation

When asked about how prison staff could reduce the risk of prisoners becoming radicalised, some participants explained that it is important to be flexible and accommodate prisoners' religiosity with healthcare provision that makes allowances for associated traditions and practices. One participant discussed how, in providing prisoners with the same access to healthcare in prison, staff can potentially start to suspend the negative 'us and them' rhetoric that can influence extremist thinking and action,

*"I can't say that every healthcare professional or every officer is as facilitative as they could be, but my perception is that there has been definite improvement in flexing the system to people's belief systems and religious needs... But particularly for people who are vulnerable to radicalisation, those behavioural approaches just help a little bit to be a counterweight to this, "Every westerner is a potential enemy"... inclusivity and consistency, so that you can actually evidence that people are getting the same response, whether they come from Syria or Sunderland." Participant 6*

This echoes some of the existing evidence base on risk factors for radicalisation relating to grievances fuelled by perceived and actual discrimination. Grievances can fuel an ideology that acts as justification for committing terrorist acts (Speckhard, 2012). Examples of grievance-fuelled terrorism include post-attack vengeance combined with a distrust of the media, police and authorities (Speckhard, 2012). The latter example of distrust in particular members of the criminal justice system is relevant here, when discussing risk factors for prison radicalisation. More specifically, in the context of prison radicalisation, as Silke (2014) points out, poor treatment of terrorist prisoners can serve to reinforce their extremist views in time for their release. Silke (2014) highlights the case of the previous Al Qaeda leader, Ayman al-Zawahiri, who was tortured in an Egyptian prison and went on to become even more committed to his extremist views and more dangerous upon release from prison.

Participants' views regarding how to interact with prisoners who use extremist language, were explored. There were discussions about whether staff should close down an interaction with a prisoner if he begins to use extremist language and express extremist views with some participants explaining that such expressions of extremism should warrant closing the interaction down immediately and then going on to report the incident.

*"I think if you start asking specific questions, then you just run the risk of and probably more than likely alienate people and just offend people effectively because you are just making assumptions based on factors that are probably in truth completely irrelevant."*

*Participant 3*

Some participants explained that the best way to deal with prisoners expressing extremist views would be to challenge them,

*"We'd challenge them. We'd challenge them in different ways. "Do you want to explain a bit more about that? Why do you think it is right?" Yes, you probe. You do lots of probing questions, and challenge their ways of thinking, really. And explore – you'd explore their ways of thinking, wouldn't you?"* Participant 9

Other participants explained that it would be useful to gather more intelligence by continuing the conversation,

*"If he's telling me this then I need to know ... what his belief system is. Because then you're in a process of information gathering, not the information challenge. So if he says, you know, "I think that it was a good idea that Lee Rigby died, and that he should have been killed," I might say, "Oh, that's an interesting perspective that you're sharing with me. Where's that come from?" It would be open-ended questions with regard to what they thought about it, what... And then they'd start sharing information. Then I'd be clocking it all and then feeding it back. That's what my job is."* Participant 7

To summarise, the main themes were: a high engagement with and acceptance of Prevent Duty use in prisons; a good staff understanding of prison radicalisation; perceptions that caring for convicted terrorists is complex and a view that operationalising Prevent in prisons is feasible. The findings demonstrate a predominantly positive attitude towards the Prevent Duty with it being regarded as a 'safeguarding' responsibility. Prevent Duty training was largely well received by staff and enthusiasm was shown in regards to improving the package and increasing the frequency of its delivery. Staff did present unique challenges that they are faced with when contributing towards the prevention of prison radicalisation, because of the prison environment, therefore suggesting that perhaps bespoke training should be offered to prison clinicians rather than the 'one size fits all' training that is currently offered to all healthcare staff.

## **4.0. Study limitations**

### **4.1. Study strengths**

There were no other studies found investigating UK category A prison clinicians' perceptions of and experiences with the incorporation of the Prevent strand of the UK Government's counter-terror strategy, Contest, into their professional roles. There have been no other studies, qualitative or quantitative, that ask such clinicians exactly what, if anything, they think should be incorporated into their capacity, caring for prisoners convicted of Islamist inspired terrorism, to help with the UK Government's counter-terror efforts. This study therefore begins to bridge this gap in research on this important topic.

### **4.2. Study weaknesses**

Sampling issues meant that only particular clinicians could be interviewed. As Healthcare Assistants were too busy to be interviewed, potential insights from them could not be explored. This was a shame as it was originally hoped that due to their predicted higher exposure to and interactions with prisoners face-to-face (healthcare assistants tend to do provide patients with the most frequent face-to-face care), they would be able to provide rich data pertaining to their experiences caring for convicted terrorists. Nevertheless, the clinicians that *were* interviewed, regardless of their less frequent contact with terrorist prisoners, provided very helpful insights into caring for this kind of prisoner and the use of the Prevent duty within the high security prison setting.

The controversial and sensitive nature of the subject of radicalisation could inflate the risk of social desirability bias; a type of participant response bias that sees respondents answering questions according to what they think is favourable to others (Coolican, 2013). In the case of respondents answering questions regarding possible risk factors for and warning signs of radicalisation, laced with political sensitivities, it can be an uncomfortable conversation to have. For instance, some participants actually confirmed that they were worried about what they should and should not say according to what is politically correct. There was a fear of coming across as racist or Islamophobic, for instance. As participants largely were unsure of exactly what was acceptable to say, they may have given answers that were not completely honest.

The interview schedule struggled when the participant had not had any training whatsoever (neither from the prison or the healthcare organisation) on radicalisation and counter-

terrorism. Asking people to envisage what they might do hypothetically if they were to find themselves in a situation relating to radicalisation did not seem to work too well with people who had not thought about the topic before, up until the interview.

## **5.0. Study Implications**

### **5.1. Future policy and practice**

Although this research study is small scale its findings and is therefore difficult to generalise, it does raise some tentative implications for future policy regarding training of the existing and future prison medic workforce. The mode of delivery of the UK Government's WRAP training to prison clinicians, merits consideration. For example, the delivery style of WRAP training may need tailoring to suit the diverse range of prison healthcare professionals. Where one member of staff might benefit more from online training, another might learn better from interactive, face-to-face training. Some staff may respond better to a mixture of the two media. The content of WRAP training is crucial and considerations should be made as to whether prison clinicians would benefit more from a more widespread, national knowledge base of the issue or a more contextualised, local-specific community issues.

These findings raise questions about whether different clinicians should be given different responsibilities for preventing radicalisation. For instance, GPs are meant to be pillars of the community and a role model for others. Pharmacists are simply there to dispense medications to patients. Recovery workers get involved in all areas of the prisoners' lives from their housing and employment opportunities upon release right through to their relationships. Their view of and work with prisoners is a holistic one.

These findings also raise the question of what makes up 'acceptable' language in such situations. Staff appear to be frightened of being viewed as racist or Islamophobic and this could stand in the way of them doing their jobs to the best of their abilities.

### **5.2. Future research**

It would be interesting to conduct a comparison study pertaining to prison versus community clinicians' attitude towards the Prevent duty and its role in the healthcare sector

to investigate whether one is more accepting than the other and if so, the possible reasons behind such a finding. If one sector is more willing to engage with the government's counter-terrorism policy it could be helpful to look into why this might be and whether the 'less engaged' staff could be encouraged to engage more with counter-terrorism efforts. It would be interesting to explore the notable anxiety among some staff about acceptable language use around convicted terrorists and prisoners who express extremist views. This could be a helpful enquiry into whether it acts as a potential barrier to successful incorporation of the Prevent duty into day-to-day professional responsibilities.

## **6.0. Conclusions**

### **6.1. Conclusion**

Prison healthcare staff consulted in this study appear to be much more accepting of the government's counter-terrorism Prevent duty than expected. The apparent stigma surrounding the Prevent duty was not reinforced by these research findings. There was a high level of staff engagement with the Prevent duty with the majority of participants having completed the associated training and having a positive attitude towards the government's counter-terrorism objectives. Almost all participants were passionate about preventing radicalisation in prisons and the fair treatment of convicted terrorists. Additionally, they expressed a strong belief that preventing radicalisation is every prison employee's responsibility.

### **6.2. Recommendations**

As the findings show, prison healthcare staff are faced with a unique set of challenges to when detecting potential cases of radicalisation in their patients. Moreover, high security prison clinicians are much more likely to come into contact with and care for terrorists. The counter-terrorism training they receive is however, no different to the training that community clinicians receive. These research findings suggest that this is counter-intuitive given that prisoners are a particularly vulnerable group of patients and the prison culture can be conducive to radicalisers' recruitment efforts. As such, the development of future training should consider a more bespoke package for healthcare employees that work in prisons.

## Appendices

### Appendix 1

Letter of invitation to participate in research



Frances Hankins  
One Navigation Walk  
Hebble Wharf  
Wakefield  
WF1 5RH

06 September 2016

**Ref:** Letter of invitation to participate in research

Dear XXX

I am a Research Assistant for Spectrum Community Health CIC and also a part time postgraduate student completing an MSc in Criminology at the University of Huddersfield. I intend to conduct some research into prison healthcare staff perceptions of the current protocols, procedures, policies and training that they are required to adhere to and complete when caring for prisoners convicted of Islamist violent extremist offences. The study is called; ***Prison-based clinicians and radicalisation: How can clinicians effectively engage with prisoners convicted of religiously motivated violent extremist offences for the benefit of the prisoners' health and that of the wider public?***

I aim to interview a small number of Spectrum health care staff from both HMP Eastside and HMP Westside. The interviews will take no longer than one hour and will be conducted just outside the establishments but still within the grounds i.e. within a family visitor's or learning centre, and will follow a semi-structured format.

The research project provides a safe setting for Spectrum prison health care staff to

share their experience in providing health care for incarcerated patients whose index offence relates to Islamist violent extremism. I am particularly interested in your thoughts on and engagement with the Government's Counter Terrorism strategies in working with these offenders.

Further details about the project are given in the attached participant information sheet. Your views will be invaluable in gaining the much needed insights of healthcare professionals in this highly topical policy area .

I do hope that you will take up the opportunity to participate in this research.

Thanking you in anticipation of your cooperation

Yours sincerely

Fran Hankins  
Miss Frances Hankins  
Research Assistant



## **Appendix 2**

Participant information sheet: Version 3 Dated 18/08/2016



Prison-based clinicians and radicalisation:

How can clinicians effectively engage with prisoners convicted of religiously motivated violent extremist offences for the benefit of the prisoners' health and that of the wider public?

### INFORMATION SHEET FOR INDIVIDUAL INTERVIEWS

You are being invited to take part in a study which is looking at prison healthcare staff perceptions of the current protocols, procedures, policies and training that they are required to adhere to and complete when caring for prisoners convicted of Islamist violent extremist offences.

Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if there is anything that is not clear or if you would like more information.

What is the study about?

The purpose of this study is to explore;

prison clinicians' current engagement with and acceptance of counter-radicalisation protocols, procedures and training when caring for prisoners convicted of offences relating to Islamist violent extremism

prison clinicians' perceptions of the efficacy of existing counter-radicalisation protocols, procedures and training for prison clinicians caring for prisoners convicted of offences relating to Islamist violent extremism

prison clinicians' perceptions of the possible risk factors and health consequences of radicalisation

Why have I been approached?

You have been asked to participate because you are a member of Spectrum Community Health CIC with an active role in the health care provision for prisoners residing in a security category A prison which may well entail caring for prisoners convicted of Islamist violent extremist offences. We are interested in learning about YOUR views and perceptions of this type of work. We intend to select participants that represent a broad range of leadership responsibilities and clinical professional roles who are actively involved in this work (i.e. GPs, nursing staff, healthcare assistants and mental health workers).

Do I have to take part?

No. It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to stop the interview at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your employment with Spectrum Community Health CIC.

What will I need to do?

If you agree to take part in the research you will be asked to take part in a semi-structured interview. This interview will explore prison clinicians' perceptions of the current and potential protocols, policies, procedures and training related to caring for prisoners convicted of Islamist violent extremism. The interview should last no more than one hour. If there are any questions during the interview which you feel uncomfortable answering, you do not have to answer these questions and this will not affect your employment rights. The interview will be audio recorded with your permission. The recording will be transcribed and anonymised by a member of the research team. Transcripts will be stored electronically on a secure computer system for five years which only the research team will have access to. The original recording will be deleted from the recording device once transcriptions are completed.

You may be invited to take part in a following focus group at a later date in which similar issues are discussed. It is hoped that this group environment will enable clinicians to 'bounce' ideas and views off one another; something that is not possible to achieve in the individual interviews.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential, (with the usual caveat that where someone indicates a risk of serious harm to themselves or others, I would need to pass this information to Spectrum Community Health CIC's Safeguarding Lead).

What will happen to the information?

All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, no individual will be identifiable from any such outputs. Participants can withdraw the information that they have provided up until 6 weeks after the interview has taken place. In order to arrange this, please send an email to the below email address requesting for your data to be withdrawn.

[fran.hankins@spectrum-cic.nhs.uk](mailto:fran.hankins@spectrum-cic.nhs.uk)

Who can I contact for further information?

If you require any further information about the research, please contact me on:

Name: Frances Maria Hankins

E-mail: [fran.hankins@spectrum-cic.nhs.uk](mailto:fran.hankins@spectrum-cic.nhs.uk)

Telephone: 01924 675167 (Extension 5167)

### **Appendix 3**

Participant consent form



#### CONSENT FORM FOR INDIVIDUAL INTERVIEWS

Title of Research Project: Prison-based clinicians and radicalisation: How can clinicians effectively engage with prisoners convicted of religiously motivated violent extremist offences for the benefit of the prisoners' health and that of the wider public?

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research as outlined in the

information sheet version 3, dated 18/08/16

I consent to taking part in it

I understand that I have the right to withdraw from the research at any time

without giving any reason

I give permission for my words to be quoted (by use of pseudonym)

I understand that I can withdraw the information given up until 6 weeks after the interview has been conducted

I understand that the information collected will be kept in secure conditions

for a period of 5 years at Spectrum Community Health CIC's head office

I understand that no person other than the researcher/s and facilitator/s will

have access to the information provided.

I understand that my identity will be protected by the use of pseudonym in the

report and that no written information that could lead to my being identified will be included in any report.

I understand that all information disclosed within the interview will be kept confidential unless I indicate a risk of serious harm to myself or others, in which case the researcher would need to pass this information to Spectrum Community Health CIC's Safeguarding Lead.

I understand that I might be invited to take part in a future focus group interview

discussing similar issues to those covered within the individual interviews.

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below.

|                           |                          |
|---------------------------|--------------------------|
| Signature of Participant: | Signature of Researcher: |
| Print:                    | Print:                   |
| Date:                     | Date:                    |

(one copy to be retained by Participant / one copy to be retained by Researcher)

## **Appendix 4**

### ***Glossary of terms***

Islamophobia: a term used to describe prejudice towards Muslims (Sadek, 2017).

Terrorist prisoner: Prisoners convicted and incarcerated for violent (operational) terrorism or non-violent terrorism (e.g. plotting terrorist attacks). These violent and non-violent terrorism-related offences can be motivated by Islamist extremism ideology or other extremist ideologies such as far right extremism. However, in the scope of this study staff will be specifically asked about Islamist violent and non-violent terrorist offenders.

Prisoners at risk of radicalisation: Pertaining to any inmates that might be radicalised by: other inmates convicted of index terrorist offences (terrorist violence i.e. operational); inmates convicted of index terrorist offences (non-violent offences e.g. downloading extremist material); inmates thought to be radicalising but not carrying index or other terrorism offences. All of the above can be motivated by Islamist extremism ideology or other extremist ideologies not relating to Islam, however, this study focuses on Islamist extremism.

Extremism: "Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas." UK Government (2011)

Radicalisation: "the process by which a person comes to support terrorism and forms of extremism leading to terrorism". The Home Affairs Committee (2012, p. 4)

Terrorism: "the use or threat of action... designed to influence the government or to intimidate the public or a section of the public... for the purpose of advancing a political, religious or ideological cause." Terrorism Act (2000)

## **Appendix 5**

Interview schedule



Miss Frances Maria Hankins

MSc by Research in Criminology and Criminal Justice

Prison-based clinicians and radicalisation: How can clinicians effectively engage with prisoners convicted of religiously motivated violent extremist offences for the benefit of their health and that of the wider public?

### Participant Interview Schedule

#### Section 1: introduction

- Introduce self - name, job title and role, a bit about my MSc project (state study aims and objectives here in brief and reason why I'm doing this study) and my interest in the area (and make this specific to my line of questioning).
- Make participants aware that all information disclosed within the interview will be kept confidential, unless any participants indicate that they or anyone else is at risk of serious harm, in which case I would need to pass this information to Spectrum Community Health CIC's Prevent / Safeguarding Lead. Explain that I am just interested in people's individual views (not the corporate/organisational line).
- Introduce a term which is widely accepted like 'countering radicalisation or extremism' and explain the definition behind this term.
- Ask participants to introduce themselves with their name, job title and a bit about their role including how long they have worked in the role and whether had/have contact with radicalised prisoners.
- Ask participants what they know of the government's expectations of them in contributing towards countering radicalisation or extremism. Be prepared here to tell them what this is, and what it means in practice (clinically and legally).
- Ask participants if they have any questions / comments before the interview questions commence.



- Ask participants if it is okay to audio-record the interview.

Section 2: prison clinicians' perceptions of the possible health determinants and health consequences of radicalisation

- What do you understand by the term 'radicalisation'? (Open question)
- What would you consider to be your level of knowledge regarding radicalisation?
- In the prison in which you practise, which potential forms of terrorism concern you?
- What do you consider to be possible early warning signs of possible radicalisation?

Section 3: prison clinicians' current engagement with and acceptance of counter-radicalisation protocols, procedures and training when caring for prisoners convicted of offences relating to Islamist violent extremism.

- Have you accessed Prevent Training?
- Please provide two key 'take home messages' which you took from the training.
- What roles, if any, do you think you should incorporate into your daily job as a prison clinician, to help with counter-extremism / radicalisation? (Prompt: What should you incorporate into your capacity, caring for prisoners convicted of violent extremist offences?)

TIP for interviewer: tease out the difference between what participants think they 'should' do, 'could' do and what they actually do.

- How do you think you should engage with prisoners convicted of violent-extremist offences?

TIP for interviewer: unpack what 'engage' means – how do participants communicate with these prisoners and what is their understanding of sympathising versus empathising with these prisoners.

- How easy or difficult do you think it is (Prompt: from clinical practise experience) or would be to engage with prisoners convicted of violent-extremist offences in the above ways?

TIP for interviewer: Identify speculation from practice here. Also tease out whether this is affected by the particular health care the participant provides.

- Have you ever had any experiences of tension / conflicts of interest between your typical health care duties and responsibilities whilst complying with the government's counter-terrorism strategies? (Prompt: provide an example of maintaining patient confidentiality versus acting as an 'informant'. Perhaps they have concerns of compromising their use of ethics within practice / perhaps feeling as if they are abusing their position? If so, how were these resolved, if at all? How did it leave the respondent feeling; personal level and professional level? Implications?)

TIP for interviewer: if clinicians state they have not had (or not knowingly had) dealings with such prisoners, ask how they think such potential conflicts of interest might arise. What challenges do they think they might encounter when engaging with prisoners convicted of violent extremist offences?

- How comfortable are you that identifying possible indicators of radicalisation is a role for prison health care staff?
- How confident do you feel in making a referral for somebody who has been (or at risk of becoming) radicalised?
- How many referrals have you made in the last year?
- If you have made a referral please describe the warning sign(s) which triggered the referral.

Section 4: prison clinicians' perceptions of the efficacy of existing counter-radicalisation protocols, procedures and training for prison clinicians caring for prisoners convicted of offences relating to Islamist violent extremism.

- What do you think of the Prevent training you received? (Prompt: was it helpful? / How could it be improved? How prepared did you feel to take on the duties that Prevent entails, having been 'trained'?)
- How easy or difficult did you find the training? (Prompts: clear / confusing)
- What is the minimum amount of training you think prison health care staff should receive for successfully supporting counter-extremism/radicalisation when caring for prisoners convicted of violent-extremist offences?
- What do you think success might look like when providing health care for prisoners convicted of violent extremist offences? (Prompt: explore role boundaries and how they could support counter-extremism/radicalisation within their day-to-day health care roles when caring for prisoners convicted of violent-extremist offences. More radically, should they support it if they feel it contravenes the principles of their roles?)

Section 5: close of interview

- Ask participants if they have any questions or further comments to make; anything that they would like to tell you which you have not already covered. Ask if there is anyone they think I should talk to that would be especially useful?
- Ask participants if they would be happy to potentially participate in a focus group interview with other prison health clinicians in future.
- Thank participants for their time – reinforce confidentiality, tell them what will happen to data, how used.

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